

Clinical, Empirical and Ethical Considerations in the Treatment of Borderline and Narcissistic Personality Disorders

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Disorders: Understanding Narcissistic and Borderline
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Goals of Presentation

- Highlight the significance of borderline personality disorder (BPD)
- Discuss empirical evidence for treatment of BPD
- Present findings from a recently completed meta-analysis
- Discuss the implications of these findings
 - Note similarities and differences between effective treatments
 - Discuss recommendations for the field
- Review evidence and suggestions for treatment of NPD

Borderline Personality Disorder is a Major Public Health Concern

- Highly Prevalent
 - 1 – 6% General Population (Grant, et al., 2008; Lenzenweger, et al., 2007 ; Torgersen, et al., 2001)
 - 10 – 20% Psychiatric Outpatients (Zimmerman , et al., 2005; Magnavita, Levy, et al., 2010)
 - 20-25% Psychiatric Inpatient (Zanarini, et al., 2004)
 - 6% of primary care patients (Gross, et al., 2002)
- In fact, more prevalent than schizophrenia, bipolar disorder, and autism combined

The Significance of Borderline Personality Disorder

- Highly Lethal
 - 75% engage in self-injurious behaviors
 - 3-10% Suicide Rate (8% in recent meta-analysis of 1,100 patients)
 - 50 to 400 x the general rate
 - Compares to 2.3% for anorexia nervosa and 1.3% for unmedicated bipolar disorder
 - 3.5 average suicide attempts
 - 78% of suicides occur within 5 years of discharge from the hospital
 - Suicides most likely when patients are in 20's & early 30's

Time to BPD Dx after first Psychiatric Contact

- Average of 6 years to 10 years in treatment before dx; (Meyerson et al., 2009; Zanarini, et al., 1998; 2004)
- 74% misdiagnosed
- Most common false-positive diagnoses were
 - bipolar disorder (17%)
 - depression (13%)
 - anxiety disorders (10%). (Meyerson et al., 2009)

BPD Commonly Comorbid but in an Uncommon way

- Axis I Disorders
 - Mood Disorders
 - Major depression
 - Dysthymia
 - Bipolar I and II
 - Anxiety Disorders
 - Eating Disorders
 - Substance Use Disorders
 - PTSD
- Axis II Disorders
 - Narcissistic
 - Antisocial
 - Histrionic
 - Avoidant
 - Dependent
 - Paranoid
 - OCPD

Complex comorbidity—that is, both internalizing and externalizing disorders (Zanarini, et al., 1998; 2004)

BPD Comorbidity is Meaningful

- BPD comorbidity results in poorer course for a range of disorders
 - ↓ Inter-episode functioning
 - ↓ employment, ↑ # medications, ↑ ETOH and SUDs,
 - ↓ treatment response and ↑ suicidality

BPD Comorbidity is Meaningful

- BPD comorbidity negatively affects treatment outcome for otherwise effective treatments
 - ↓ efficacy for Major depression , Bipolar disorder, Anxiety disorders, Eating disorders, Substance Use Disorders, PTSD (Ames-Frankel et al., 1992; Baer et al., 1992; Chambless et al., 1992; Cloitre & Koenen, 2001; Coker et al., 1992; Cooper et al., 1996; Feeny et al., 2002; Greenberg et al., 1995; Johnson et al., 1990; Nurnberg, 1989; Ross et al., 2003; Rossiter et al., 1993; Shea et al., 1992; Sullivan et al., 1994; see Mennin & Heimberg, 2000 and Kaplan & Garfinkel, 1999 for reviews)

First Evidence Based Principles

- Given the prevalence of BPD
 - All clinicians need to develop specific expertise in at least identifying and diagnosing BPD
- Given that BPD is frequently comorbid with a range of Axis I disorders and negatively affects outcome
 - Whenever a patient meets criteria for a common comorbid disorder, it is incumbent upon the clinician to assess for BPD
- Multiple dx; particularly this complex pattern, may suggest presence of BPD

The Relationship between BPD and Other Disorders Tends to be One-sided

- BPD affects MDD; but MDD does not affect BPD
 - The rate of remissions of borderline personality disorder was not affected by whether patients had co-occurring MDD.
 - Improvements in MDD were not followed by improvements in BPD.
 - The rate of MDD remissions was significantly reduced by co-occurring borderline personality disorder.
 - Improvements in BPD often followed by improvements in MDD

A Similar Relationship for BPD and Bipolar Disorder

- For BPD, comorbid BD does not affect course (# or type of criteria, demographics, GAF, comorbidity, hospitalizations, remission)
- For BD patients, comorbid BPD does indeed affect course (↓ employment, ↑ # medications, ↑ ETOH and SUDs) and treatment response (medication compliance and response)

More Evidence-Based Principles

- When BPD and other disorders co-occur, they can have independent courses, but more often improvements in other disorder are predicted by prior improvements in BPD
- Thus, clinicians should not ignore BPD in hopes that treatment of MDD, Bipolar, PTSD will be followed by improvement of BPD
 - Studies indicate the opposite!

Clinicians are Not Good at Diagnosing BPD

- Clinicians left to their own judgments diagnosed BPD in 0.4% (2) of almost 500 patients seen compared to 14.4% (72) by structured interview (Zimmerman & Mattia, 1999).
 - Less than 3% of the cases are identified!
 - 97%+ of cases are missed!
- Providing findings from the structured interviews significantly ↑ BPD dx (about 10%)

Clinicians are Not Good at Diagnosing BPD

- At Penn State before implementing semi-structured interviews for PDs the prevalence rate for BPD was 1.6% and 4.2% after supervision.
- After structured interviews, the prevalence rate ↑ to about 20% for BPD

Another Evidence-Based Principle

- Structured or formal interviews identify many cases of BPD are missed in ordinary clinical practice.
- Feedback from structured assessments provides information that clinicians find helpful in thinking about their patients.

Treatment of Borderline Personality Disorder

- BPD historically been thought to be difficult to treat
 - High drop-out
 - Chaotic use of services
 - High lethality
 - Many clinicians are intimidated by BPD patients and pessimistic about the outcome for such patients
 - Therapist burnout
 - Prone to enactments and iatrogenic behaviors

Treatment of Borderline Personality Disorder

- However accumulating data suggests that we can indeed treat BPD
- How best to intervene?
 - What are the best evidence based practices?
 - Are medications useful?
 - What psychotherapies are there?
 - How might you choose between the different treatments?
 - What are the evidence based principles that can be derived from the literature to help the practicing clinician?

Seminal Study: Linehan et al., 1991

DBT vs. TAU

- Compared a manualized integrative cognitive behavioral therapy called Dialectical Behavior Therapy (DBT) with community treatment as usual (TAU)
 - DBT had significantly less drop-out (16.7%/20% vs. 50%)
 - DBT had fewer suicide attempts (mean = 6.8 vs. 33.5 attempts)
 - DBT had fewer days inpatient hx (mean 8.5 vs. 38.8 days).
 - However:
 - DBT patients had more treatment
 - Significant dose differences
 - At any give time half the pts in TAU were not in any tx
 - DBT was free, TAU patients paid for treatment
 - One-tailed statistical tests; findings not significant using the more appropriate two-tailed tests

DBT Sweeps the US and the World

- Many managed care companies (e.g., Massachusetts Behavioral Health Partnership), have defined special benefits for DBT
- Certain companies will only reimburse DBT tx of BPD
- Several state departments of mental health (e.g., Illinois, Connecticut, Massachusetts, New Hampshire, North Carolina, Maine) have now enthusiastically endorsed DBT as the treatment of choice for clients with BPD.
 - These states have provided funding and coordination for training in DBT.
- APA Trust will give you a discount if you agree to use DBT
- NICE guidelines in the UK mentions only one treatment by name, DBT, as the treatment of choice for parasuicidal women with BPD

Evaluation of DBT

- Although DBT has garnered the most evidence to date; the data is far from conclusive nor does it suggest specificity
 - Highly efficacious in comparison to TAU
 - Small N studies
 - Direct comparisons to bona-fide treatments find few, in any, reliable differences
 - Lack of effects in completer analyses
 - Follow-up findings are inconsistent
- Clearly there is room for other interventions

A Widening the Scope for Treating BPD: Different Strokes for Different Folks

- Limited, partial, and temporary effects
 - ~ 50% improve
 - Symptom vs. functional and personality changes
 - GAF scores that average about 60-65
 - Mixed follow-up findings
- BPD is heterogeneous
 - Shouldn't expect one treatment to work for all BPD patients

What are the Psychotherapy Treatment Options for BPD?

