Integrating DBT & GPM

Dr. Lois W. Choi-Kain

MMHC Grand Rounds & New England MHTTC

January 10th, 2024

SAMHSA

MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D, served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

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Presented 2022

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- STRENGTHS-BASED AND HOPEFUL
- INCLUSIVE AND ACCEPTING OF DIVERSE CULTURES, GENDERS, PERSPECTIVES, AND EXPERIENCES
- HEALING-CENTERED AND TRAUMA-RESPONSIVE
- INVITING TO INDIVIDUALS PARTICIPATING IN THEIR OWN JOURNEYS
- PERSON-FIRST AND FREE OF LABELS
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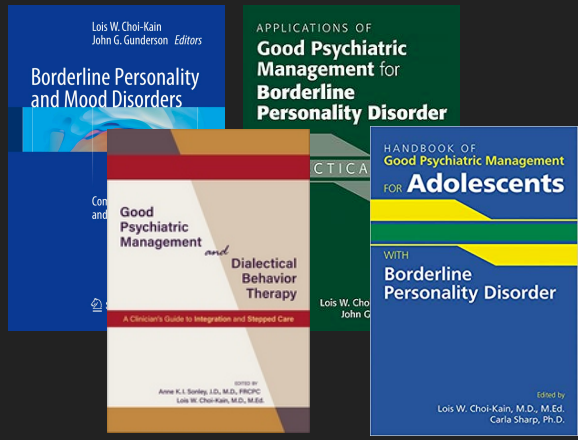
- RESPECTFUL, CLEAR AND UNDERSTANDABLE
- CONSISTENT WITH OUR ACTIONS, POLICIES, AND PRODUCTS

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

MMHC CHOI-KAIN 2024

CONFLICTS

- Springer Publishing: Royalties
- American Psychiatric Association Publishing: Royalties
- Boehringer Ingelheim: Consulting
- Tetricus Consulting:



McLean *Gunderson*
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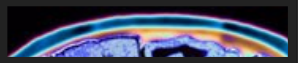
HISTORY OF EVIDENCE BASED TREATMENTS FOR BPD





1990-1999

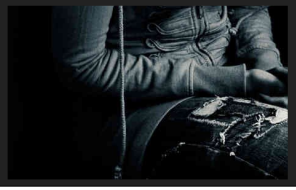
- DBT vs. TAU x2
- MBT partial vs. TAU
- STEPPS +TAU v TAU

2000-2008

- DBT v TBCE
- TFP v. ECP
- SFT v. TFP
- TFP v. DBT v. Supportive

2009-2018

- DBT v. GPM
- MBT v. SCM
- MBT v. Supportive
- DBT, DBT-I, DBT-S


" I'm sending you to a specialist . . don't tell him you know me. "

McLean Gunderson
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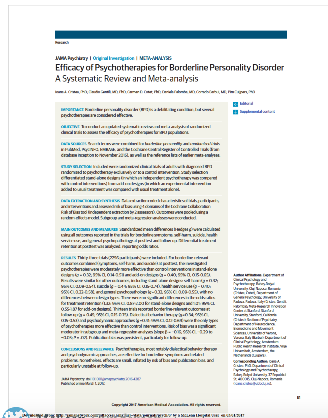
CRISTEA ET AL., 2017


Research

JAMA Psychiatry | Original Investigation | META-ANALYSIS

Efficacy of Psychotherapies for Borderline Personality Disorder
A Systematic Review and Meta-analysis

Ioana A. Cristea, PhD; Claudio Gentili, MD, PhD; Carmen D. Cotet, PhD; Daniela Palomba, MD; Corrado Barbui, MD; Pim Cuijpers, PhD

Editorial
Supplemental content

IMPORTANCE Borderline personality disorder (BPD) is a debilitating condition, but several psychotherapies are considered effective.

OBJECTIVE To conduct an updated systematic review and meta-analysis of randomized clinical trials to assess the efficacy of psychotherapies for BPD populations.

DATA SOURCES Search terms were combined for *borderline personality* and *randomized trials* in PubMed, PsycINFO, EMBASE, and the Cochrane Central Register of Controlled Trials (from database inception to November 2015), as well as the reference lists of earlier meta-analyses.

STUDY SELECTION Included were randomized clinical trials of adults with diagnosed BPD randomized to psychotherapy exclusively or to a control intervention. Study selection differentiated stand-alone designs (in which an independent psychotherapy was compared with control interventions) from add-on designs (in which an experimental intervention added to usual treatment was compared with usual treatment alone).

DATA EXTRACTION AND SYNTHESIS Data extraction coded characteristics of trials, participants, and interventions and assessed risk of bias using 4 domains of the Cochrane Collaboration Risk of Bias tool (independent extraction by 2 assessors). Outcomes were pooled using a random-effects model. Subgroup and meta-regression analyses were conducted.

MAIN OUTCOMES AND MEASURES Standardized mean differences (Hedges g) were calculated using all outcomes reported in the trials for borderline symptoms, self-harm, suicide, health service use, and general psychopathology at posttest and follow-up. Differential treatment retention at posttest was analyzed, reporting odds ratios.

RESULTS Thirty-three trials (2256 participants) were included. For borderline-relevant outcomes combined (symptoms, self-harm, and suicide) at posttest, the investigated psychotherapies were moderately more effective than control interventions in stand-alone designs (g = 0.32; 95% CI, 0.14-0.51) and add-on designs (g = 0.40; 95% CI, 0.15-0.65). Results were similar for other outcomes, including stand-alone designs: self-harm (g = 0.32; 95% CI, 0.09-0.54), suicide (g = 0.44; 95% CI, 0.15-0.74), health service use (g = 0.40; 95% CI, 0.22-0.58), and general psychopathology (g = 0.32; 95% CI, 0.09-0.55), with no differences between design types. There were no significant differences in the odds ratios for treatment retention (1.32; 95% CI, 0.87-2.00 for stand-alone designs and 1.01; 95% CI, 0.55-1.87 for add-on designs). Thirteen trials reported borderline-relevant outcomes at follow-up (g = 0.45; 95% CI, 0.15-0.75). Dialectical behavior therapy (g = 0.34; 95% CI, 0.15-0.53) and psychodynamic approaches (g = 0.41; 95% CI, 0.12-0.69) were the only types of psychotherapies more effective than control interventions. Risk of bias was a significant moderator in subgroup and meta-regression analyses (slope β = −0.16; 95% CI, −0.29 to −0.03; P = .02). Publication bias was persistent, particularly for follow-up.

CONCLUSIONS AND RELEVANCE Psychotherapies, most notably dialectical behavior therapy and psychodynamic approaches, are effective for borderline symptoms and related problems. Nonetheless, effects are small, inflated by risk of bias and publication bias, and particularly unstable at follow-up.

JAMA Psychiatry. doi:10.1001/jamapsychiatry.2016.4287
Published online March 1, 2017.

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Corresponding Author: Ioana A. Cristea, PhD, Department of Clinical Psychology and Psychotherapy, Babeș-Bolyai University, 37 Republicii St, 400015, Cluj-Napoca, Romania (ioana.cristea@ubbcluj.ro).

