What is BPD?

“The disorder that doctors fear most”
(Time, 2009 Jan)

1. Patient anger
2. Suicide attempts
3. Threats of suicide
(Hellman et al., 1988)


Emotion Dysregulation
1. Affective lability
2. Problems with anger

Interpersonal Dysregulation
3. Chaotic relationships
4. Fears of abandonment

Self Dysregulation
5. Identity disturbance/confused sense of self
6. Sense of emptiness

Behavioral Dysregulation
7. Intentional self-harm
8. Impulsive behavior

Cognitive Dysregulation
9. Dissociative responses &/or paranoid ideation

(Re-organized)

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: 5 of 9 criteria (pervasive) ⇒ 126 combinations

DBT theory & Conceptualization

Causes of BPD
BPD : Genetic vs. Cultural?

- Genetic effects – 45% variance
- Unique environmental effects – 55% variance (family relationship & childhood trauma)
- Gene-environment interaction:
  - Those with “sensitive” genotype will be at greater risk to develop BPD if an undesirable environment is present

Distel et al., *PLoS ONE*, 2009

BPD is a Pervasive Disorder of the Emotion Regulation System

BPD criterion behaviors function to regulate emotions or are a natural consequence of emotional dysregulation

Conceptual Model: The Biosocial Theory of DBT

- **BIOLOGICAL** predisposition to more frequent and intense emotions
- **ENVIRONMENT** failed to:
  - Provide skills for managing frequent and intense emotions and/or
  - Made emotionality worse through trauma, neglect, abuse, or other invalidation

BPD results from transaction of biological vulnerability with invalidation over time

Emotion Vulnerability

- **High sensitivity**
  - Immediate reactions
  - Low threshold for emotional reaction
- **High reactivity**
  - Extreme reactions
  - High arousal dysregulates cognitive processing
- **Slow return to baseline**
  - Long-lasting reactions
  - Contributes to high sensitivity to next emotional stimulus

Emotion Dysregulation

Inability to Modulate Emotions

Emotional Vulnerability
Invalidating Environment

Punishes or ignores behavior or the internal experience of the person independent of actual validity or importance

Characteristics of an Invalidating Environment

1. **INDISCRIMINATELY REJECTS** communication of private experiences and self-generated behaviors
2. **PUNISHES** emotional displays and **INTERMITTENTLY REINFORCES** emotional escalation
3. **OVERSIMPLIFIES** ease of problem solving and meeting goals

Types of Invalidating Families

- Chaotic Family
- Perfect Family
- Ordinary Family

Linehan Biosocial Theory

- Emotional dysregulation in child (diathesis) and a failure to validate the child's feelings by the parents (stress) leads to a vicious cycle.
- The emotional dysregulation may be inadvertently reinforced by parents if it becomes one of the only times the child receives parental attention.

DBT Bio-Social Theory

- Informs the treatment approach
- Engenders attitude of effective compassion
- Provides a framework for the therapist in interacting with the person
- Defines relationship between presenting problems and treatment

Pervasive Emotion Dysregulation
Evidence based treatment for BPD

BPD is under-diagnosed & under-treated

- Despite high prevalence, high impact, high comorbidities and good inter-rater reliability, attention to BPD remains woefully low relative to that paid to other major psychiatric disorders.
- The diagnosis is underused and most mental health professionals avoid or actively dislike patients with BPD.
- Treatment nihilism?

BPD Medications: Treat comorbidities!

- 84.5% of BPD patients met criteria for Axis I disorder, mean = 3.2
- Most common =
  - Mood Disorders (bipolar disorder I and II, major depression, dysthymia)
  - Anxiety disorders, including PTSD
  - Substance use disorders
  - Others: Eating disorder, other personality disorder, ADHD

Medications and BPD

- Medications are most useful for treating underlying symptoms of anxiety, depression, and impulsiveness.
- Anti-depressants (SSRI’s) – help to regulate depression and labile moods.
- Mood Stabilizers – help to regulate emotions and reduce impulsiveness and anger.
- Atypical Antipsychotics – help reduce impulsive and reckless behavior.

Evidence based Psychotherapy for BPD: meta-analysis (Stoffers JM, 2012)

- Studies identified: 28 RCTs (n=1804) met the inclusion criteria (1950~2010).
- Both comprehensive and non-comprehensive psychotherapies have shown some benefit for BPD core pathology and associated general psychopathology, with DBT being the most studied technique.
- only DBT has sufficient studies to pool the results & draw conclusion
DBT Outcomes

**Reduces:**
- Suicidal behaviors
- Intentional self-injury
- Substance dependence
- Depression
- Hopelessness
- Anger
- Eating disorders
- Impulsivity
- Dissociation
- Anxiety
- **BPD severity**

**Increases:**
- Adjustment (general & social)
- Positive self-esteem
- Interpersonal relation

Prediction of Effective Psychotherapy for BPD (Omar, et al. 2014, July)

- Systematic review and subgroup analysis in 25 RCT
- Significant reductions in self-harm and depression and improvement in social functioning was found for treatments that include **more than one session per week** and those that included **group-based sessions**, but were **not found for those that deliver in individual sessions or one or few sessions per week**.