- A number of psychotherapy treatments have shown efficacy in RCTs
 - CBT Based
 - Dialectical Behavior Therapy (DBT)
 - Schema Focused Psychotherapy (SFPT)
 - System Training for Emotional Predictability and Problem Solving (STEPPS)
 - Emotion Regulation Group Therapy (ERGT)
 - Motive-Oriented Therapy Relationship (MOTR)
 - PDT (Psychodynamic) Based
 - Mentalization Based Therapy (MBT)
 - Transference Focused Psychotherapy (TFP)
 - Dynamic Deconstructive Psychotherapy (DDP)
 - Gunderson's Psychodynamic Model (PDT-G) used in McMain et al

Other Promising Options

- Conversational Model (CM; Meares, 2004)
- Cognitive Analytic Therapy (CAT; Ryle, 1997)
- Modified CT (Brown et al., 2004)
- Interpersonal Psychotherapy (Markowitz et al., 2006)
- Interpersonal Group Psychotherapy (Marziali & Munroe-Blum, 1994)
- Emotion Focused Psychotherapy (Pos & Greenberg, 2010)

Understanding the Literature

- How do we understand the larger literature?
- Sheer number of studies and few direct comparisons as well as the variability among these studies (dose, controls, quality, outcomes) makes it difficult for researchers and clinicians to draw accurate and usable inferences regarding treatment options

What's a Clinician to do?

- Questions arise as to how best to intervene?
 - Are all the existing evidence-based-treatments equivalent?
 - Given the heterogeneity of BPD, are there any moderators that would increase our understanding of existing literature?
 - That is, are some treatments better for a particular group of patients and other treatments for more appropriate for another group of patients?

What's a Clinician to do?

- Are there design issues that affect treatment outcome that need to be taken into account when evaluating the evidence?
- Can specific principles be identified?

The Evidence Pyramid for Treatment Effectiveness Questions



USE THE BEST EVIDENCE AVAILABLE

Meta-Analysis

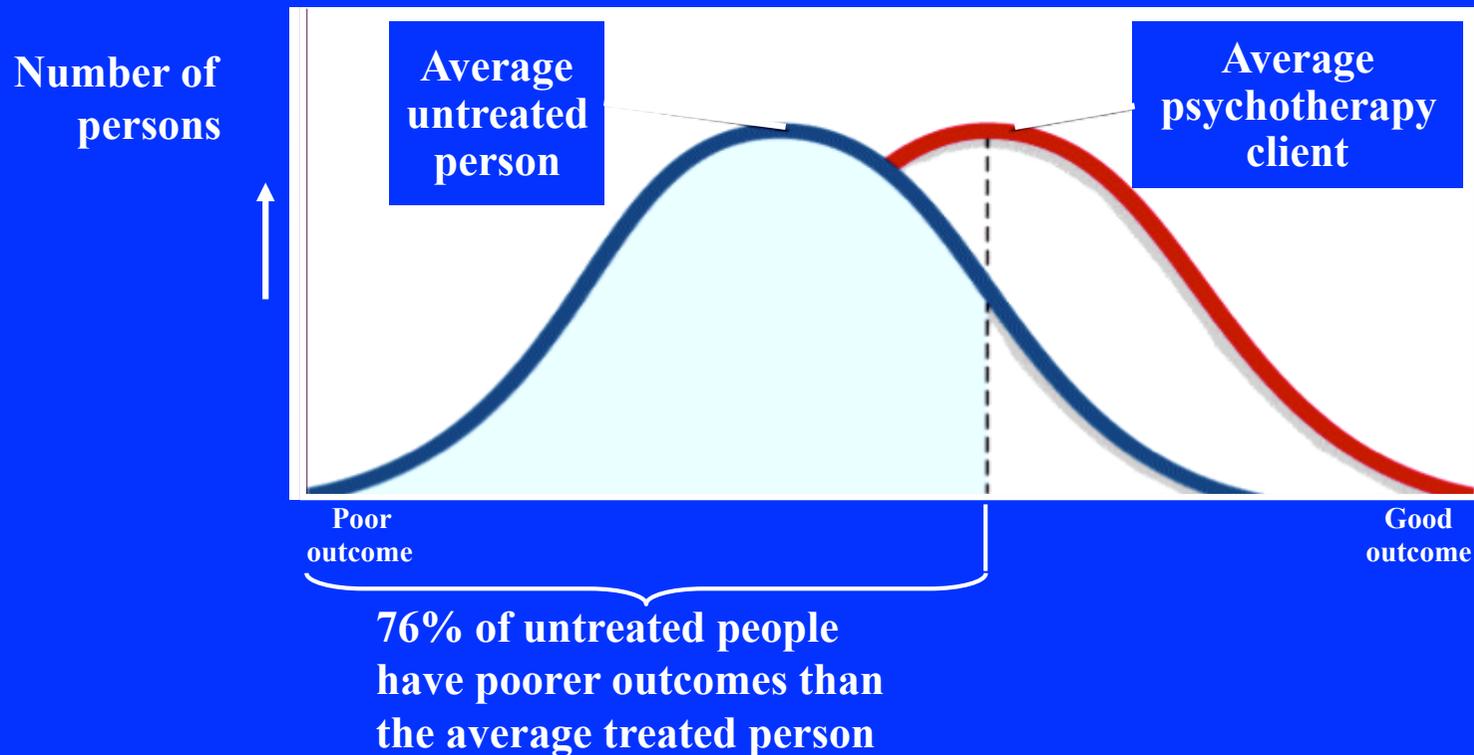
- A comprehensive meta-analysis would facilitate the organization of the extant literature on the treatment of BPD and would provide general information about the effects of treatment as well as allow for examination of moderators of treatment outcome.

Meta-Analysis

- Meta-analysis
 - procedure for statistically combining the results of many different research studies
 - Focuses on the *direction* and *magnitude* of the effects across studies, not statistical significance
- The effect sizes (ES) represents the strength of an effect (dependent variable) and standardizes findings across studies such that they can be directly compared

What Does an Effect Size Mean?

- The percentile is obtained by identifying the point on the normal curve that reflects the effect size



Psychological therapies for people with borderline personality disorder (Review)

Stoffers JM, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K



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<http://www.cochranelibrary.com>



Psychological therapies for people with borderline personality disorder (Review)
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Stoffers et al. (2012)

Author's conclusions

There are **indications of beneficial effects** for both comprehensive psychotherapies as well as non-comprehensive psychotherapeutic interventions for BPD core pathology and associated general psychopathology. **DBT has been studied most intensely, followed by MBT, TFP, SFT, and STEPPS.** However, none of the treatments has a very robust evidence base, and there are some concerns regarding the quality of individual studies. Overall the findings support a substantial role for psychotherapy in the treatment of people with BPD but clearly indicate a need for replicatory studies.

Author's conclusions

Overall, the author's found a moderate effect size of .39 for DBT. However, in RCT's in which DBT was compared to an active control or specific BPD treatment, they found a non-significant between group effect size of .01.

Author's Conclusions

The authors concluded that some problems experienced by BPD patients may be amendable to therapy. However, all treatments should be considered experimental.

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Dialectical Behavior Therapy for Borderline Personality Disorder: A Meta-Analysis Using Mixed-Effects Modeling

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University of Applied Sciences (HAW) Ost

Objective: At present, the most frequently investigated psychological intervention for borderline personality disorder (BPD) is dialectical behavior therapy (DBT). We conducted a meta-analysis to estimate the efficacy and long-term effect sizes of DBT. **Method:** Systematic bibliographic research was conducted in full-text abstract literature from online databases (PubMed, PsycINFO, PsycFirst, PsycArticles, Medline). The included studies in which the patients with diagnosis of BPD were treated, the treatment did not comprise all components specified in the DBT manual or in the suggestions for outpatient DBT program, patients failed to be diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders*, and the intervention group comprised fewer than 10 patients. Using a mixed-effects hierarchical modeling approach, we calculated global effect sizes and effect sizes for specific and subspecific outcomes. **Results:** Calculations of postintervention global effect sizes were based on 16 studies. Of these, 8 were randomized-controlled trials (RCTs) and 8 were non-randomized studies (NRS). The dropout rate was 22.4% per participant. A moderate global effect and a moderate effect size for suicidal and self-harm behaviors were found, also including a moderate to large effect size for borderline-specific measures. There was no evidence for the influence of other moderators (e.g., quality of studies, setting, duration of treatment). A small improvement was shown from posttreatment to follow-up, including 5 RCTs only. **Conclusions:** Future research should compare DBT with other evidence-based specific treatments that have also demonstrated their efficacy using several long-term follow-up assessment points.

