Evidence Based Treatments for Borderline Personality Disorder

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Overview of Goals

- Define evidence based treatments
- Brief review of Borderline Personality Disorder (BPD)
- Brief review of empirical evidence for specific treatments for BPD
- Introduction to two evidence based treatments for BPD:
  - Dialectical Behavior Therapy
  - Transference Focused Psychotherapy
What is Evidence Based Treatment?

"clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population" - Chambless & Hollon, 1998

• Empirically supported treatments (ESTs) are those that have been shown to be superior in efficacy to a placebo or other treatment

• The Task Force criteria for a treatment to be considered well-established include:

  1. At least two good between-groups design experiments or 10 or more single-case design experiments by at least two different investigators demonstrating a treatment’s superiority to a pill, psychological placebo, or other treatment, or demonstrating a treatment’s equivalence to an already existing (well-established) treatment;

  2. Treatment manuals are required in the studies; and

  3. Patient characteristics must be clearly specified in the studies.
Borderline Personality Disorder

- Borderline personality disorder (BPD) is a prevalent, chronic, and debilitating disorder
  - High rates of self-injury, suicide attempts, and early mortality from suicide and illness-related complications
  - High rates of psychiatric comorbidity
  - Frequent and chaotic use of health services
Evidence-Based Treatments for BPD

- At least 7 specialized treatments for BPD have been empirically supported in controlled trials
  - Dialectical Behavior Therapy (DBT)
  - Mentalization Based Therapy (MBT)
  - Transference Focused Psychotherapy (TFP)
  - Schema Focused Therapy (SFT)
  - Cognitive Therapy (CT)
  - Systems Training for Emotional Predictability and Problem Solving (STEPPS)
  - General Psychiatric Management (GPM)
Evolution of BPD Diagnosis: Origins as a Psychoanalytic Concept

- Stern (1938) and Knight (1953)
  - Patients who regressed in unstructured treatment
  - Thought to be on the borderline of neurosis and psychosis
  - Affective lability, unstable relationships, transient psychotic symptoms, impulsivity, chronic suicidality

- Kernberg (1967)
  - Broad level of personality organization
  - Explicit description of clinical characteristics that differentiated borderline personality from neurosis and psychosis
Evolution of BPD Diagnosis:
BPD as a Syndrome

- BPD was articulated as a syndrome by Grinker (1968) in the first empirically-based criterion set:
  - Failures in self-identity
  - Anaclitic relationships (characterized by strong dependence on another)
  - Depression based on loneliness
  - Predominance of expressed anger
Borderline Personality Disorder: Current DSM IV-TR (APA, 2000) Criteria

- A pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts as indicated by 5 or more of the following:
  - Frantic efforts to avoid real or imagined abandonment
  - A pattern of unstable and intense interpersonal relationships characterized by alternating extremes of idealization and devaluation
  - Identity disturbance: markedly and persistently unstable self-image or sense of self
  - Impulsivity in at least 2 areas that are potentially self-damaging (spending, sex, substance abuse, reckless driving)
  - Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior
  - Affective instability due to marked reactivity of mood (i.e., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours to a few days)
  - Chronic feelings of emptiness
  - Inappropriate, intense anger or difficulty controlling anger (i.e., frequent displays of temper, constant anger, recurrent physical fights)
  - Transient stress related paranoid ideation or severe dissociative symptoms
To diagnose BPD, all of the following criteria must be met:

A. Significant impairment in personality functioning, manifest by:
   1. Impairments in self functioning (identity or self-direction)
   2. Impairments in interpersonal functioning (empathy or intimacy)

B. Elevated personality traits in the following domains:
   1. Negative affectivity (emotional lability, anxiousness, separation insecurity, depressivity)
   2. Disinhibition (impulsivity, risk taking)
   3. Antagonism (hostility)

And the above impairments must be:

C. Relatively stable across time and consistent across situations.

D. Not better understood as normative for the individual’s developmental stage or socio-cultural environment.

E. Not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).
Prevalence of BPD

- Estimates suggest that BPD occurs in:
  - 1-4% of community samples
  - 6% of primary care samples
  - 10-11% of psychiatric outpatients
  - 15-20% of psychiatric inpatients
• 30-60% of patients diagnosed with other PDs also meet criteria for BPD
  – BPD is the most common personality disorder around the world