E1

A CONTROL GROUP BALANCED FOR THE INVOLVEMENT OF THE STUDY TEAM IN TREATMENT OR WITH A MANUALIZED PROTOCOL IS AS EFFECTIVE AS PSYCHOTHERAPIES TAILORED FOR BPD

- **Small to moderate effects** for stand-alone designs, **nonsignificant** results for add-on designs
- **Different types of psychotherapies:** no significant differences
- **Treatment retention:** no significant differences between experimental and control groups
- **Treatment intensity:** not related to treatment outcomes

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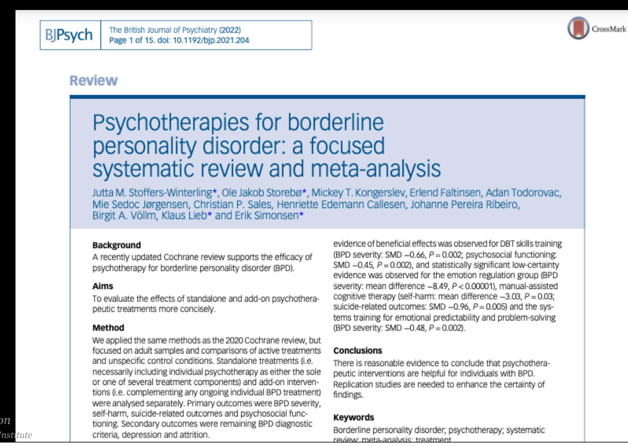
STATE OF KNOWLEDGE ABOUT PSYCHOTHERAPIES 2023


BJPsych | The British Journal of Psychiatry (2022)
Page 1 of 15. doi: 10.1192/bjp.2021.204

CrossMark

Review

Psychotherapies for borderline personality disorder: a focused systematic review and meta-analysis

Jutta M. Stoffers-Winterling*, Ole Jakob Storebø*, Mickey T. Kongerslev, Erlend Faltinsen, Adan Todorovac, Mie Sedoc Jørgensen, Christian P. Sales, Henriette Edemann Callesen, Johanne Pereira Ribeiro, Birgit A. Völlm, Klaus Lieb* and Erik Simonsen*

Background
A recently updated Cochrane review supports the efficacy of psychotherapy for borderline personality disorder (BPD).

Aims
To evaluate the effects of standalone and add-on psychotherapeutic treatments more concisely.

Method
We applied the same methods as the 2020 Cochrane review, but focused on adult samples and comparisons of active treatments and unspecific control conditions. Standalone treatments (i.e. necessarily including individual psychotherapy as either the sole or one of several treatment components) and add-on interventions (i.e. complementing any ongoing individual BPD treatment) were analysed separately. Primary outcomes were BPD severity, self-harm, suicide-related outcomes and psychosocial functioning. Secondary outcomes were remaining BPD diagnostic criteria, depression and attrition.

evidence of beneficial effects was observed for DBT skills training (BPD severity: SMD −0.66, P = 0.002; psychosocial functioning: SMD −0.45, P = 0.002), and statistically significant low-certainty evidence was observed for the emotion regulation group (BPD severity: mean difference −8.49, P < 0.00001), manual-assisted cognitive therapy (self-harm: mean difference −3.03, P = 0.03; suicide-related outcomes: SMD −0.96, P = 0.005) and the systems training for emotional predictability and problem-solving (BPD severity: SMD −0.48, P = 0.002).

Conclusions
There is reasonable evidence to conclude that psychotherapeutic interventions are helpful for individuals with BPD. Replication studies are needed to enhance the certainty of findings.

Keywords
Borderline personality disorder; psychotherapy; systematic review; meta-analysis; treatment

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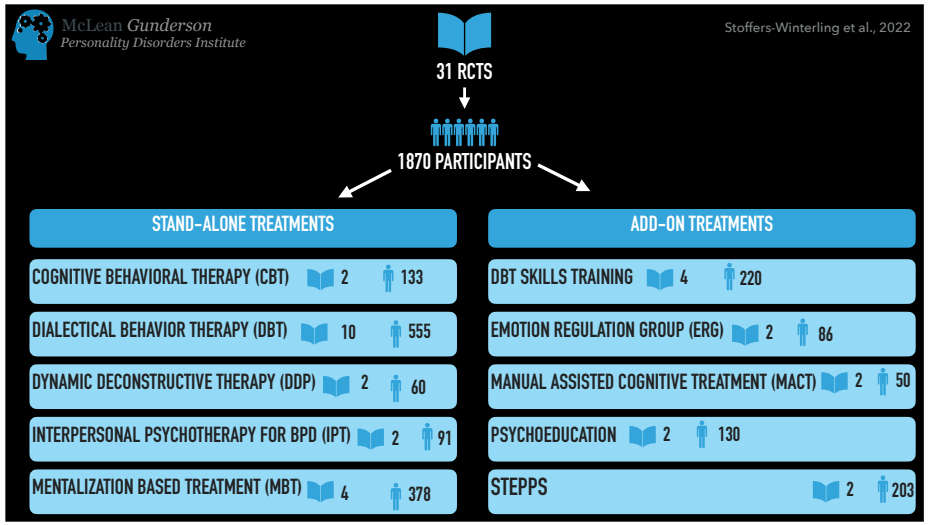

STAND-ALONE TREATMENTS

* = significant effect; — = no data/not reported

Stoffers-Winterling et al., 2022

	CBT	DBT	DDP	IPT-BPD	MBT
# Studies	2	10	2	2	4
BPD Severity	*		*		
Self-Harm		*			*
Suicide			—	—	*
Psychos. Func.		*	*		
Anger	—	*	—		—
Aff. Inst.	—		—	*	—
Emptiness	—	—	—		—
Impulsivity	—		—	*	—
Interpersonal			—	*	
Abandonment	—	—	—		—
Identity Disturbance	—	—	—		—
Dissoc. / psychotic	—				—
Depression			*		
Attrition					

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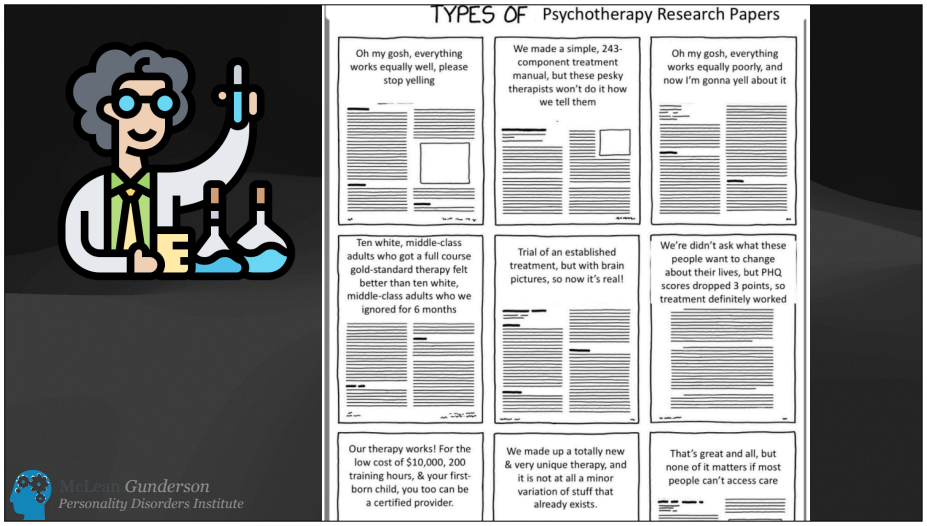
ADD-ON TREATMENTS

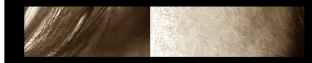
* = significant effect; — = no data/not reported

Stoffers-Winterling et al., 2022

	DBT Skills	ERG	MACT	Psychoed.	STEPPS
# Studies	4	2	2	2	2
BPD Severity	*	*	—		*
Self-Harm	—		*	—	
Suicide		—	*	—	—
Psychos. Func.	*		—		*
Anger	*	—	—	—	—
Aff. Inst.	*	*	—	—	
Emptiness		—	—	—	—
Impulsivity	*	*	—	*	
Interpersonal		*	—		*
Abandonment	—	—	—	—	—
Identity Disturbance	—	—	—	—	—
Dissoc. / psychotic	*	—	—		*
Depression	*	*	*		
Attrition				—	*