Keywords: meta-analysis, borderline personality disorder, dialectical behavior therapy, effectiveness study

Supplemental materials: <http://dx.doi.org/10.1002/2798.chap10101.supp>

Dialectical behavior therapy (DBT; Linehan, 1993a, 1993b) is currently the most frequently investigated psychological intervention for borderline personality disorder (BPD). This comprehensive treatment program focuses on (a) providing the motivation for change by detailed chain analysis, validation strategies, and management of interdependent contingencies in individual therapy sessions a week; (b) increasing target-oriented and appropriate behavior by teaching skills in a weekly group format (training, including radical attention and exposure, emotion regulation, acceptance of emotional distress, and interpersonal effectiveness, etc.); (c) ensuring the transfer of newly learned skills to everyday life by telephone coaching and crisis management; and (d) supporting therapists' motivation and skills with a weekly consultation hour.

A treatment target hierarchy determines the problem focus of each session. Reducible or suicidal problems and self-harm behaviors are given the highest priority in DBT (Linehan, 1993a, 1993b), considering that these behaviors predict completing suicide (Briere, Bunt, Doh, & Holo, 2004). Subsequently, patients were trained in skills geared to help them stay in outpatient therapy, followed by a selection of emotional skills (distress tolerance, quality-of-life issues or individual targets were addressed). Given that individuals with BPD are prone to frequent use of psychiatric facilities (Berthel et al., 2001), the original outpatient manual was modified for inpatient treatment (Swanson, Sanderson, Dalli, & Linehan, 2001). In previous studies (Joles et al., 2004; Klum et al., 2006; Kröger et al., 2008), findings support the assumption that a 3-month inpatient treatment program reduced self-harm, general psychopathology, depression, anxiety, dissociation, and self-harming behaviors or posttreatment and at follow-up.

The efficacy and effectiveness of DBT are summarized in several reviews (e.g., Lieb, Zeman, Schmitt, Fendler, & Bieleck, 2004; Cochrane, 2009). The current Cochrane Review refers to the results from some (Kroger et al., 2008; Linehan, Arntsen, Simeone, Akhavan, & Hertz, 1994; Linehan et al., 2000, 1999; van den Bosch, Koelen, Sijm, Verdel, & van der Brink, 2009) but not all available randomized controlled trials (RCTs; Clarkin, Levy, Lenzenweger, & Sternberg, 2007; Linehan, Corliss, Murray et al., 2006; Linehan, McElroy, Bremer, Suppe, & Gallop, 2008; McMillin et al., 2009; Simpson et al., 2004). It also includes a meta-analytic group therapy focusing on self-harm (Lewinsohn, 2009).

Klum, Kröger, & Kosfelder, (2010)

Psychological therapies for people with borderline personality disorder (Review)

Binks G, Fenton M, McCarthy L, Lee T, Adams CE, Duggan C



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Psychological therapies for people with borderline personality disorder (Review)
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Binks et al. (2009)

Major Meta-analyses of BPD

Critiques of Meta-Analysis and Recommendations

- Critiques
 - Heterogeneity “Apples and oranges”
 - Quality “Garbage in garbage out”
 - Inclusion and exclusion criteria
 - Dissemination bias “file draw problem”

Critiques of Meta-Analysis and Recommendations

- Number of guidelines for conducting and reporting of meta-analyses
 - Quality measure
 - AMSTAR (Shea et al., 2009)
 - Reporting Guidelines
 - MARS (APA, 2008)
 - PRISMA (Moher et al., 2009)

Comprehensive Meta-Analysis and Meta-Regression

- Rather than limit the studies included, we included every study we could find. This allowed us to examine design issues that other studies could not address
- We also adhered to all accepted reporting and conducting guidelines AMSTAR, MARS, PRISM

METHOD

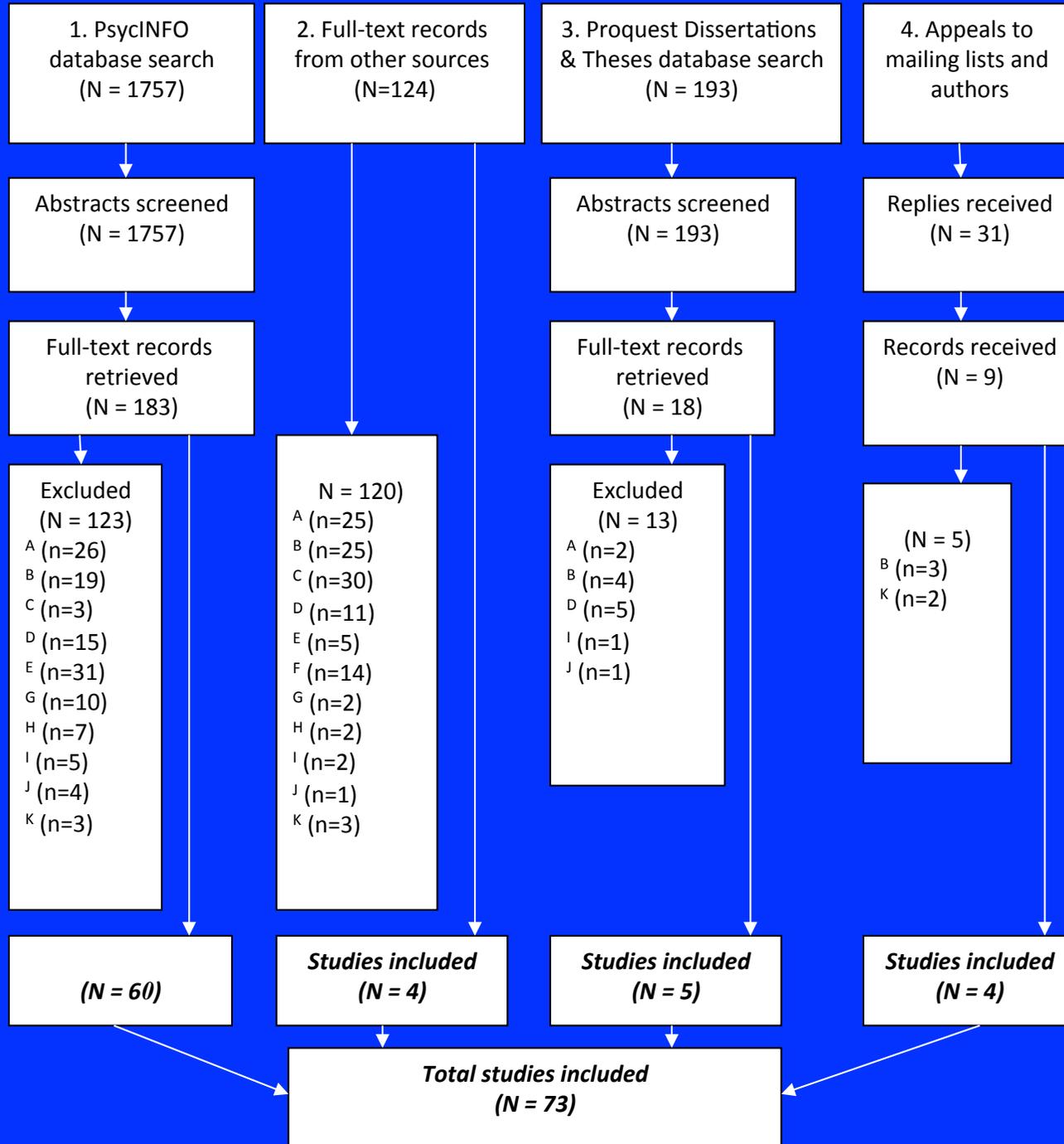
Literature Search

- PsycINFO, ProQuest Dissertations searches
 - Keywords: “Borderline personality,” “Psychotherap*,” “Therap*,” “Treatment”
- Indexes of relevant journals
 - *Archives of General Psychiatry, AJP, JCCP, JPD, Behavior Research & Therapy*
- Conference abstracts (e.g., ISSPD, SPR, ABCT)
- Reference sections of retrieved articles
- Email appeals to mailing lists
 - e.g., ISSPD, ARPD, SPR, Div. 12, Div. 29, ABCT, psychodynamicresearch
- Identified 2,105 possible studies