Four Essentials of Effective BPD Treatment

1. Establishment of a strong therapeutic alliance
2. Availability of skilled therapists
3. Funds / insurance coverage
4. Time

- **THERE IS NO QUICK FIX**

Introduction of dialectical behavior therapy for BPD

DBT is designed for the **severe and chronic, multi-diagnostic, difficult-to-treat patients**

with **both Axis I and Axis II disorders**

DBT is a comprehensive **principle-driven** treatment that includes **protocols** that tell you **how to figure out what to do**
Structure the Philosophy of Care

Behavioral Science
Mindfulness
Dialectical Philosophy

Structure Treatment Assumptions:
DBT Assumptions about Patients

1. Patients are doing the best they can
2. Patients want to improve
3. Patients need to do better, try harder, and/or be more motivated to change
4. Patients must learn new behaviors in all relevant contexts
5. Patients cannot fail in DBT
6. Patients may not have caused all of their own problems, but they have to solve them anyway
7. The lives of suicidal, BPD individuals are unbearable as they are currently being lived

Structure Treatment Assumptions:
DBT Assumptions about therapy

1. The most caring thing a therapist can do is help patients change in ways that bring them closer to their own ultimate goals
2. Clarity, precision, and compassion are of the utmost importance in the conduct of DBT
3. The therapeutic relationship is a real relationship between equals
4. Principles of behavior are universal, affecting therapists no less than patients
5. DBT therapists can fail
6. DBT can fail even when therapists do not
7. Therapists treating BPD patients need support

DBT Structure treatment by 5 Functions

1. Enhance client capabilities
2. Improve motivation for treatment
3. Assure generalization of new behavior to all relevant contexts
4. Structure the treatment environment
5. Enhance therapist capabilities and motivation to treat effectively
Standard DBT Modes

• Outpatient Individual Psychotherapy
• Outpatient Group Skills Training
• Telephone Consultation
• Therapists’ Consultation Meeting
• Uncontrolled (Ancillary) Treatments
  – Pharmacotherapy
  – Acute-Inpatient Psychiatric

Structure the Modes of Treatment

Standard DBT is Outpatient Treatment

Structure the Goals of Treatment

DBT Structures Treatment Targets by Level of Disorder

The Overarching DBT Goal is...

• A LIFE Worth Living
  • depends on
  • where you start

The Path to “Life Worth Living”
Where You Start Depends on...

level of disorder

Stage 1 Primary Targets
Dialectical Synthesis
Severe Behavioral Dyscontrol → Behavioral Control

- Decrease
  - Life-threatening behaviors
  - Therapy-interfering behaviors
  - Quality-of-life interfering behaviors

- Increase behavioral skills and adaptive responding

The “ABCs” of Behaviorism

Antecedents, 0r Cues
Emotional Dysregulation
Behavior
Consequences
Treatment Strategies

• Contingency management.
• Cognitive therapy.
• Exposure based therapies.
• Pharmacotherapy.

Teach Skillful Behavior to Replace Problem Behavior

<table>
<thead>
<tr>
<th>Behaviors to Increase</th>
<th>Behaviors to Decrease</th>
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<tbody>
<tr>
<td>Core Mindfulness</td>
<td>Identity Confusion</td>
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<tr>
<td>Interpersonal Effectiveness</td>
<td>Emptiness</td>
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<tr>
<td>Emotion Regulation</td>
<td>Interpersonal Chaos</td>
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<tr>
<td>Distress Tolerance</td>
<td>Fears of Abandonment</td>
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<td>Labile Affect</td>
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Levels of Validation

1. Staying Awake: Unbiased listening and observing
2. Accurate reflection
3. Articulating the unverbalized emotions, thoughts, or behavior patterns
4. Validation in terms of past learning or biological dysfunction
5. Validation in terms of present context or normative functioning
6. Radical Genuineness

Balance Treatment Strategies

CHANGE

Irreverence
Problem Solving
Reciprocity
Validation
Consultation to the Patient
Team Consultation

ACCEPTANCE

Environmental Intervention
Core
Dialectics
Teach four skills

Six Month Treatment Cycle

Increasing Behavioral Skills

- Skill Acquisition
  - Instructions
  - Modeling

- Skill Strengthening
  - Behavior Rehearsal
  - Feedback

- Skill Generalization
  - Homework Assignments
辯證行為治療在台灣的發展

• DBT 自學階段 (2006-2009)
  - 2006年9月: 辦讀會，辯護技巧訓練手冊 [讀書]
  - 2006年11月: DBT skills training groups [從教中華]
  - 2007年: PILOT STUDY of modified DBT [結合研究]