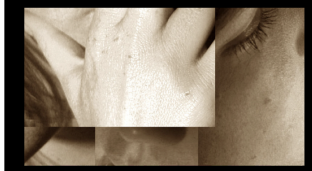
LIMITATIONS OF EVIDENCE BASED TREATMENTS FOR BPD



LIMITED ACCESS

- Demand > Supply
- EBTs are insufficient
- Generalist care improves access

Iliakis et al., 2019



DROPOUT

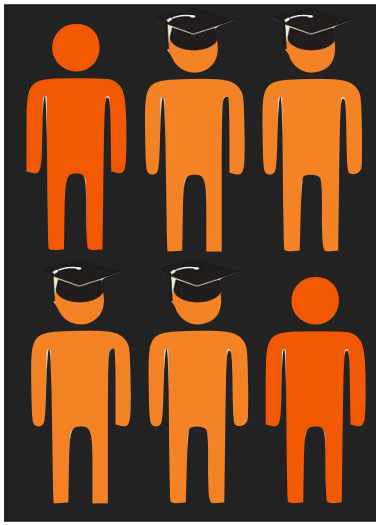
- 22% across studies
- 28% in RCTS
- 30% adjusting for bias
- Usually in first half of tx

Iliakis, Ilagan and Choi-Kain 2021

NON-RESPONSE

- 28 studies
- 2436 participants
- 48.8% non-response
- No difference in types

Woodbridge et al., 2021



- **22.3%** of BPD patients drop out of treatment, across study types
  - This jumped to **28.2%** for outpatient RCTs
  - And **29.9%** when adjusting for publication bias
- Odds of dropout were **NOT** higher in control conditions than in the intervention conditions
- **WHY?** Dissatisfaction with treatment, expulsion from treatment, and lack of motivation
- **WHEN?** Primarily in the first half of treatment

DROPOUTS FROM PSYCHOTHERAPY

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Iliakis, Ilagan and Choi-Kain 2021


One size
does NOT fit all
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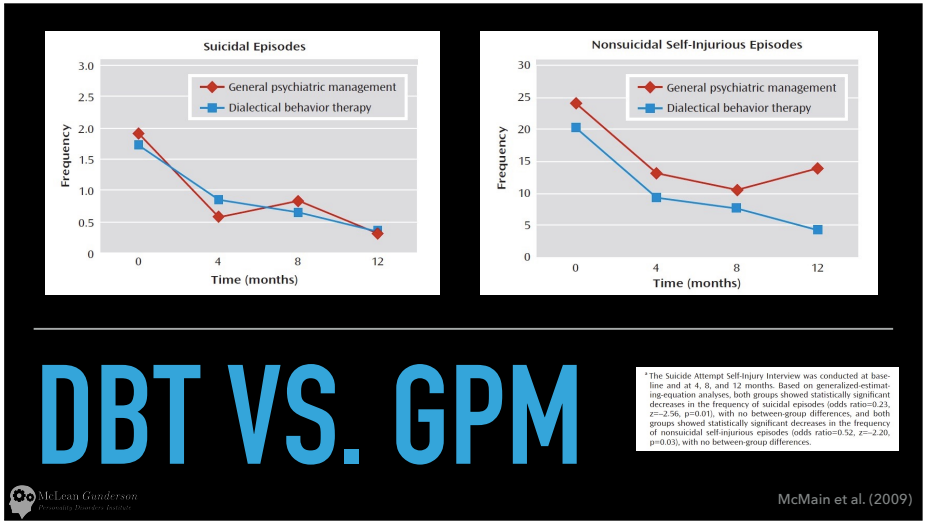
Suicidal Episodes
General psychiatric management
Dialectical behavior therapy
Frequency
3.0
2.5
2.0
1.5
1.0
0.5
0
0
4
8
12
Time (months)
Nonsuicidal Self-Injurious Episodes
General psychiatric management
Dialectical behavior therapy
Frequency
30
25
20
15
10
5
0
0
4
8
12
Time (months)
DBT VS. GPM
[a] The Suicide Attempt Self-Injury Interview was conducted at baseline and at 4, 8, and 12 months. Based on generalized-estimating-equation analyses, both groups showed statistically significant decreases in the frequency of suicidal episodes (odds ratio=0.23, z=–2.56, p=0.01), with no between-group differences, and both groups showed statistically significant decreases in the frequency of nonsuicidal self-injurious episodes (odds ratio=0.52, z=–2.20, p=0.03), with no between-group differences.
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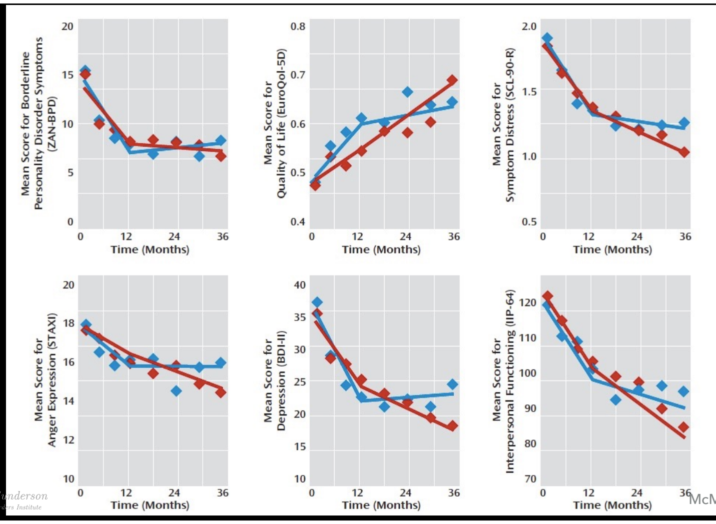
McMain et al. (2009)



McMain et al. (2012)

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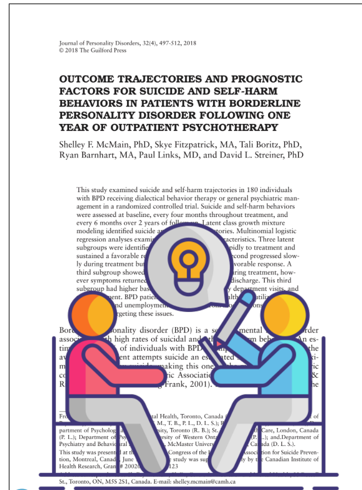

Journal of Personality Disorders, 32(4), 497-512, 2018
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OUTCOME TRAJECTORIES AND PROGNOSTIC FACTORS FOR SUICIDE AND SELF-HARM BEHAVIORS IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER FOLLOWING ONE YEAR OF OUTPATIENT PSYCHOTHERAPY

Shelley F. McMain, PhD, Skye Fitzpatrick, MA, Tali Boritz, PhD, Ryan Barnhart, MA, Paul Links, MD, and David L. Streiner, PhD

This study examined suicide and self-harm trajectories in 180 individuals with BPD receiving dialectical behavior therapy or general psychiatric management in a randomized controlled trial. Suicide and self-harm behaviors were assessed at baseline, every four months throughout treatment, and every 6 months over 2 years of follow-up. ...

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TRAJECTORIES OF TREATMENT RESPONSE

- Secondary analysis of RCT comparing DBT and GPM (McMain et al., 2009). Data fit a model of 3 classes:
  - **Class 1** *"Rapid and recovered"* (n=138): lowest suicide and self-harm behavior at baseline
  - **Class 2** *"Slow and recovered"* (n=14): higher suicide and self-harm behavior at baseline, slow decrease, equivalent rate to Class 1 after discharge
  - **Class 3** *"Recovered and relapsed"* (n=11): highest baseline rates, rapid decrease during treatment, increase to near-baseline after discharge

McMain et al 2018

WHAT WORKS FOR WHOM

- Rapid and recovered 84.6%
- Slow and recovered 8.6%
- Rapid and relapsed 6.8%

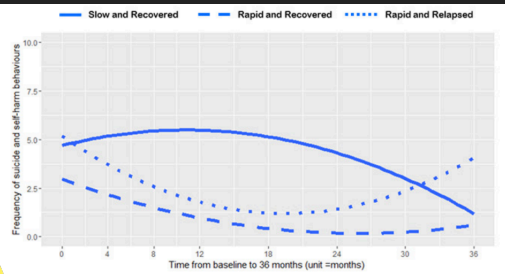

FIGURE 1. Trajectories of frequency of suicide and self-harm behaviors by trajectory group over 1 year of outpatient treatment for BPD and 2 years post-discharge.