Inclusion Criteria

- English-language reports: 14 excluded
- Psychotherapy (not drug therapy): 12 excluded
- Treatment for BPD, not an associated diagnosis (e.g., depression): 8 excluded
- Sample of BPD patients, not mixed-diagnosis samples or individuals with self-harm: 51 excluded
- Suitable statistics reported: 30 excluded
 - Means and standard deviations (approx. Normal) after therapy for both groups
 - Dichotomous outcomes (success/failure)

A = Duplicate report on sample;
 B = non-BPD sample;
 C = review paper;
 D = no suitable statistics reported;
 E = non-outcome study;
 F = non-English-language report;
 G = non-psychotherapy intervention;
 H = case study;
 I = adolescent sample;
 J = unspecified treatment;
 K = treatment for another disorder



Included Studies

- 73 Unique studies
- 32 provided between group effects
 - 221 separate estimates
 - N = 1729
- 70 of these studies contained pre-post effect size estimates
 - 466 estimates
 - N = 1756

Included Studies

- Samples
 - Mean age: 31 (range = 22 to 36.1)
 - Mean female sex: 88.2% (range = 59 to 100)
- Treatments
 - Controlled (between groups)
 - 10 psychodynamic, 7 RCT
 - 22 cognitive-behavioral/behavioral , 19 RCT (14 DBT)
 - Pre-post
 - 17 PDT
 - 44 CBT
- Mean study quality: 15.3 overall (19.2 for RCTs) (range = 11 to 28)

Average Within Group Effect Size

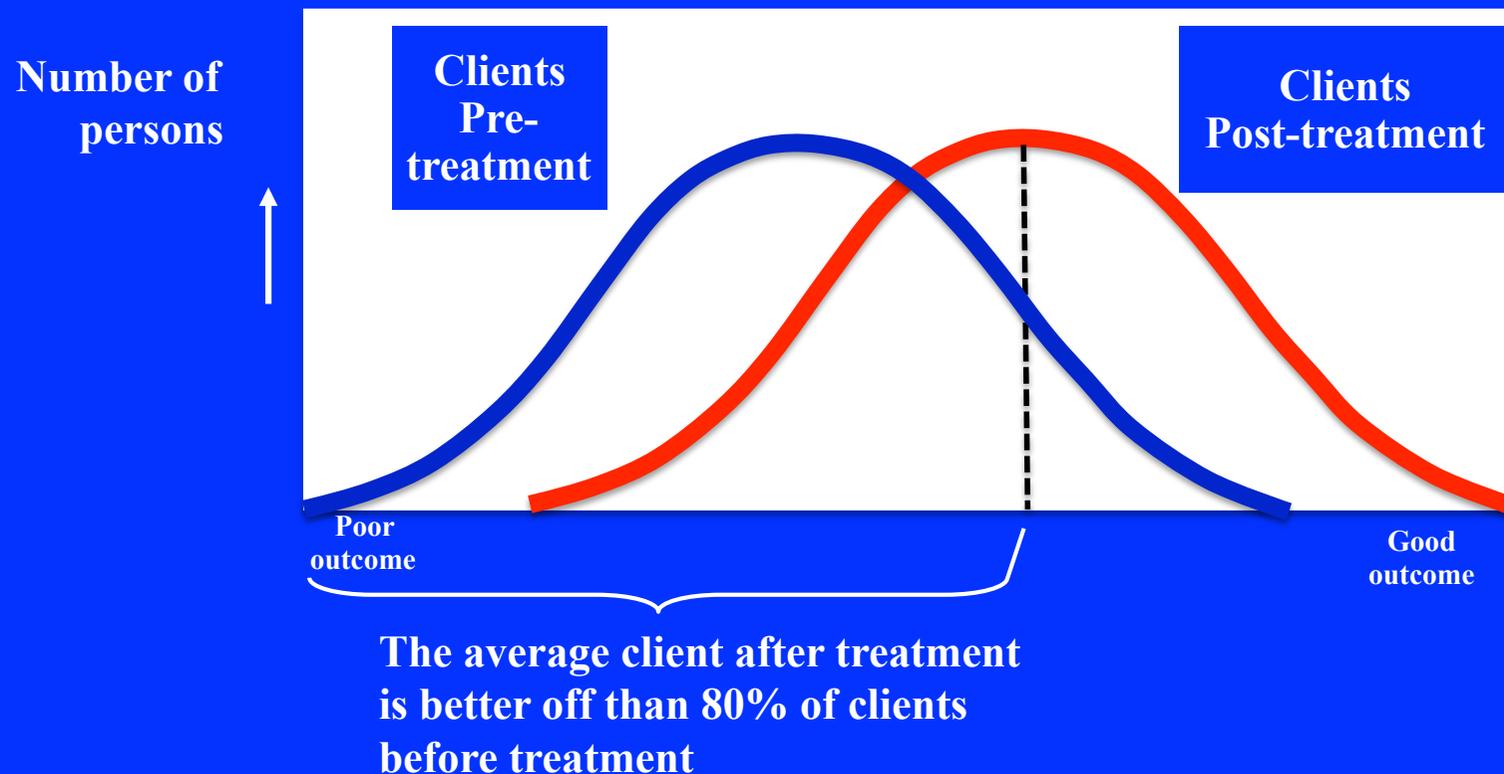
$$g = 0.828$$

(Posttest scores better than baseline)

95% confidence interval: $0.723 < ES_{sg} < 0.934$

What Does a 0.828 ES Mean?

- Pre-post effect size of 0.828 is considered large



Average Between Group Effect Size

Size

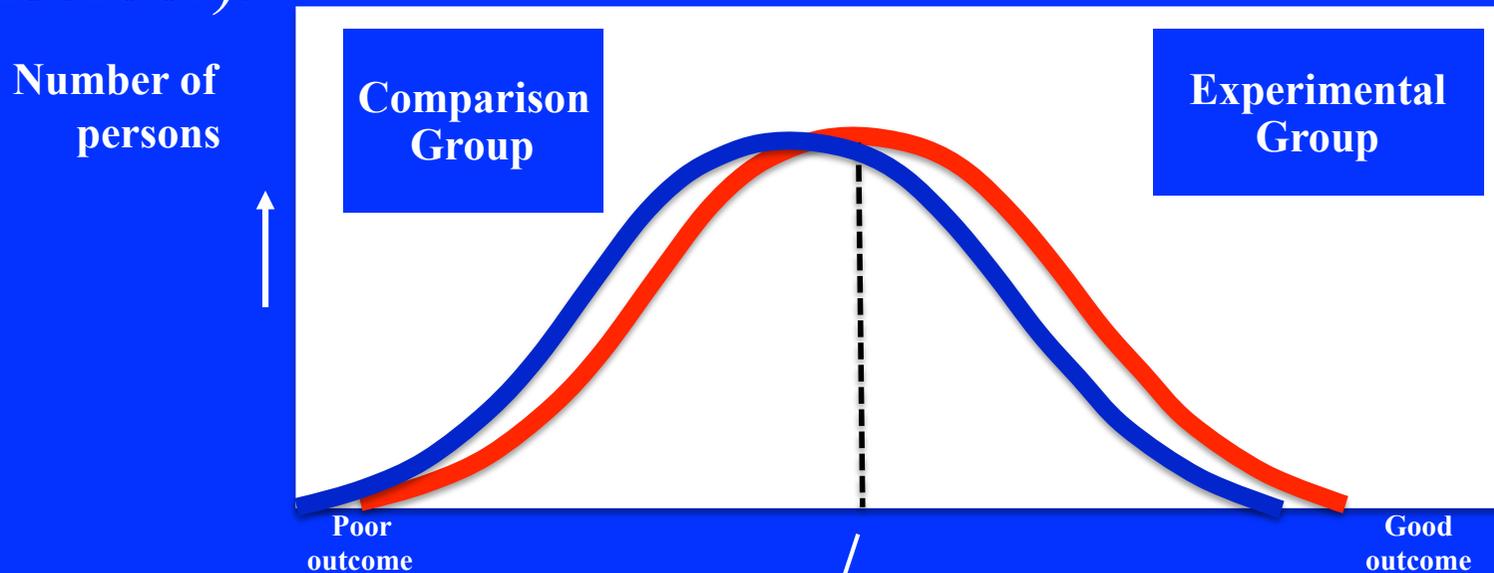
$$g = 0.231$$

(Experimental group superior)