• Approx. 75% of those with BPD in clinical settings are women
  – Recent evidence suggests that there is no discernable sex difference for the occurrence of BPD in the general community
  – Men with behaviors that would meet criteria for BPD may be more likely to get an Antisocial PD diagnosis, whereas women are more likely to get a BPD diagnosis
Onset between adolescence and early adulthood
  – BPD is usually first diagnosed between ages 18-25
  – Diagnosis often does not become apparent right away

Diagnostic Signs:
  – high levels of dysphoria, esp. in context of interpersonal distress
  – long-standing pattern of emotional and behavioral dysregulation
  – a pattern of reactions to real or perceived loss, betrayal, or disloyalty with depressive symptoms, suicidal gestures, angry outbursts, or self-destructive behavior
  – emptiness and loneliness
  – oscillation from idealization to devaluation
  – dichotomous thinking
  – chaotic use of mental health & medical services
  – several comorbid Axis I diagnoses across multiple categories (e.g., mood, anxiety, eating, and substance-related disorders)
“Complex Comorbidity”

- A pattern of “complex comorbidity” may be a prominent marker for BPD (Zanarini et al., 1998)
  - Comorbidity of internalizing and externalizing spectrum disorders
  - Lifetime rates of Axis I disorders in 379 BPD patients:
    - 96% Mood Disorders
    - 88% Anxiety Disorders
    - 64% Substance Use Disorders
    - 53% Eating Disorders
- One study found that 98% of 59 BPD patients had a concurrent Axis I diagnosis; almost 70% had 3 or more Axis I diagnoses (Zimmerman & Matia, 1999)
Axis II Comorbidity

- Nearly 95% of patients meeting criteria for BPD also meet criteria for at least one other personality disorder (Widiger et al., 1991)
  - Frequently comorbid with other cluster B disorders and with schizotypal PD
Effects of Comorbidity

- Presence of BPD at intake is associated with poor short and long-term outcome of Axis I disorders
  - Presence of BPD in those with comorbid bipolar disorder negatively affected clinical course of bipolar, but presence of bipolar did not affect course of BPD (i.e., remission rates, functional adjustment, or treatment utilization) *(Gunderson et al., 2006)*
  - BPD needs to be assessed and should take precedence in treatment plan
Evidence supports the construct validity and reliability of BPD diagnosis in adolescence
- Diagnostic signs: patterns of affective instability, aggression, and impulsivity since early childhood
- Important to address BPD symptoms early
- Evidence for efficacy of DBT modified for adolescents
Course

- Little is known about the course of the disorder without treatment
- Data suggest that the majority of BPD patients no longer meet criteria for the disorder by middle age
  - Even those who remit still show severe impairment in functioning, esp. social function (Zanarini et al., 2011)
  - Considerable heterogeneity in longitudinal course (Lenzenweger, 2010)
  - Of Axis I comorbid disorders, co-occurring substance use disorders are most associated with failure to remit (Zanarini et al., 2004)
Some evidence indicates that older BPD patients are less impulsive and less likely to deliberately self-harm (Blum et al., 2008; Shea et al., 2009; Stevenson et al., 2003)

- Those who initially improve may eventually show a reversal of this improvement in later life
- Older pts tend to have worse physical health, greater health care utilization, are more likely to be on disability, and are more socially isolated
Suicide Risk

• At least 75% of those with BPD attempt suicide
  – Approx. 10% eventually complete suicide

• Factors that incr. risk for suicidal behavior:
  – Prior attempts
  – Comorbid MDD
  – Substance use disorder
  – Hoplessness
  – Impulsivity
  – Turbulent early life
  – Antisocial traits

• Chronic suicidality should be taken seriously by clinicians
  – “clinicians must avoid the mistake of thinking that a pattern of repeated attempts indicates little desire to die” – Black et al., 2004
Etiology