TABLE 2. Means, Standard Deviations, and Proportions for Between-Class Comparisons From Multinomial Logistic Regression

	Class Membership		
Variable	Rapid and Sustained	Slow and Improved	Rapid and Regressed
SCL-90-R	1.83 (.78)	1.85 (.69)	2.07 (.33)
BDI-II	35.1* (11.5)	37.1 (11.1)	46.1 (5.9)
Mean number of ED visits	1.77* (2.8)	1.21 (1.93)	4.09 (6.4)
Percent employed	52.3**	57.1**	9.1
Percent DBT	50.0	47.1	81.8

Note. Difference reference class is Rapid and Regressed; SCL-90-R = Symptom Checklist; BDI-II = Beck Depression Inventory II; ED = emergency department; DBT = dialectical behavior therapy. *$p < .05$. **$p < .01$.

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Table 2. Descriptions of attained moderator variables (combined $n = 156$)

Moderator variable	Direction of moderation	DBT β	GPM β	Omnibus model p value	Interaction semi-partial r
GSI symptom severity	More general symptoms: GPM > DBT	0.79	0.13	0.002**	0.20
Childhood emotional abuse	More emotional abuse: DBT > GPM	−0.15	0.23	0.008**	0.17
Dependent personality traits	More dependent personality: DBT > GPM	−0.11	0.22	0.015*	0.16
Zanarini-impulsivity score	More impulsive BPD symptoms: GPM > DBT	0.24	−0.07	0.028*	0.14
Social adjustment scale	More maladjusted: DBT > GPM	−0.16	0.20	0.041*	0.13
Beck depression inventory	More depressed: DBT > GPM	−0.13	0.25	0.074	0.11

Note: β represents a standardized beta for comparison. Lower AUC values indicate better long-term outcomes on the GSI.

WHO RESPONDS BETTER TO WHAT?

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WHO RESPONDS BETTER TO WHAT?

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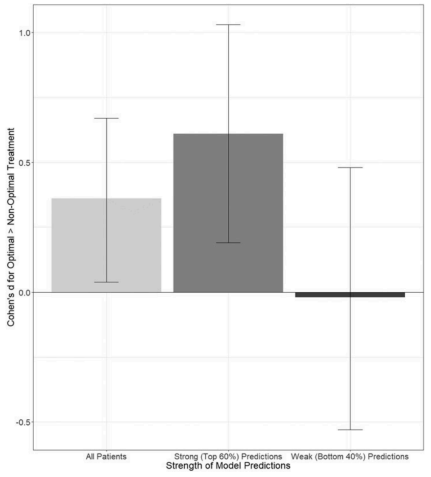
MATCH ONLY MATTERS FOR SOME AND NOT OTHERS

Fig. 1. The estimated advantage of randomization to a patient's model indicated optimal treatment over non-optimal treatment based on a combined moderator profile generated through cross-validated predictions. Bars reflect 95% bootstrapped confidence intervals, with non-overlap with the 0 point indicating significant cross-validated predictive value on GSI outcomes of the combined moderator. The average patient assigned to their optimal treatment was estimated to have significantly better long-term outcomes ($p = 0.028$). Among patients with a relatively stronger prediction (top 60% percentile), there was furthermore a significant advantage ($p = 0.004$) that was retained when engaging in a conservative statistical check ($p = 0.043$). However, patients with weaker predictions (bottom 40% percentile) were generally estimated to have no significant benefit to being assigned a predicted optimal treatment ($p = 0.929$).



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- 2/3 of subjects remitted
  - 39% Disability
  - 53% Unemployment
- Work was not emphasized in either DBT or GPM
- Prognosis related to employment

SYMPTOMATIC V. FUNCTIONAL

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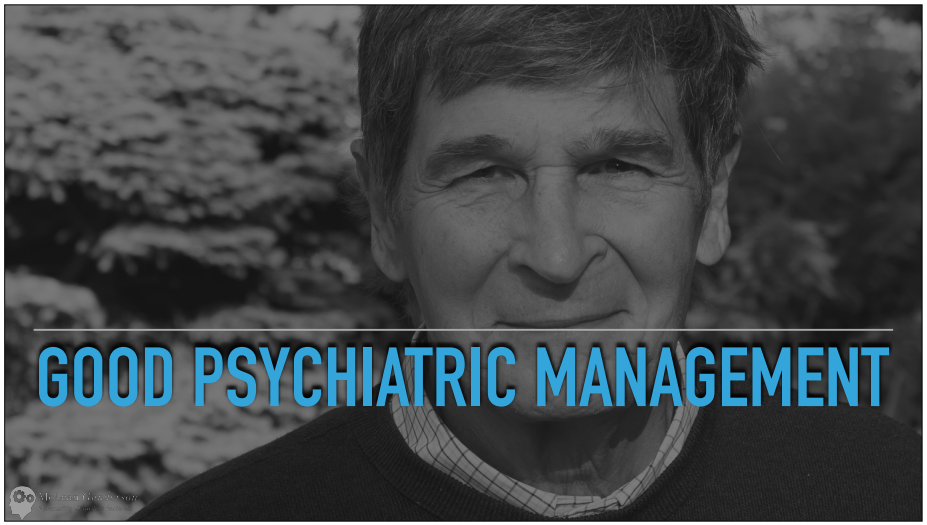
GOOD PSYCHIATRIC MANAGEMENT

GPM: DOING WHAT WORKS

DBT

- Homework
- Practical Problem Solving
- "Getting a life" as goal

GPM

TFP

- Attention to anger
- Use of interpretation
- Addresses devaluation

- Not Knowing Stance
- Attention to attachment
- Promotes social learning

MBT

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INTERPERSONAL COHERENCE

Interpersonal stress

Support by the other

CONNECTED
IDEALIZING, DEPENDENT

ALONENESS
PARANOID, IMPULSIVE

DESPAIR
SUICIDAL

Holding environment

Gunderson & Links (2014)