95% confidence interval: $0.150 < g < 0.313$

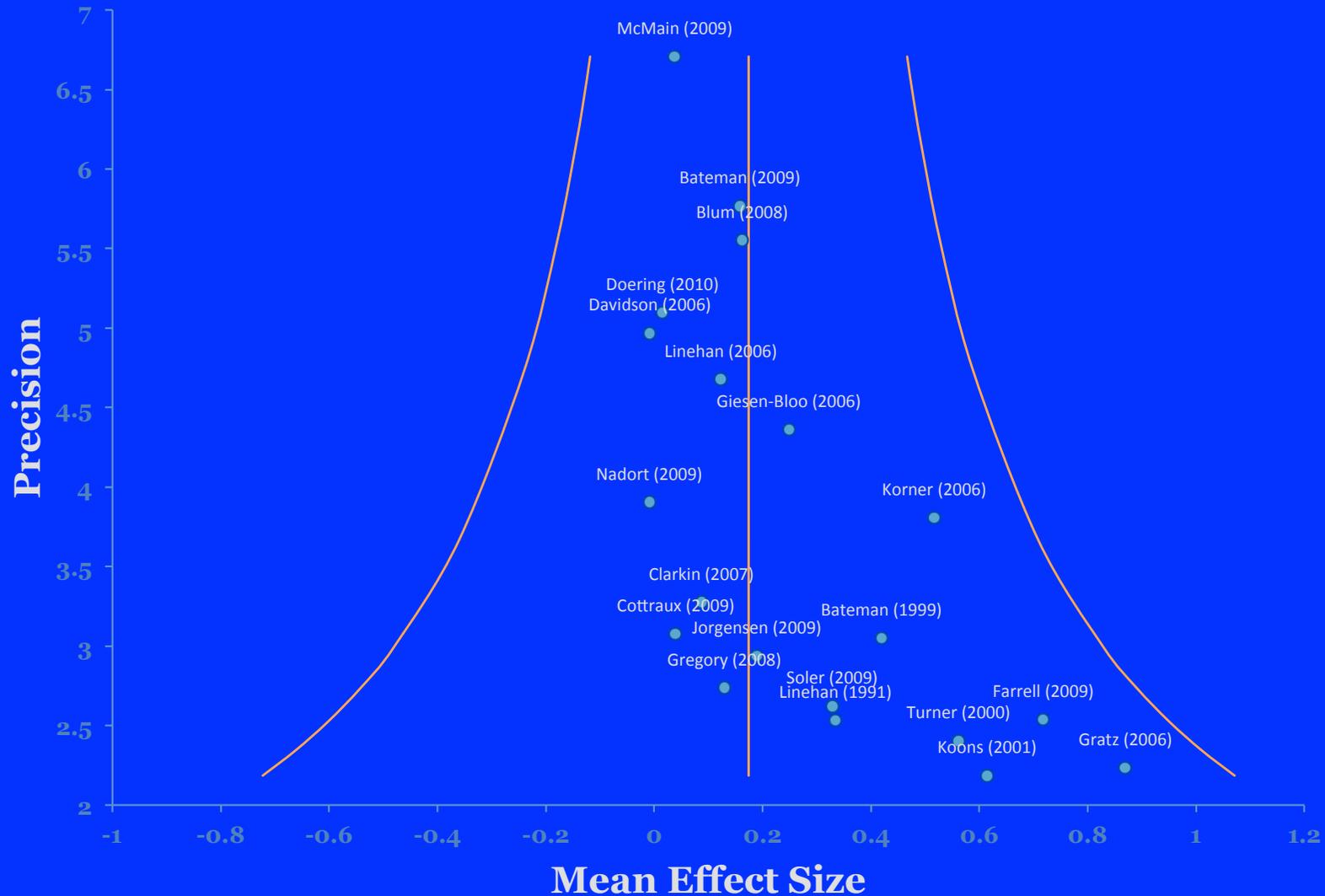
What Does a 0.231 ES Mean?

- A between groups effect size of 0.231 is small
- $NNT = 9$ (2 to 5 considered effective; differs by disorder).

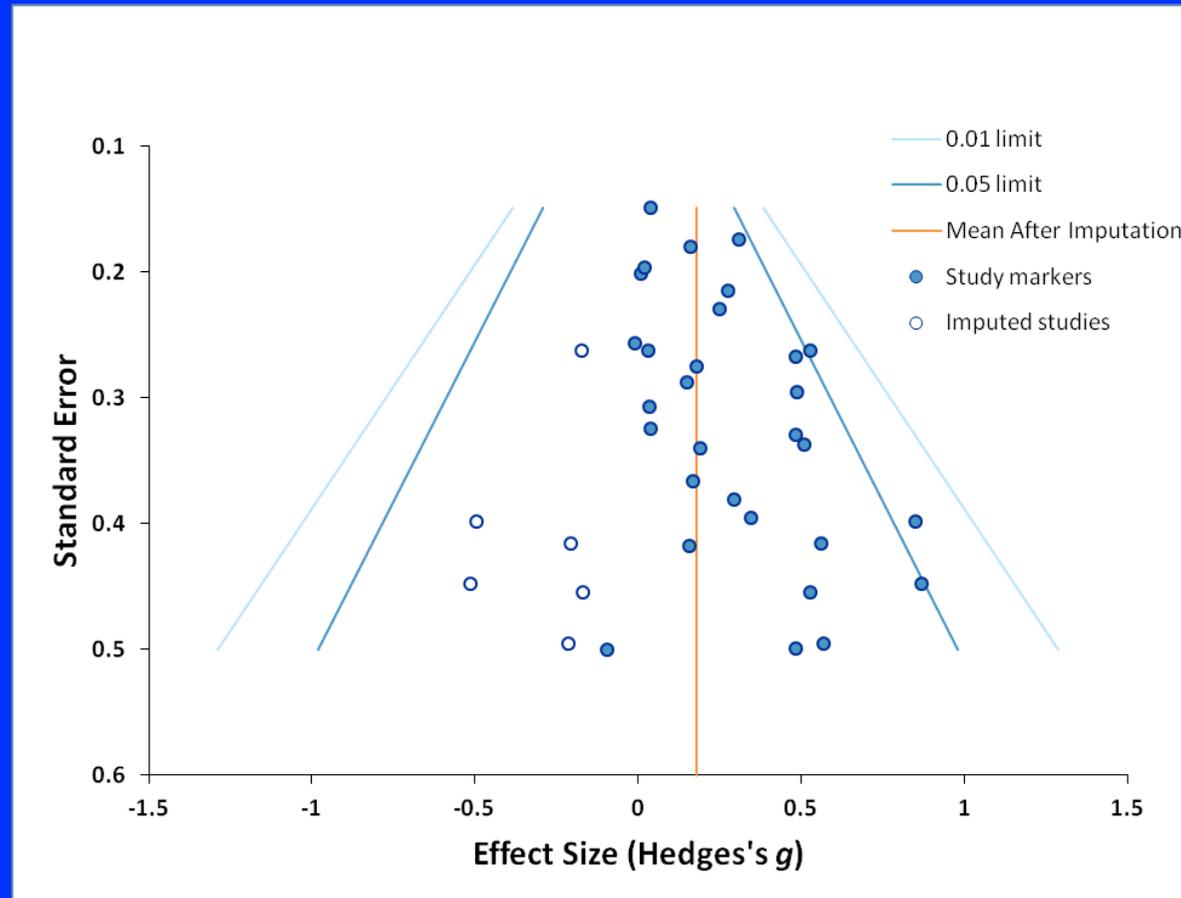


The average client in the experimental group is better off than 58% of clients in the comparison group