- Risk factors seem to be nonspecific to BPD in particular, but rather, seem to set the stage for a number of impulsive-spectrum psychopathologies
  - Neurological functioning
  - Genetic trait dispositions
  - Trauma, abuse, neglect, and family environment
- Most etiological theories emphasize interaction between biological disposition (e.g., biological vulnerability to emotional dysregulation, constitutional aggression) and environmental adversity (e.g., invalidation, trauma, inadequate parenting)
Psychopharmacological Treatment

- Psychotherapy is considered the best treatment for BPD
- Medications are often used to treat individual symptoms
  - Antipsychotics for paranoid thinking, mild thought disorder, and irritability
  - Mood stabilizers for impulsivity and behavioral dyscontrol
  - SSRIs for depression and impulsive aggression
- MAOIs and tricyclics are not recommended for suicidal or self-injurious patients
  - Both are lethal and can be used to self-harm
BPD patients are typically prescribed several different classes of medications
  – Only moderately effective (~50% response rate)
  – Medications may lose efficacy over time
  – Overmedication over long periods of time may lead to metabolic syndrome

Medications don’t change underlying personality problems -- best used as supplement to psychotherapy, not as primary treatment
Effectiveness of Specialized Treatments for Borderline Personality Disorder: A Brief Review of Empirical Studies
Dialectical Behavior Therapy (DBT)

- Adaption of CBT consisting of individual therapy, telephone coaching, and group psychoeducation
- Targets emotion dysregulation and impulsive behaviors
- By far, the most-studied of all specialized treatments for BPD, with more than 3 dozen studies
• DBT is generally superior to TAU in reducing self harm, parasuicidal behavior, and suicidal ideation (Linehan et al. 1991, 1999, 2002; Koons et al., 2001)
  – Two studies suggested DBT also superior for reducing depression, anxiety, and hospital admissions, and improving treatment retention
  – One study failed to show difference between DBT and TAU in reducing suicidal behavior (Verheul et al., 2003)
DBT vs. Treatment by Experts
(Harned et al., 2008; Linehan et al., 2006)

- DBT more effective than tx by experts in:
  - Remission of co-occurring substance-dependence disorders (Harned et al., 2008)
    - But no differences in remission of other Axis I disorders
  - Tx retention and reducing suicide attempts, hospitalizations, ER visits, medical risk of acts of self-harm (Linehan et al., 2006)
DBT Skills Training
(Soler et al., 2009)

- DBT skills training was more effective than non-manualized standard group therapy in:
  - Treatment retention
  - Reducing depression, anxiety, irritability, anger, affective instability, and general psychiatric symptoms
DBT vs. Client-Centered Therapy
(Thornton et al., 2000)

- DBT was superior to client-centered therapy in reducing
  - Parasuicidal behavior
  - Suicidal ideation
  - General psychiatric severity
- DBT was not superior in reducing anxiety
DBT vs. Transference Focused Psychotherapy and Supportive Psychotherapy
(Clarkin et al., 2007)

- 90 patients randomized to one of 3 treatments by expert clinicians: DBT, TFP, and dynamic supportive psychotherapy

- Transference Focused Psychotherapy (TFP)
  - Structured, manualized psychodynamic treatment
  - Twice-weekly individual psychotherapy with hierarchy of tx targets
  - Emphasis on here-and-now relationship between patient and therapist
  - Goals: integration, modulation, and enrichment of polarized affective states and concepts of self and others
DBT vs. TFP vs. Supportive
(Clarkin et al., 2007; Levy et al., 2006)

- All 3 treatments were effective in:
  - reducing depression and anxiety
  - improving global fx and social adjustment

- Differences between treatments:
  - Only TFP and DBT showed improvements in suicidality
  - Only TFP and supportive therapy showed improvements in anger and impulsivity
  - Only TFP was associated with change in irritability and assault
  - Only TFP led to increases in attachment security and mentalization, i.e., ability to reflect on mental states in self and others

- Recent study provided further evidence of efficacy of TFP over treatment by experienced community therapists (Doering et al., 2010)
DBT vs. General Psychiatric Management
(McMain et al., 2010)