UNDER THE HOOD OF
GPM
CHEVROLET
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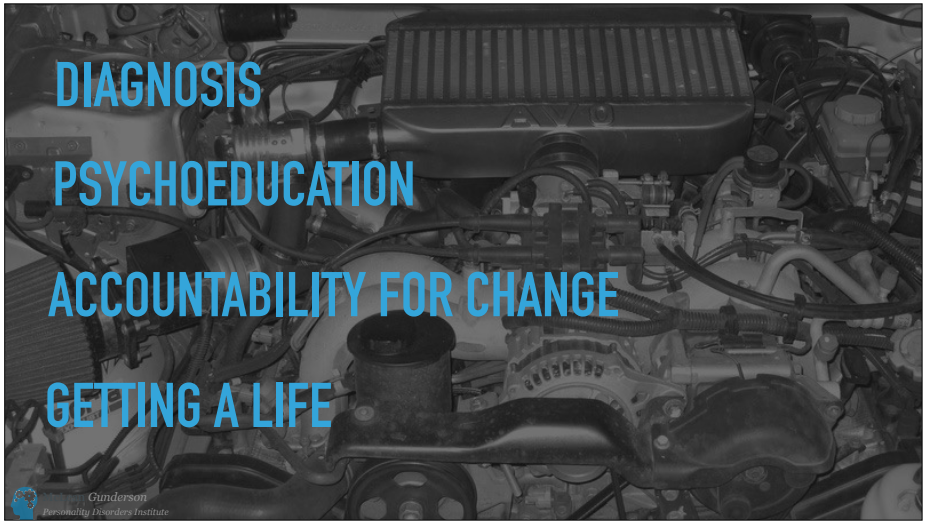
DIAGNOSIS
PSYCHOEDUCATION
ACCOUNTABILITY FOR CHANGE
GETTING A LIFE
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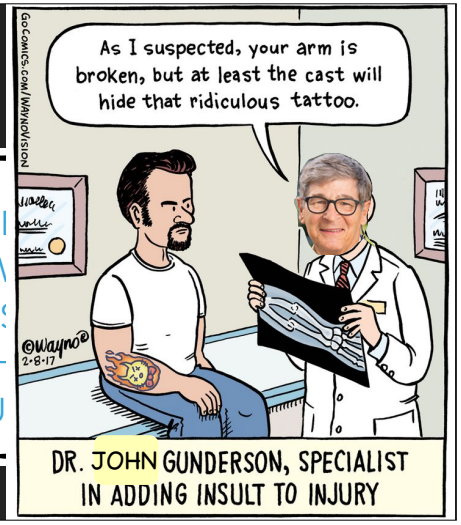
DIAGNOSIS

"THIS MEANS YOU WI
DISPOSITION FOR BPD. \
HYPERSENSITIVE IN WAY
IT DIFFICULT FOR OTH
HELPFU



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DIAGNOSIS

PSYCHOEDUCATION

ACCOUNTABILITY FOR CHANGE

GETTING A LIFE

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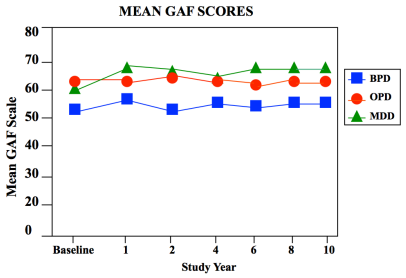
PSYCHOEDUCATION

FUNCTIONING OVER TIME



Gunderson et al., Arch Gen Psychiatry 2011

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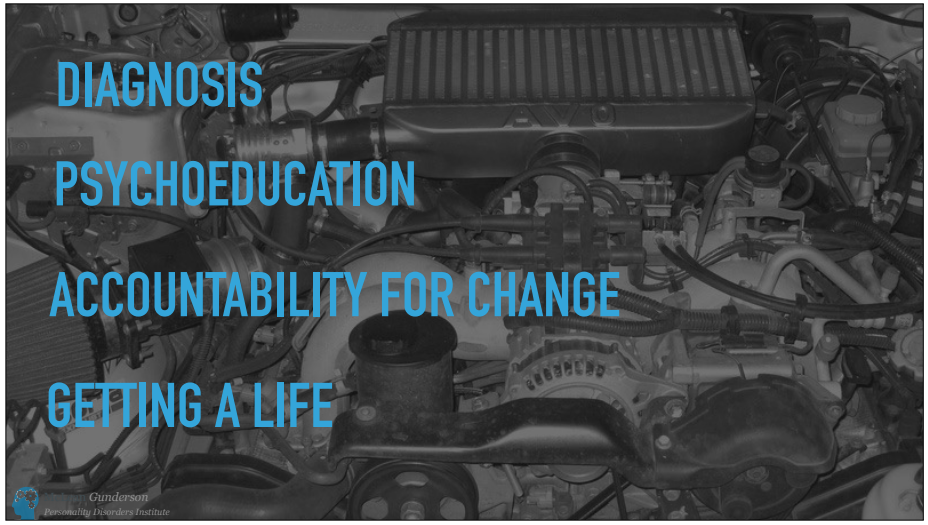
MMHC 2024 CHOI-KAIN

SIX SESSION GPM GROUP

- ***Ridolfi et al., 2020 (N=96) :***
  - GPM-PEG: greater improvements in BPD for all sectors (ZAN-BPD) except impulsivity at post-treatment and sustained 2-months post
  - 46% of treatment group > 50% reduction in BPD symptoms compared to 3% waitlist



ACCOUNTABILITY: EXPECTATION TO CHANGE

(FACILITATING NATURAL COURSE OF ILLNESS)

WE WILL ONLY CONTINUE TREATMENT IF IT IS ACTUALLY WORKING

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DIAGNOSIS

PSYCHOEDUCATION

ACCOUNTABILITY FOR CHANGE

GETTING A LIFE

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GETTING A LIFE

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- 2/3 of subjects remitted
  - 39% Disability
  - 53% Unemployment
- Work was not emphasized in either DBT or GPM
- Prognosis related to employment

SYMPTOMATIC V. FUNCTIONAL

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DIAGNOSIS

PSYCHOEDUCATION

ACCOUNTABILITY FOR CHANGE

GETTING A LIFE

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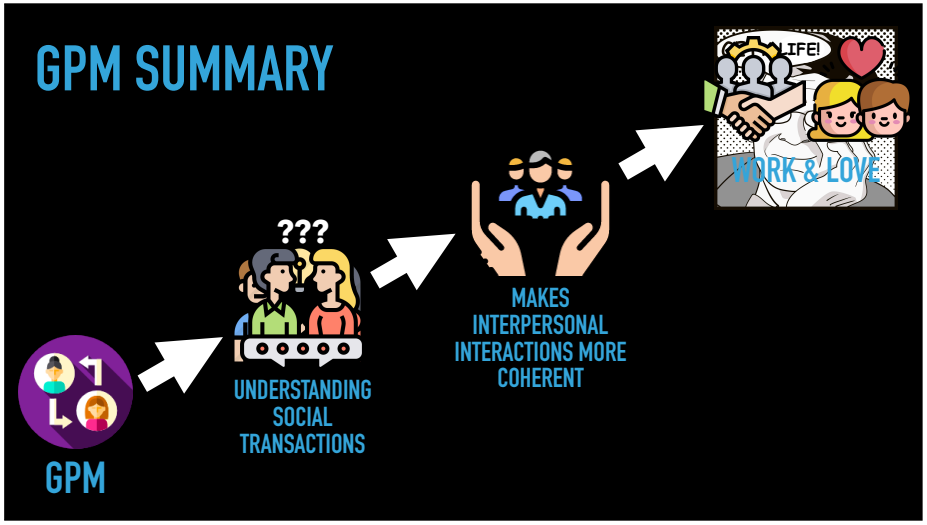
CHEVROLET