Funnel Plot: Publication Bias



Trim-and-Fill Plot



MODERATORS

Moderators of effect size

- Design characteristics/artifactual variables
 - Dichotomized outcome vs. continuous
 - Publication year
 - Study quality
 - Type of control group (wait list vs. TAU vs. specific txt vs. EST)
- Outcome measurement characteristics
 - Completer analysis vs. intent-to-treat
 - Rater (self-report, treater, independent/blind assessor)
 - Domain (BPD symptom, other symptom, functioning, personality)
- Treatment characteristics
 - Orientation (dynamic vs. cognitive-behavioral/behavioral)
 - Intensity (h/w), length (w), total attention (h)
 - Individual vs. group vs. both
 - Inpatient vs. outpatient vs. partial hospitalization
- Sample characteristics
 - Age (M)
 - Female sex (proportion)
 - GAF at pre-treatment (M)
 - Proportion with co-occurring diagnoses (MDD, PTSD, ASPD, NPD)



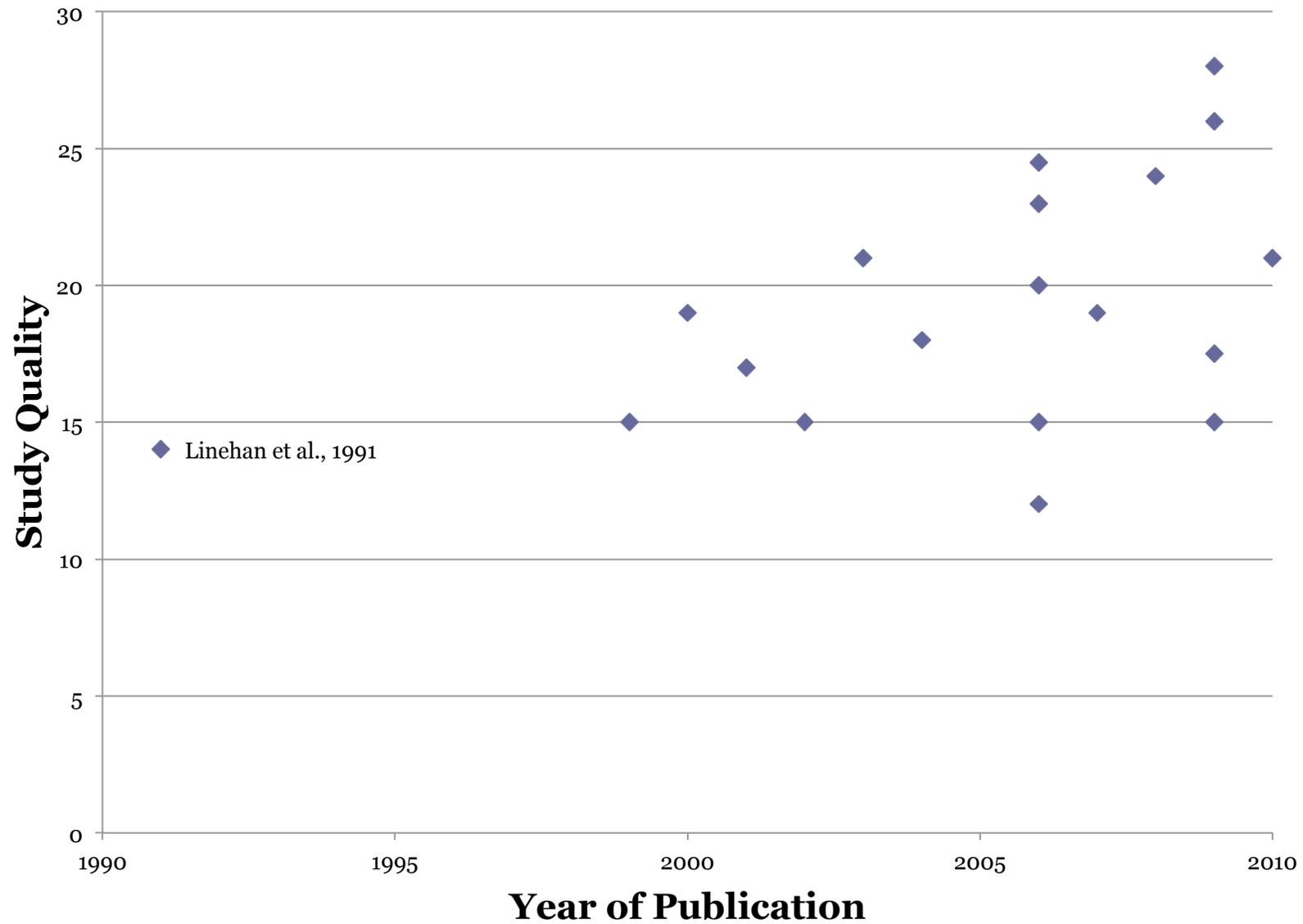
Moderators- Comparison Condition

- The between group ES = .23, NNT = 9
- However, type of comparison group moderated the BG ES
- ES for Comparisons with
 - Component control = .02, NNT = $\sim \infty$
 - Another EST = .003, NNT = $\sim \infty$
 - Non-EST active treatment = .01, NNT = $\sim \infty$
 - TAU = .28, NNT = 6
 - Waitlist = .45, NNT = 4

Treatment Moderators

- Theoretical orientation and type of treatment
 - Psychodynamic vs. CBT/behavioral, no difference
 - Between groups effect, $b = .00341$ $p = .97$
 - Within groups effect, $b = .256$ $p = .08$ (+ PDT)
 - Non-DBT vs. DBT, no difference
 - Between groups effect, $b = -0.00436$, $p = .95$
 - Within groups effect, $b = .165$, $p = .09$ (+ non-DBT)

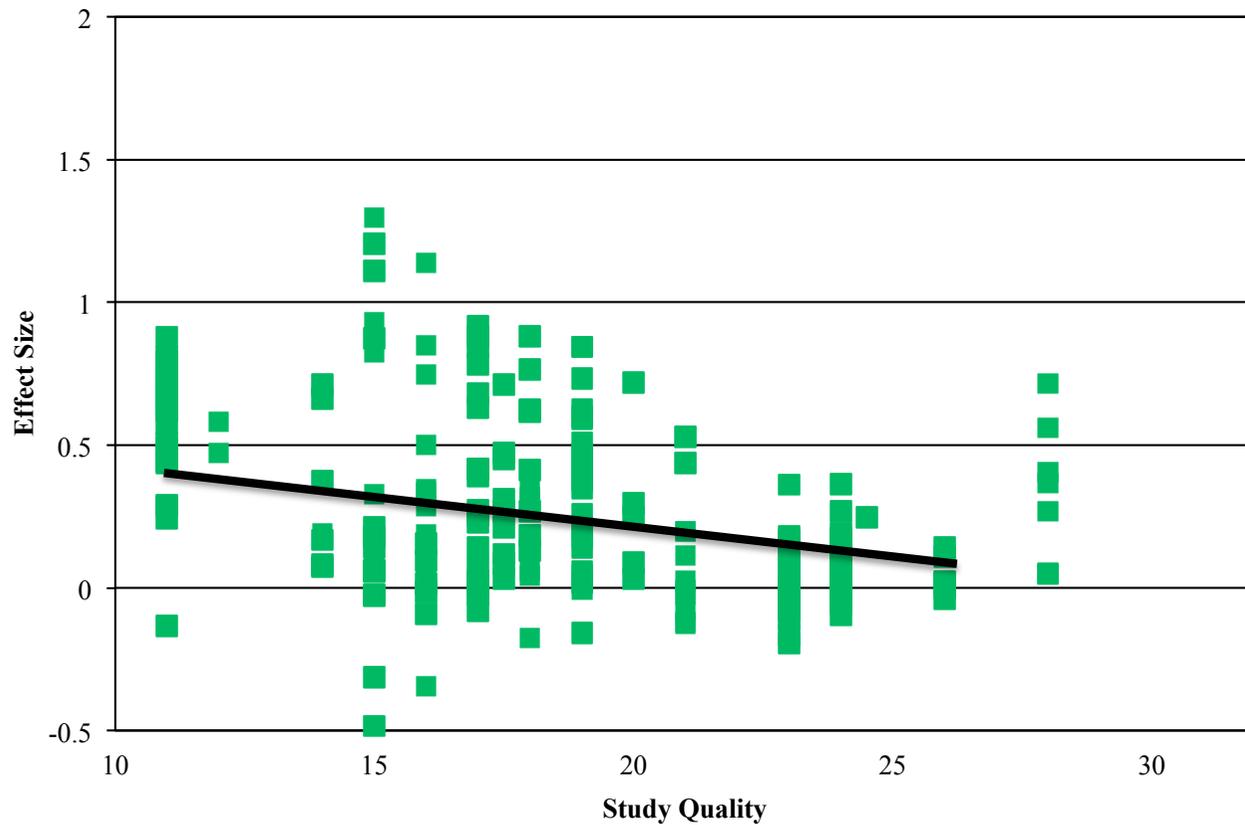
Study Quality by Year of Publication, 1991-2010