• DBT was compared to General Psychiatric Management delivered by experts

• General Psychiatric Management (GPM)
  – Developed Based on American Psychiatric Association guidelines for treatment of BPD
  – Consists of psychodynamically informed therapy and symptom-targeted medication management
  – Targets impaired attachment relationships
DBT vs. General Psychiatric Management

(McMain et al., 2010)

- DBT and GPM were efficacious across a broad range of outcomes, with no between-group differences in improvement
  - Suicide attempts and self harm episodes: frequency and medical risk
  - Health care utilization: emergency room use and psychiatric hospital days
  - General symptoms: Depression, anger, interpersonal functioning, symptom distress
  - BPD symptoms
Two years post-treatment, both DBT and GPM had further improved or maintained gains

**Significant further improvements:**
- Frequency of suicidal and self-harm behaviors
- Anger, interpersonal functioning, and symptom distress
- Overall quality of life
- Depression (further improvements in GPM only)

**Maintenance of gains:**
Psych hospital days, BPD symptoms, medical risk of suicidal behaviors, ER visits, Depression (DBT)
Mentalization Based Therapy  

- Manualized psychoanalytic treatment that focuses on increasing mentalizing capacities in BPD patients
  - Goal is to increase the ability to make sense of oneself and others on the basis of intentional mental states (e.g., desires, feelings, beliefs)
- Two RCTs have demonstrated effectiveness of 18 months of MBT in both day hospital and outpatient settings
  - Demonstrated maintenance of treatment effects at 18 month follow-up
  - Continued maintenance of treatment effects 5 yrs after MBT was complete, but general social fx remained impaired
Schema-Focused Therapy

- Schema-Focused Therapy (SFT)
  - Integrative cognitive therapy
  - Goal is to change personality structure
- Three years of SFT compared to TFP (*Giesen-Bloo et al., 2006*)
  - Higher dropout in TFP
  - Both groups improved, but more SFT patients recovered or improved in terms of BPD severity, general dysfx, personality concepts, and quality of life
- Interpret with caution -- TFP group included twice as many recently suicidal pts, and group differences were only apparent in intent-to-treat analyses (includes those who dropped out) and not in completer analysis (includes only those who stayed in treatment)
Meta-analysis of 41 Trials of Psychotherapy for BPD
(Ellison et al., presented at 2010 SPR meeting, manuscript in prep)

• Psychotherapy is effective for BPD!
  – Average ES ($d$) = .904 (95% CI: 0.757, 1.052)
  – Effect size difference between controlled and uncontrolled trials was not significant

• Effect size difference between dynamic and CBT/behavioral therapies was not significant
What have we learned about treatments for BPD?

- BPD is a treatable disorder
- The most efficacious treatments for BPD are those that are:
  - *well-structured*
  - *specialized* (specifically tailored to BPD)
  - delivered by clinicians with *expertise* in treating this patient population
What have we learned about treatments for BPD?

• Beyond evidence that structured and specialized treatments are better than TAU, there is no clear evidence that one specific form of therapy for BPD is superior to another

   “…it remains unclear what the therapeutic factors are beyond the use of a highly structured program for the treatment of personality disorder.” --Bateman & Fonagy, 1999

• Need to clarify: *What works for whom, and under what conditions?*
  • Is DBT more effective with suicidal or self-injuring patients?
  • Are structured dynamic therapies such as TFP more effective for those with aggression and/or relational problems?
Transference Focused Psychotherapy for Borderline Personality

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Goals of this Presentation

• Provide an *overview* of TFP
  – Theoretical underpinnings
  – Structure of the treatment
  – Strategies, tactics, and techniques

• **Not** a comprehensive TFP training
  – Conducting TFP, esp. with difficult-to-treat clients, requires specialized training
  – Background knowledge of contemporary psychoanalytic and object relations theories and basic psychodynamic principles is helpful
  – Supervision and peer consultation are crucial to treating BPD clients with this approach
TFP Manuals & Resources


Training Programs, Seminars, and Workshops in TFP

- Personality Disorders Institute of the Weill Medical College of Cornell University
  http://www.borderlinedisorders.com

- Columbia University Center for Psychoanalytic Training and Research TFP training program
  http://wwwpsychoanalysis.columbia.edu/train/psychotherapy-programs/transference-focused-psychotherapy-program
What is Transference Focused Psychotherapy?