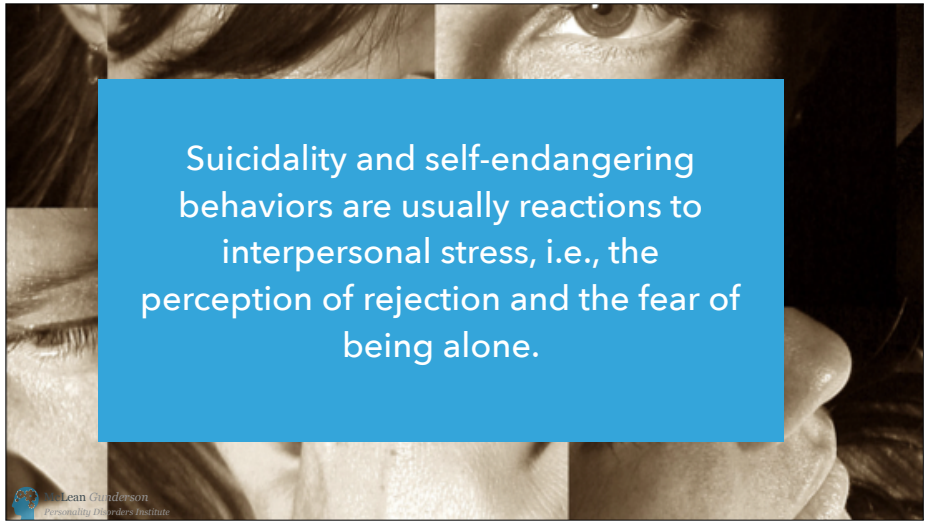

GPM SUMMARY
???
UNDERSTANDING SOCIAL TRANSACTIONS
MAKES INTERPERSONAL INTERACTIONS MORE COHERENT
IFE!
WORK & LOVE
GPM

INGREDIENTS OF GPM

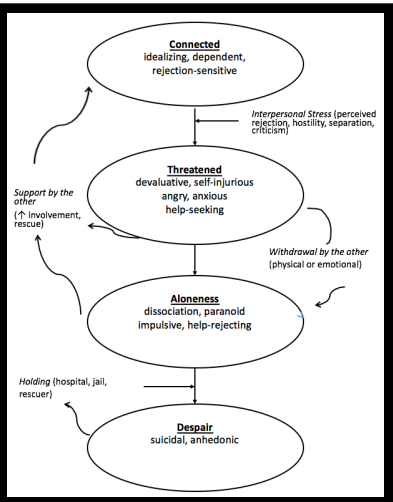
Managing Safety

crisis plan

dangerousness assessment



BPD'S INTERPERSONAL COHERENCE



I can help you to manage these behaviors, but to diminish their cause we need to help you find better social supports – people to help you with those situations.

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FACTORS AFFECTING VARIATIONS IN RISK

Increases risk

- (-) Interpersonal Events
- Substance Abuse
- Increased depression
- Step-downs

Decreases risk

- (+) Interpersonal Events
- Safety Plan
- Crisis Skills
- Low dose antipsychotics
- Hospitalization

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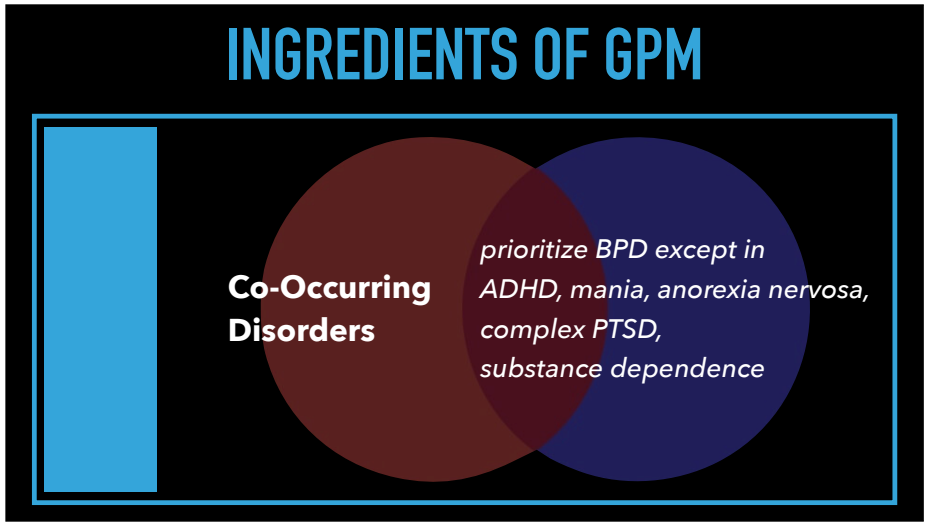
INGREDIENTS OF GPM



ADDRESS COMORBIDITY

	CONSIDERATION	EXAMPLES
PRIORITIZE COMORBIDITY WHEN	COMORBIDITY PRECLUDES INVOLVEMENT OR ACTIVE LEARNING	MANIA, ADHD, SUBSTANCE USE, ANOREXIA
PRIORITIZE BPD WHEN	COMORBIDITY IS UNLIKELY TO REMIT OR LIKELIER TO RECUR UNLESS BPD IS IN REMISSION	DEPRESSION, ANXIETY, SOCIAL PHOBIA, REMITTED BIPOLAR DISORDER (I OR II), BULIMIA
STABILIZE BPD BEFORE ADDRESSING COMORBIDITY TO	INCREASE PATIENT'S ABILITY TO TOLERATE EXPOSURE THERAPY	PANIC DISORDER, PTSD, OCD

ADAPTED FROM MERCER & LINKS, 2019

INGREDIENTS OF GPM

Pharmacotherapy

conservative prescribing
meds as adjunctive
target co-occurring disorders

INGREDIENTS OF GPM

Multimodality

team approach
family involvement
socialization
give to get, follow rules

INGREDIENTS OF GPM

Mechanism

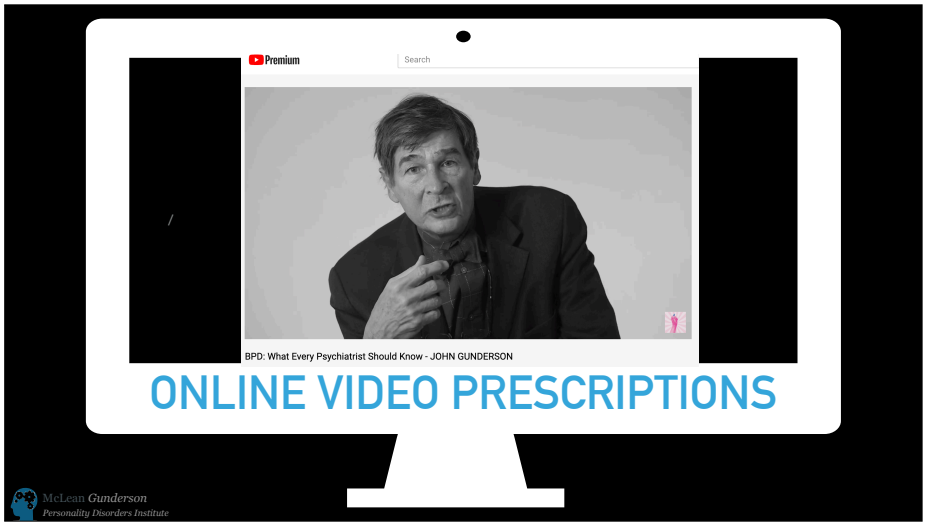
GOAL 1: THINK FIRST

GOAL 2: DEVELOP A CORRECTIVE RELATIONAL EXPERIENCE

(PEOPLE ARE FLAWED/LIMITED)

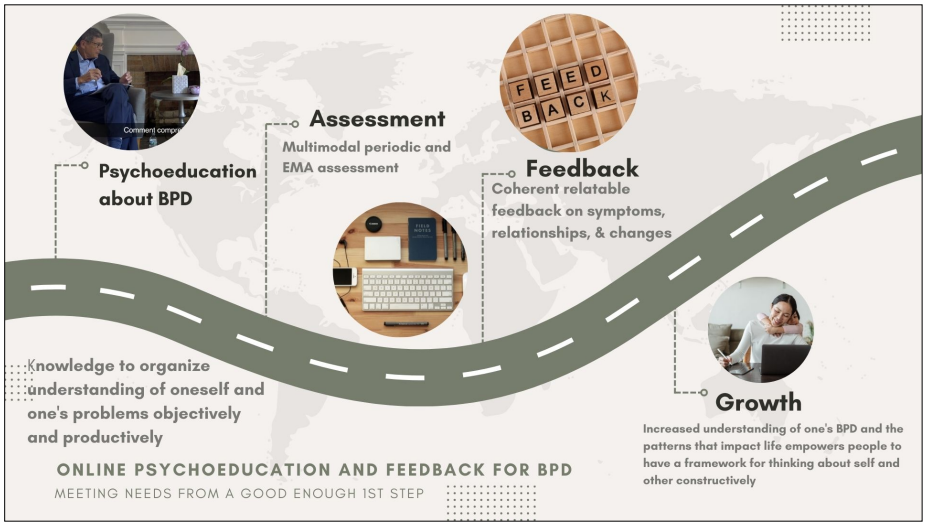
GOAL 3: GET A LIFE

(CAN SUSTAIN SELF-ESTEEM MORE DIRECTLY THROUGH WORK/SCHOOL-RELATED ACTIVITIES)