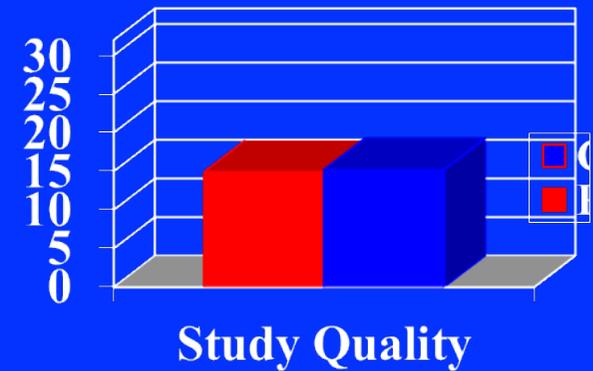
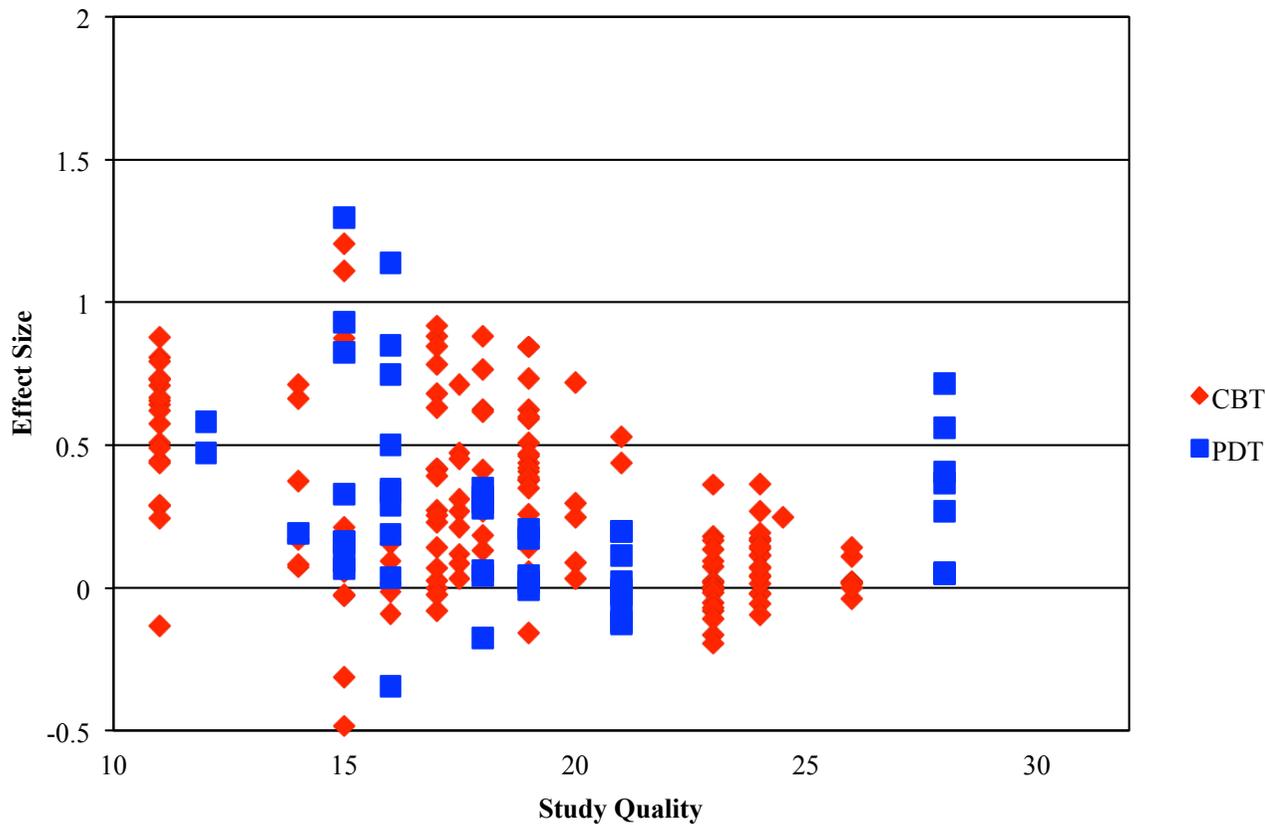
$r = .48$

Study Quality and Effect Size

An Inverse Relation



No Differences in Study Quality between CBT and PDT Treatments



$t(71) = 0.27, p = 0.79, r = .91, p = .004$ with Gerber et al ratings

Other Moderators: Method Matters

- Almost all moderators were methodological
 - Dichotomization of outcomes (vs. dimensional) ↑ ES
 - Blind raters (vs. self-report) ↑ ES
 - Non-blind raters (vs. self-report and blind raters) ↑ ES
 - Completer analysis (vs. ITT) ↑ ES
 - (study quality, control group, publication year)
- Only non-methodological/artifactual moderator among treatment and patient variables was:
 - Older samples had lower effect sizes (changed less)

Summary of Findings

- Within-group ES are large, between-group ES are small
- No differences between CBT vs. PDT treatments in both the within-group ES and between-group ES
 - no differences between DBT vs. non-DBT
- No differences in study quality between CBT and PDT
- Study quality positively correlated with publication year
- Study quality was negatively correlated with ES
- Moderators
 - Study quality , Self-report ES < observer-rated ES, Control group type (waitlist vs. TAU vs. active control)
 - Dose, completer vs. ITT, Raters (non-blind), age
- No other moderators
- Publication bias inflates estimates of efficacy (or you may not get the same results at home)
- NO EVIDENCE OF SUPERIORITY FOR DBT

Evidence Based Principles

- All clinicians need to develop expertise in identifying and diagnosing BPD
- Structured or formal assessments are important for identifying and diagnosing BPD
- Assessing for BPD is especially important when patients have common comorbid Dx or complex comorbidity
- Don't privilege the treatment of other disorders over that of BPD

Evidence Based Principles

- Little evidence that unmodified CBT or PDT are useful for BPD
- Clinicians have a range of promising treatments available to them in treating BPD
- These include both cognitive behavioral based (DBT, SFPT, STEPPS) and psychodynamic based (MBT, TFP, DDP, PDT-G)

Evidence Based Principles

- These treatments tend to be integrative
- Few reliable differences between well-delivered active treatments for BPD
- Few prescriptive indicators suggested in literature
- Communities should have more than one type of BPD treatment available to patients

Shared Properties of Efficacious Treatments for BPD

- Long-term (dose was important in the meta-analysis)
- Supervision or intervision of therapists
 - protects against burnout, enactments, colluding with pathology, passivity, and iatrogenic behaviors
- Coherent principle based model of treatment that makes sense to therapist (and patient) and guides interventions
- Clear overarching focus and priorities
 - whether that focus, is a problem behavior or an aspect of interpersonal relationship patterns

Shared Properties of Efficacious Treatments for BPD

- Close attention to the structure and frame of the treatment
 - Clear roles and responsibilities of patient and therapist are established
- Devote considerable effort to enhancing compliance (establishing frame or contract)
- Vigilant for indications of colluding with the patient, acting out, or iatrogenic behaviors and strong efforts to minimize such behaviors

Shared Properties of Efficacious Treatments for BPD

- A non-judgmental stance
 - Technical neutrality
- Therapist is active not passive
- Collaborative stance
 - Mutually agree to nature of problem, hierarchy of priorities, frame of treatment and limit setting
- Empathy without reinforcing distortions
- Flexibility
- Utilization of concurrent groups
 - Mentalizing, DBT skills, STEPPS, 12-step programs

Implications/Recommendations

- We need to widen the scope of treatments available to BPD patients
 - These findings combined with improvement rates and heterogeneity of the disorder, suggest more than one empirically supported approach should be available within communities
- More importantly, we need to be more willing to actively integrate these various approaches