• Transference Focused Psychotherapy (TFP) is a **structured** psychodynamic treatment specifically tailored to BPD based on a **contemporary object relations theory** of borderline pathology

• Manualized, but the manual is principle-based
  – Manual does not give session-by-session treatment plan
  – Organized around a cohesive theory of borderline personality and treatment principles derived from extensive clinical experience treating BPD clients
What TFP is and is not

• TFP is different from traditional psychoanalysis
  – Therapist and client sit face-to-face
  – Therapist is more active and expressive
  – Treatment is more structured (hierarchy of targets, consistent treatment frame, treatment contract, and boundary setting)
  – Focus is on here-and-now, not uncovering the past

• TFP is different from behavioral and cognitive treatments
  – Focus on underlying personality structure rather than directly on symptoms
  – Focus on unconscious defenses and internal conflicts rather than deficits in skills or conscious cognitions
  – Technical neutrality
Basic concepts in object relations theory:
- The self develops in a relational context
- Patterns of interaction with highly significant others under conditions of peak affect are internalized as memories, expectancies, and templates for self in relation to others (“representations”)
- Representations (internalized images of self and others) organize experience going forward
Object Relations Dyads

Self \(\text{AFFECTS}\) Other
Psychodynamic Model of Borderline Personality Organization

- TFP is based on the assumption that borderline symptoms arise from a chronic and stable lack of integration of internal personality structures.

- Representations of self and others (and affects associated with them) tend to be polarized, negatively tinged, chaotically shifting, and poorly modulated.
  - All-bad representations of self and others associated with intense negative affects tend to predominate the BPD client’s experience.
  - Contradictory aspects of self and others are unintegrated, i.e., one cannot be angry and love the other concurrently.
  - Lack of integration is a defensive process.
Integrated Representations of Self and Others

“I’m not proud of how I behaved, but I’m not an evil person”

“I’m angry at you right now, but I still love and value you”
Lack of integration: “Splitting”

- Clinical manifestations (what you see):
  - Lack of awareness of explicit contradictions
  - All-or-nothing cognition and inability to experience ambivalence (mixed feelings)
  - Rapid shifts between idealization and devaluation of others, shifts in attachments, and chaotic relations
  - Extremes of affect (rage, adulation, panic, anhedonia)
  - Rapid oscillations in goal-directed behavior, conceptions of personality identity, self-esteem
  - Inability to foresee consequences of intentions/behaviors
  - Relating to different others in markedly different and limited ways
Goals of TFP

• TFP attempts to integrate the split internal structures that are thought to give rise to BPD symptoms
  – Goal is to change structure, change interpersonal patterns, and increase insight in order to change symptoms
  – TFP does address symptoms, but not necessarily directly at the surface… addresses the underlying vulnerabilities that cause the symptoms
  – TFP aims to facilitate maturation along developmental continuum of personality organization
Strategies: Long-term Objectives

• Primary strategy in TFP is the facilitation of the reactivation in the treatment of object relations (i.e., transference) in a safe environment

• Activation of transference leads to the experience of affects and conflicts in the here and now, and the therapist helps the client to:
  – Gain and tolerate awareness of these internal relationship representations and their associated affects
  – Recognize distortions of real relationships and develop more realistic, integrated representations of self and others
  – Generalize the experience in therapy to other relations
Treatment Contraindications

• TFP is *contraindicated* for severely disorganized, psychotic, or with cognitively impaired clients
  – Requires shared concept of reality, differentiation of self from others, and ability for abstract thinking
Tactics: Tasks and Conditions for Treatment

• Set the treatment contract
• Select focus of attention and intervention
• Maintain common perceptions of reality
• Analyze both positive and negative transferences
• Regulate the intensity of affective involvement
Beginning Treatment