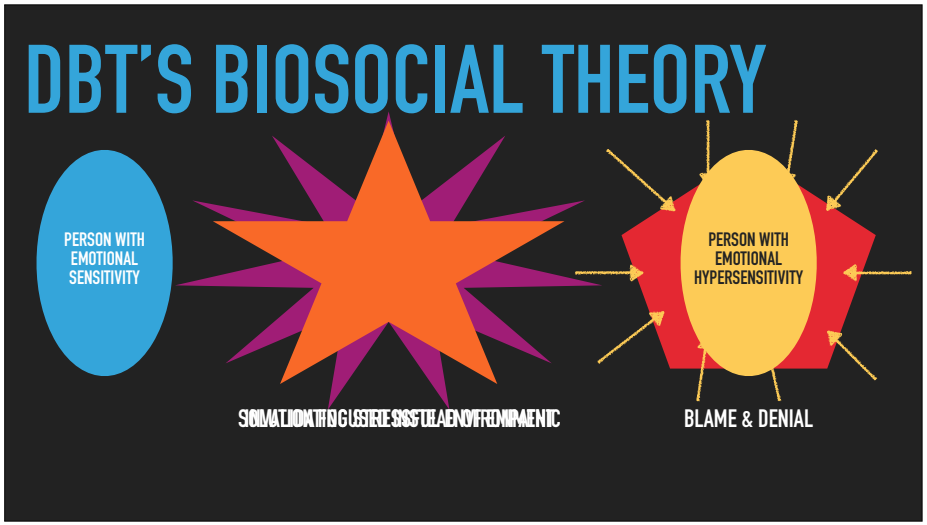


10 PRESCRIPTION VIDEOS IN 14 DAYS

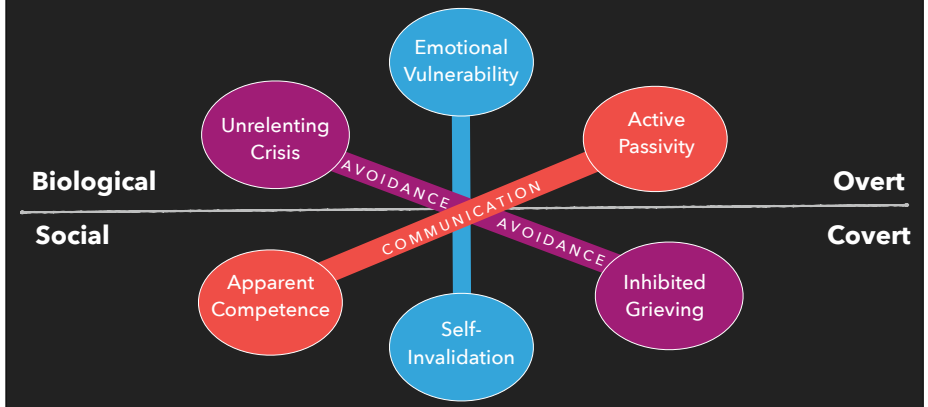
1. BPD Symptoms
2. Interpersonal Hypersensitivity
3. Basic Facts: Prevalence, Heritability
4. Long-term Course
5. Co-occurring Disorders
6. Key Principles of Treatment
7. Common Factors of Treatment
8. Medications & BPD
9. Psychotherapy
10. Review: Top 10 Tips




DIALECTICAL BEHAVIORAL THERAPY


DBT'S BIOSOCIAL THEORY
PERSON WITH EMOTIONAL SENSITIVITY
PERSON WITH EMOTIONAL HYPERSENSITIVITY
BLAME & DENIAL

BPD'S DIALECTICAL DILEMMAS



DBT DISMANTLING STUDY (N=99)

SIGNIFICANT DIFFERENCES BETWEEN SKILLS VS. STANDARD IN:

NO. OF ALL INDIVIDUAL THERAPY SESSIONS (20 VS. 42)
TOTAL TREATMENT HOURS (32 VS. 55)

DESPITE LOWER DOSE, NO SIGNIFICANT DIFFERENCES IN ANY OUTCOMES:

DROPOUT (39% VS. 24%)
SUICIDE ATTEMPTS AND NSSI EPISODES
RATE OF ED VISITS OR HOSPITAL ADMISSIONS FOR PSYCHIATRIC REASONS/SUICIDES
RATE OF CHANGE OF DEPRESSION AND ANXIETY SX

BOTH, COMPARED TO INDIVIDUAL THERAPY, RESULTED IN:

↓ NSSI ACTS, FASTER IMPROVEMENT ON DEPRESSION & ANXIETY

Linehan et al, 2015

Psychotherapy and Psychosomatics

Innovations

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The Effectiveness of 6 versus 12 Months of Dialectical Behavior Therapy for Borderline Personality Disorder: A Noninferiority Randomized Clinical Trial

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Katherine L. Dixon-Gordon[f] Timothy Henry Guimond[a, b] Cathy Labrish[a]
Wanrudee Isaranuwatchai[g, h] David L. Streiner[b, i]

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Keywords
Noninferiority · Dialectical behavior therapy · Borderline personality disorder · Suicidality · Psychotherapy outcome research

Abstract
Introduction: Evidence-based psychotherapies for borderline personality disorder (BPD) are lengthy, posing a barrier to their access. Brief psychotherapy may achieve comparable outcomes to long-term psychotherapy for BPD. Evidence is needed regarding the comparative effectiveness of short- versus long-term psychotherapy for BPD. ***Objective:*** The aim was to determine if 6 months of Dialectical Behavior Therapy (DBT) is noninferior to 12 months of DBT in terms of clinical effectiveness. ***Methods:*** This two-arm, single-blinded, randomized controlled noninferiority trial with suicidal or self-harming patients with BPD was conducted at two sites in Canada. Participants ($N = 240$, $M\,(SD)_{age} = 28.27\,(8.62)$, 79% females) were randomized to receive either 6 (DBT-6) or 12 months (DBT-12) of comprehensive DBT. Masked assessors obtained measures of clinical effectiveness at baseline and every 3 months, ending at month 24. DBT-6 and DBT-12 were outpatient treatments consisting of weekly individual therapy sessions, weekly DBT skills training group sessions, telephone consultation as needed, and weekly therapist consultation team meetings. ***Results:*** The noninferiority hypothesis was supported for the primary outcome, total self-harm (6 months: margin = −1.94, M_{diff} [95% CI] = 0.16 [−0.14, 0.46]; 12 months: margin = −1.47, M_{diff} [95% CI] = 0.04 [−0.17, 0.23]; 24 months: margin = −1.25, M_{diff} [95% CI] = 0.12 [−0.02, 0.36]). Results also supported noninferiority of DBT-6 for general psychopathology and coping skills at 24 months. Furthermore, DBT-6 participants showed more rapid reductions in BPD symptoms and general psychopathology. There were no between-group differences in dropout rates. ***Conclusions:*** The noninferiority of a briefer yet comprehensive treatment for BPD has potential to reduce barriers to treatment access.