Implications/Recommendations

- Turf wars limit innovation but most importantly ultimately hurt our patients

Narcissistic Personality Disorder



Treating NPD

- The efficacy of psychotherapeutic and psychopharmacological treatment approaches for NPD has not been systematically or empirically investigated
- Clinical practice guidelines for the disorder are yet to be formulated, and psychopharmacologic intervention is symptom-driven.
- Regardless of severity, the grandiosity and defensiveness that characterize NPD militate against acknowledging problems and vulnerabilities and make engagement in any form of psychotherapy difficult

NPD and Narcissism

- Follow-up studies find mixed evidence for the impact of narcissism on functioning (Plakun, 1989; McGlashan & Heinszen, 1989; Ronningstam, Gunderson, & Lyons, 1995; Stone, 1989)

NPD and Narcissism

- Predicts
 - Less therapy utilization
 - Client-initiated psychotherapy discontinuation (Campbell et al., 2009; Hilsenroth et al., 1998)
 - Need for excessive admiration
 - Narcissistically abused in eating disorders

Pincus, Ansell, Pimentel ... Levy (2009)

- In 26 outpatients with a range of diagnoses found
 - Grandiosity predicted ↓ medication use, ↓ attendance of partial hospitalization programs and ↑ psychotherapy session cancellations and no shows
 - Vulnerability predicted ↑ attendance of partial hospitalization programs and ↑ psychotherapy session cancellations and no shows and ↑ parasuicidal behaviors
 - Both G and V related to ↑ number of suicide attempts

Ellison, Levy, Cain, Ansell, & Pincus (2013)

- 60 outpatients (45% MDD, 21% GAD, 20% BPD, only 1 patient met criteria for NPD)
 - G predicted
 - ↑ patient initiated termination (1 pt ↑ in G predicted 2x ↑ in dropout)
 - ↓ crisis utilization, psychiatric hx, and partial hx
 - V predicted
 - ↑ ER
 - Neither G or V related to medication use, cancelations, no shows or rescheduled appointments

Ellison, Levy, Cain, Ansell, & Pincus (2013)

- V related to depression, panic, psychosis, sleep problems,
- G related to mania, fewer sleep problems
- Those with high V and high G and those with high V and low G both had higher levels of suicidality as did those with low V and low G; however those with low V and high G were less likely to report suicidality
- High levels of G and V predicted high levels of violence

What does one do when there is very little or no evidence to guide you?

- Symptom driven approach
- Examine evidence for near-neighbor disorders
 - BPD
 - High level of comorbidity
 - Theoretical and conceptual connection
 - Subset analyses from existing studies
 - Articulation of rationale and technical modifications

Empirically Supported Near-Neighbor Treatments

- Dialectical Behavior Therapy (DBT)
- Schema Focused Psychotherapy (SFPT)
- System Training for Emotional Predictability and Problem Solving (STEPPS)
- Emotion Regulation Group Therapy (ERGT)
- Motive-Oriented Therapy Relationship (MOTR)
- Mentalization Based Therapy (MBT)
- Transference Focused Psychotherapy (TFP)
- Dynamic Deconstructive Psychotherapy (DDP)
- Gunderson's Psychodynamic Model (PDT-G) used in McMain et al
- Cognitive Analytic Therapy (CAT)

Modified Empirically Supported Near-Neighbor Treatments

- Mentalization Based Therapy (Cherrier, 2013)
- Transference Focused Psychotherapy (Stern et al., 2012; Diamond et al., 2013; Levy, 2012)
- Schema Focused Psychotherapy (Young, 1994; Young & Flanagan, 1998)
- Dialectical Behavioral Therapy (Reed-Knight & Fischer, 2011).

Technical Modifications when working with NPD

- Explicit non-judgmental/inquisitive stance
- Emphasis on tact and timing
- Use of preparatory and/or preinterpretation comments
- Focus on the extra (outside)-transference
- Use therapist focused comments rather than patient focused interpretations (hold the patients projections)
- Develop shared language
- Vigilance for mental state shifts
- Prepare patient for impact of work

Evidence Based Principle

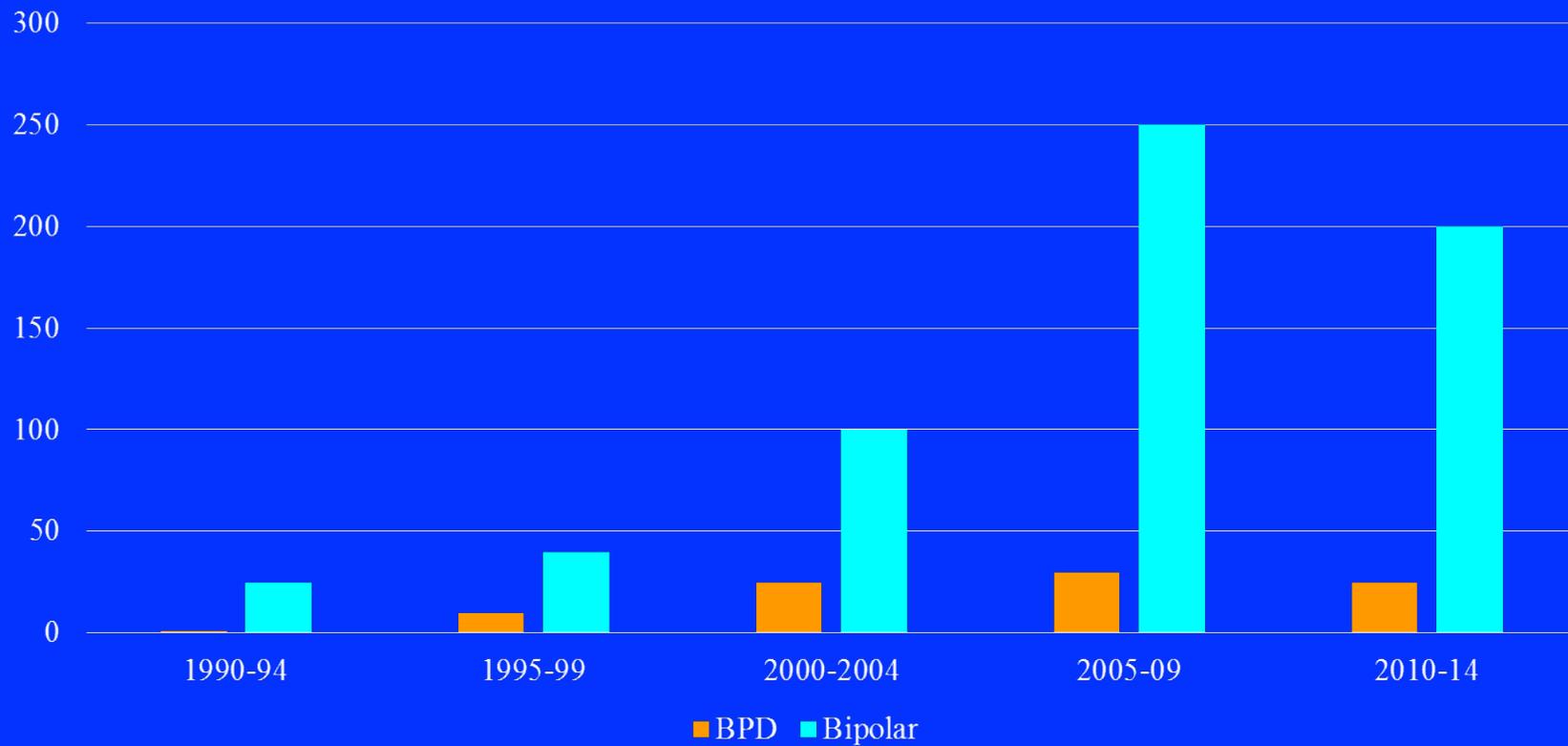
- Need for Specialized Training
 - In surveying 319 clinical Ph.D., Psy.D., and counseling programs in the United States
 - Only 24 (7.5%) of the programs reported having a faculty member with expertise in personality disorders.
 - Only 7 (2%) programs indicated that they specialize in the training and treatment of personality disorders.

Evidence Based Principle

- Need for Specialized Training
 - In contrast, 25% of programs have a faculty member with stated expertise in panic disorder
 - 10% of programs have a panic disorder specialty clinic.
 - The disparity is shocking considering the difference in prevalence (45% for PDs vs. 10% for panic disorder in outpatients).

We Need More Funding for Personality Disorders

NIH Funding in Millions



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Thank You

For more information please e-mail me at klevy@psu.edu and visit the Laboratory for Personality, Psychopathology, and Psychotherapy website at <http://levylab.psych.psu.edu>