• Pre-treatment
  – Evaluation sessions
    • First 2-4 sessions are a consultation to assess client’s needs and how can be most helpful
    • Structural diagnosis using “structural interview” – assessment of symptoms and personality structure, level of functioning, quality of object relations, characteristic defenses, etc.
  – Contracting sessions
  – Family sessions (optional)

• Therapy
Functions of the Contract

• Defining client and therapist responsibilities
• Protecting therapist’s ability to think clearly
• Providing a safe place for the client’s dynamics to unfold
• Setting the stage for interpreting the meaning of deviations from the contract
• Providing an organizing therapeutic frame that permits therapy to become an anchor in the client’s life
Standard Content of the Treatment Contract

• Client Responsibilities
  – Attendance and participation
  – Paying fee
  – Reporting thoughts and feelings without censoring

• Therapist Responsibilities
  – Attending to the schedule
  – Making every effort to understand and, when useful, to comment
  – Clarifying the limits of the therapist’s involvement (e.g., phone contact, overt ‘support’)

• Predicting threats to treatment and establishing parameters to address them
Contract: Suicidality and Self-harm

• Client must agree to take responsibility for staying alive and safe
  – Clients are asked to go to the ER if they feel that they cannot control impulses to self-harm
  – Urges and actions for self-harm are top priority for discussion
  – Goal is to control these impulses and examine the affects and relational themes that are underlying them
  – Controlling the impulses generally makes the affect more intense and available to be examined in treatment

• If therapist recommends hospitalization, client must be willing to follow therapist’s recommendation in order for treatment to continue
Hierarchy of Thematic Priority

Highest priority: behaviors that threaten the safety of the client, therapist, others, or the treatment.

Order of priority:
1. Obstacles to transference exploration
2. Overt transference manifestations
3. Nontransferential affect-laden material
Techniques of TFP

- Conducting transference analysis (systematic analysis of distortions in the relationship)
- Interpretive process:
  - Clarification
  - Confrontation
  - Interpretation
- Managing technical neutrality (attitude of concerned objectivity)
  - Neutrality does not imply indifference or emotional distance from client
  - Neutrality means not “taking sides” among conflicting experiences within the client (e.g., the part of the client pushing them to act on conflictual motivation or impulse, vs. part of client that wants to inhibit that impulse, and the reality demands on the client)
  - Deviations from neutrality are necessary at times to control dangerous behavior (e.g., suicidality) or treatment-interfering behavior
- Utilizing countertransference awareness
Transference Interpretation Process

- Series of interventions that build on one another
  - Clarification brings into focus material that is already in client’s conscious awareness… elaborating particular activated representations of self and other and associated affects (naming the players)
  - Confrontation brings other aspects that the client is only partially aware of into focus… how client sometimes takes on the opposite role in the dyad
  - Interpretation attempts to bring to light how certain aspects of client’s experience defend against other aspects that are outside their awareness
- May take many sessions to complete a single cycle of interpretation, or there may be many completed cycles in one session
Techniques: Clarification

- Statements used to call attention to potentially important material that the client is bringing up
- Provides material for interpretation by clarifying:
  - Client’s perception of self in the moment
  - Client’s perception of others (incl. therapist)
- Requesting information, not offering clarification
  - Questioning, restating, making observations (without inference)
- Examples:
  - “Help me understand that”
  - “It’s as though you’re seeing me as ______”
  - “I wonder if you think that I’m ______”
  - “You seem to be experiencing yourself as ______”
- Predominant mode of intervention early in treatment, although used throughout treatment
Techniques: Confrontation

- Used to promote self-reflection, awareness, and separation-individuation.
- Calls attention to polarized or contradictory aspects of client’s behavior or dynamics, and invites client to reflect on these different aspects.
- Provides opportunities for integrating conflicting aspects of client’s experience.
- Must be made from an empathic position, not critical, hostile, punitive, or challenging.
  - Honest inquiry into an apparent contradiction in client’s verbal and non-verbal communication.
Confrontation: Examples

- “You say you’re committed to our work together, yet you’ve missed the last two sessions without contacting me, and you’ve hardly said a word since you’ve come in today. What could be going on?”
- “You’re saying you’re furious, but you’re looking at me with a smile…”
- “You confirm that what I’m saying is important, yet you immediately switch the topic… do you notice that happening?” and follow-up, “How do you understand that?”
Techniques: Interpretation