• DBT 正式訓練期 (2009 – 2012)
  - 2009年邀請Katie來台舉辦DBT工作坊
  - 2010年3月: Marsha & Katie - intensive training (Part I)
  - 2010年9月: 吳書儀醫師至西雅圖接受DBT訓練
  - 2010年10月: Marsha & Katie – intensive training (part II)
  - 2010年11月: 跨國督導、討論Linehan’s DBT治療錄影帶
  - 2011年7-12月: 陳淑欽心理師至西雅圖接受DBT訓練
  - 2012年10月: Katie – intensive training (Part III)

• DBT 研究監測療效: 2010年4月迄今
  - 三組治療團隊，提供DBT臨床服務，並結合研究以持續監測療效

美国本土以外，合格的辯證行為治療專家人數，世界第二，僅次義大利；亞洲第一

DBT 療效監測：結合服務與研究

• 台灣邊緣性人格疾患合併自殺行為者接受一年辯證行為治療之療效研究 (open trial):
  2010年7月 - 2012年6月

• 台灣邊緣性人格疾患合併自殺行為者接受一年辯證行為治療之療效研究 (RCT):
  2013年8月 - 2016年7月 國科會三年計畫

• 台灣邊緣性人格疾患合併自殺行為者對於辯證行為治療有療效之生物指標（吳書儀/劉珣瑛）

DBT open trial: 研究方法
(2010年7月 ~ 2012年6月)

• Standard DBT：為期一年的每周一次個別治療、團體治療、團隊會議、諮詢電話
• 治療團隊：DBT二組治療團隊(精神科醫師3位、心理師5位、社工師2位、護理師2位)
• 個案：DSM-IV BPD、Borderline Symptoms List-23 40分以上、過去自殺行為二次或以上、18歲以上、MMSE 26分以上、IQ > 85、簽同意書；排除急性精神病與嚴重身體疾病
• 治療前、治療後第3、6、9、12個月評估

DBT open trial: Strength & limitations

• Strength
  – the first study to show that DBT was well accepted by suicidal BPD Taiwanese and was associated with significant improvement from pre- to post-treatment in multiple domains

• Limitations:
  – Study design was an open trial ~ no comparison group: improvement could be due to some other intervention-based factors (natural course of illness, medications, or non-specific therapeutic elements like attention, or a placebo effect.)
  – No information on adherence ratings for any of the DBT sessions conducted in this study.
  – Used self-reported measures

Results of open trial

<table>
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<tr>
<th></th>
<th>Baseline</th>
<th>3M</th>
<th>6M</th>
<th>9M</th>
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<td>43.9(22.3)</td>
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<td>朋友支持</td>
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<td>11.0(3.9)</td>
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1. Borderline personality disorder (BPD) patients with suicide behavior received one-year dialectical behavior therapy (DBT) effectiveness: Randomized controlled study (NCT00848185)

2. Taiwanese borderline personality disorder (BPD) patients with suicide behavior: Efficacy of dialectical behavior therapy (DBT) (NCT00848185)

DBT RCT: study design
(NSC 2013/08 ~ 2016/07)

- a randomized controlled trial
- DBT vs. comparison group
  - DBT group: Weekly individual treatment (60 minutes), group therapy (2 hours), team meetings (weekly, approximately 1 hour), consultation, and medication treatment
  - Comparison group: 1-year course individual psychotherapy (not DBT model)
- Semi-structured interview by a blind assessor and self-report assessments, at baseline, 4-m, 8-m and 12-m

DBT RCT: study design
(NSC 2013/08 ~ 2016/07)

- Inclusion criteria:
  - Conformed to DSM-IV BPD diagnosis
  - Past five years had two suicide or self-harm behaviors
  - Past three months had at least one self-harm
  - 18-60 years old
  - Signed consent

- Exclusion criteria:
  - Schizophrenia
  - First type bipolar affective disorder
  - Mania
  - Dementia
  - Intellectual disability
  - Severe physical disease
  - Previously dependent on substance for over 30 days
  - Serious physical disease (e.g., cancer) that may need hospitalization within one year or may move out of Taiwan within one year

DBT RCT: study design
(NSC 2013/08 ~ 2016/07)

- Referral: Cases may be referred to the study. If you have a case, you can contact 28094661 ext. 3053, 3055 & 3056 to contact Dr. Huang Hui-Jung.
- Study procedures:
  - Researchers contact the cases and explain the study and treatment content. After signing the consent form, participants are randomized and completed baseline assessment by another group of researchers. They start the treatment.
  - Free/ Insurance charged (every three months for one visit)

Questions and comments~
Please refer to treatment cases.