• A hypothesis about unconscious determinants of present experience, and an attempt to increase the client’s awareness of the impact of unconscious material on their thoughts, affects, and behaviors
  – Links client’s manifest material to unconscious influences, with goal of expanding self-awareness of needs wishes, fears, etc.
• Frequency increases as therapy progresses
• Most impactful with “hot” topics – when client is affectively engaged in the experience being interpreted (as long as client is not too dysregulated to receive it)
Interpretation with BPD Clients

- Interpretation spells out the nature of the object relation that is activated and then makes an inference about the potential defensive function:
  - “You experience me right now as a neglectful, withholding therapist and you feel unimportant, insignificant, and abandoned, which leaves you feeling sad and angry. But, could it be easier to see me as totally neglectful, even negligent, than to realize that I could care about you but also have limitations on the extent of care I can provide for you?”
Indicators of Integration and Structural Change

• Client’s comments indicate reflection on and exploration of therapist’s interventions
  – Client is able to accept the interpretation of defense mechanisms
  – Client can contain and tolerate the awareness of hatred (or other aggressive affects) and fantasies
• Can experience guilt, express gratitude, and mourn loss of idealized conceptualizations of self and others
• Client can tolerate and reflect on having mixed feelings or having contradictory thoughts and emotions at the same time:
  – “A part of me wants to get better and live a healthier, happier life, but another part of me is afraid of what this might mean and would rather stay where I am…”
  – “I love my wife dearly and respect her, but I find myself feeling angry and resentful when she…”
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Brief Overview of Dialectical Behavior Therapy

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Goals of this Presentation

• Provide an overview of DBT
  – Brief history of development of the treatment
  – Theoretical Underpinnings
  – Treatment targeting and Intervention Strategies
  – Standard Modes of Intervention

• Resources for Comprehensive DBT Training:
  – http://behavioraltech.org/
  – http://www.ticllc.org/

Other DBT Books and Supplements to the Manual

Dialectical Behavior Therapy

- Developed by Marsha Linehan, PHD through an iterative process in the 1980’s
- Originally developed for people with chronic suicide ideation, multiple suicide attempts, and non-suicidal self-injury
- Initial efforts were to provide standard CBT treatments
- CBT treatments applied to identified problems on their own failed and Acceptance strategies were added
- Treatment manual published in 1993
- Now widely applied to a wide category of multi problem, complicated clients for whom traditional treatments have failed
What is DBT?

- DBT is a principle driven treatment that includes protocols.
- DBT provides guidelines for what to do when in complicated situations
- DBT is flexible and adapts as the evidence base for treatment of specific problems changes
How is DBT different from other treatment for Borderline PD?

• Therapist stance: nonjudgmental, nonpejorative, and collaborative
• Therapist-client relationship marked by transparency
• Focus is on changing behavior (Behavior Therapy is the backbone of DBT)
• Adds acceptance based strategies
• Client treated as an equal who is capable of changing
• Emphasizes importance of providing support to therapists
• BPD is a disorder of the emotion regulation system

• BPD behaviors function:
  – to regulate emotions
  – or are a natural consequence of emotion dysregulation
Behavioral Conceptualization

Cue, Trigger, Prompting Event

Emotion Dysregulation

Escape Avoid

Problem Behavior

Temporary Relief
Bio Social Theory

Biological Vulnerability

Invalidating Social Environment

Pervasive Emotion Dysregulation
Biologic Vulnerability

More, Faster, Stronger, Longer

• High Sensitivity
  – Quick reactions at lower thresholds

• High Reactivity
  – Intense emotional arousal contributing cognitive dysregulation

• Slow Return to Baseline
  – Emotional arousal lasts longer before return to baseline
Invalidating Environments

• A person is born into a social environment that is unable to teach the person how to manage in life with the emotional biology he/she has

• The environment persistently dismisses, ignores, negates primary emotional responses independent of the validity of the response

• In the most extreme situations, invalidating environments are abusive or neglectful
DSM Criteria Reorganized

• Emotion Dysregulation (Affective Instability)
• Interpersonal Dysregulation (Frantic Avoidance of abandonment and Chaotic Relationships )
• Self Dysregulation (Identity Disturbance and chronic feelings of emptiness )
• Behavioral Dysregulation (Recurrent suicidal behaviors and other impulsive behaviors )
• Cognitive Dysregulation (Transient Stress Related dissociation and paranoia )
Behavioral Targeting

• Stages of Treatment
  – Stage 1
    • Severe Behavioral Dyscontrol
  – Stage 2
    • Quiet Desperation
  – Stage 3
    • Problems in Living
  – Stage 4
    • Incompleteness
Stage 1 Primary Targets

Focus on Improving Behavioral Control

• Decrease
  – Life Threatening Behaviors
  – Therapy Interfering Behaviors
  – Quality of Life Interfering Behaviors

• Increase Behavioral Skills
  – Mindfulness
  – Interpersonal Effectiveness
  – Emotion Regulation
  – Distress Tolerance
  – Self-Regulation
Secondary Targets

- Unrelenting Crises
- Apparent Competence
- Self-Invalidation
- Active Passivity
- Emotion Vulnerability
- Inhibited Emotional Experiencing
Defining Dialectics

Two contradictory viewpoints that co-exist in the world

Change comes about from synthesis between the two ideas
Core Dialectic in DBT

Change versus Acceptance
DBT: Therapist Strategies

- Change
  - Irreverence
  - Problem Solving
  - Consultation to the Client

- Acceptance
  - Reciprocity
  - Validation
  - Environmental Intervention

- Consultation team

Consultation team
DBT: Standard (Used in Research) Modes

- Outpatient therapy
- Outpatient skills training (usually group)
- Telephone Consultation
- Therapist consultation team
- Uncontrollable ancillary treatments
  - Pharmacotherapy
  - Therapeutic/residential school programs/inpatient units/etc
ONE primary therapist per patient. Therapist is responsible for:
• Treatment Planning
• Ensuring progress toward all DBT targets
• Integrating other modes of therapy
• Consultation-to-the-patient on effective behaviors with every other provider (DBT and Non-DBT)
• Everyone works for the patient and reports to the primary therapist
• Management of crises and life-threatening behaviors
Structure of the Individual Session

- Warm greeting
- Diary card review
  - (if no diary card, do chain analysis/problem solving and have client do diary card in session)
- Set agenda based on the hierarchy of problem behaviors noted in diary card
- Wind down toward the end of session with less painful topics
DBT Problem Solving (Change) Strategies

- Behavioral Analysis
- Insight
- Solution analysis
- Skills training
- Contingency management
- Exposure
- Cognitive Modification
- Didactic
- Orienting
- Commitment
Case Formulation

**Chain Analysis**

What happened moment to moment that led to the problem behavior and what consequences maintain it?

- Gather History to determine stage of treatment
- Identify specific target behaviors and their priority for intervention
- Do Chain Analysis of Problem behaviors as they arise
- Look for patterns of controlling variables for each primary target
Structure of Skills Training Sessions

- Skills training is usually done in groups
- Primary goal of skills training is to teach skills
  - Client sometimes describe group as a “class” versus a “therapy” group
  - Therapist does not attend to group “process” issues as a primary change mechanism
- Some groups open or close with a mindfulness exercise
- Key components are:
  - Homework/diary card review
  - Teach new skills
Telephone Consultation

• Enhances generalization of behavior change to life
• Reasons to call
  – Coaching in a crisis *before* client has engaged in the problem behavior
  – Repair any problems/issues in therapy relationship prior to the next session
  – Provide the therapist with *good* news
• Calls are generally short, focused, and collaborative
Consultation Team

• Enhances therapist capability and motivation
• Therapy for the therapist
• Structure:
  – Team Mindfulness practice
  – Read a consultation agreement
  – Set agenda
  – (brief) Administrative Issues (associated with the team, not the program)
  – Teaching/Consultation
  – Prepare for next meeting