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OPEN ACCESS

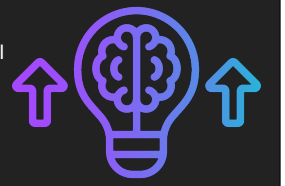
FASTER TRIAL

- First data on optimal length of BPD therapy
- 240 patients with BPD + chronic suicidality randomized to receive:
  - Standard 12-month DBT
  - Brief 6-month DBT
- Measuring:
  - Clinical outcomes (frequency of suicidal or NSSI, healthcare utilization, psychiatric and emotional symptoms, general and social functioning, and health status).
  - Cost effectiveness (e.g. missed work days and lost productivity)

McMain et al 2022

FASTER TRIAL RESULTS

- 6-month DBT not inferior to 12-month DBT for reducing suicidal or NSSI, general psychopathology, BPD symptoms, increasing coping skills.
- Noninferiority shown at 24 months for overall self-harm and general psychopathology.
- No difference in rate of diagnostic remission at 24 months.
- Secondary analysis (Traynor et al., in preparation) showed 6-month treatment was *superior* for patients with :
  - Impaired inhibitory control shown in performance-based impulsivity, not self-reported impulsivity)



Research

JAMA | Original Investigation

Effect of Offering Care Management or Online Dialectical Behavior Therapy Skills Training vs Usual Care on Self-harm Among Adult Outpatients With Suicidal Ideation
A Randomized Clinical Trial

Gregory E. Simon, MD, MPH; Susan M. Shortreed, PhD; Rebecca C. Rossom, MD, MS; Arne Beck, PhD; Gregory N. Clarke, PhD; Ursula Whiteside, PhD; Julie E. Richards, MPH, PhD; Robert B. Penfold, PhD; Jennifer M. Boggs, PhD, MSW; Jula Sinith, MS

IMPORTANCE People at risk of self-harm or suicidal behavior can be accurately identified, but effective prevention will require effective scalable interventions.

OBJECTIVE To compare 2 low-intensity outreach programs with usual care for prevention of suicidal behavior among outpatients who report recent frequent suicidal thoughts.

DESIGN, SETTING, AND PARTICIPANTS Pragmatic randomized clinical trial including outpatients reporting frequent suicidal thoughts identified using routine Patient Health Questionnaire depression screening at 4 US integrated health systems. A total of 18 882 patients were randomized between March 2015 and September 2018, and ascertainment of outcomes continued through March 2020.

INTERVENTIONS Patients were randomized to a care management intervention (n = 6230) that included systematic outreach and care, a skills training intervention (n = 6227) that introduced 4 dialectical behavior therapy skills (mindfulness, mindfulness of current emotion, opposite action, and paced breathing), or usual care (n = 6187). Interventions, lasting up to 12 months, were delivered primarily through electronic health record online messaging and were intended to supplement ongoing mental health care.

MAIN OUTCOMES AND MEASURES The primary outcome was time to first nonfatal or fatal self-harm. Nonfatal self-harm was ascertained from health system records, and fatal self-harm was ascertained from state mortality data. Secondary outcomes included more severe self-harm (leading to death or hospitalization) and a broader definition of self-harm (selected injuries and poisonings not originally coded as self-harm).

RESULTS A total of 18 644 patients (9009 [48%] aged 45 years or older; 12 543 [67%] female; 9222 [50%] from mental health specialty clinics and the remainder from primary care) contributed at least 1 day of follow-up data and were included in analyses. Thirty-one percent of participants offered care management and 39% offered skills training actively engaged in intervention programs. A total of 540 participants had a self-harm event (including 45 deaths attributed to self-harm and 495 nonfatal self-harm events) over 18 months following randomization: 172 (3.27%) in care management, 206 (3.92%) in skills training, and 162 (3.27%) in usual care. Risk of fatal or nonfatal self-harm over 18 months did not differ significantly between the care management and usual care groups (hazard ratio [HR], 1.07; 97.5% CI, 0.84-1.37) but was significantly higher in the skills training group than in usual care (HR, 1.29; 97.5% CI, 1.02-1.64). For severe self-harm, care management vs usual care had an HR of 1.03 (97.5% CI, 0.71-1.51), skills training vs usual care had an HR of 1.34 (97.5% CI, 0.94-1.91). For the broader self-harm definition, care management vs usual care had an HR of 1.10 (97.5% CI, 0.82-1.33), skills training vs usual care had an HR of 1.27 (97.5% CI, 0.97-1.41).

CONCLUSIONS AND RELEVANCE Among adult outpatients with frequent suicidal ideation, offering care management did not significantly reduce risk of self-harm, and offering brief dialectical behavior therapy skills training significantly increased risk of self-harm, compared with usual care. These findings do not support implementation of the programs tested in this study.

Visual Abstract
Editorial page E26
Supplemental content

A LITTLE DOES NOT GO A LONG WAY

- Randomized controlled trial of online care (n=18,882 adults with frequent suicidal ideation in 4 healthcare systems) comparing:
  - management modeled after collaborative care
  - DBT skills training
    - Mindfulness, mindfulness to current emotion, paced breathing, opposite action
    - TAU across four US integrated health systems
- Neither add on empirically supported suicide reduction intervention (care mgt or DBT) significantly reduced self-harm.
- **Light DBT skills significantly increased self-harm rates.**

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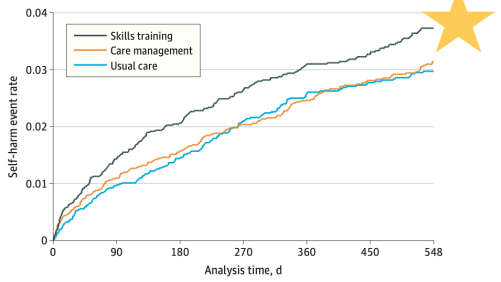
Simon et al 2022

Effect of Low-Intensity Outreach Programs vs Usual Care on Self-harm in Outpatients With Suicidal Ideation

Original Investigation Research

Figure 2. Time to First Instance of Fatal or Nonfatal Self-harm by Initial Randomization Group



No. at risk							
Skills training	6227	5773	5395	5043	4759	4543	4298
Care management	6230	5833	5422	5081	4788	4555	4302
Usual care	6187	5799	5388	5043	4763	4546	4294

Fatal self-harm was ascertained by linkage to state mortality data. Nonfatal self-harm was ascertained from health system electronic health record and insurance claims data, including injuries and poisonings diagnosed as self-harm and injuries and poisonings receiving selected other diagnoses but confirmed as self-harm by review of full-text medical records (eAppendix 6 in Supplement 2). The hazard ratio for care management vs usual care is 1.07 (97.5% CI, 0.84-1.37), and the hazard ratio for skills training vs usual care is 1.29 (97.5% CI, 1.02-1.64).

DBT TOOLKIT

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6 LEVELS OF VALIDATION

1. Stay awake, look and listen, don't judge
2. Reflect back to the person what they have said to you
3. Saying what the person might have felt/thought/want to do (articulate)
4. It's normal and understandable given history and biology (past)
5. It's normal and understandable (present)
6. Radical genuiness

6 LEVELS OF CONFRONTATION

1. Feedback anyone would want to hear (e.g. zipper, food in teeth)
2. Feedback, having to do with choices (e.g. pants look unflattering)
3. Feedback about behaviors/habit (minor- focus on consequences)
4. Feedback about a person's makeup/tendencies (past; e.g. being late)
5. Feedback about a person's tendencies (present; normal)
6. Radical Transparency

COMMITMENT STRATEGIES

- Foot in the door
- Door in the face
- Freedom to choose
- Enter the paradox
- Pros and cons
- Devil's advocate
- Extending
- Lemonade out of lemons

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STRATEGIES FOR TREATMENT-INTERFERING BEHAVIOR

- Non-judgmental approach
- Can apply to patient or clinician behaviors
- Explore and problem solve; do not place blame or find fault
- Discuss this concept early

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SESSION FLOW: DIARY CARDS AND AGENDA SETTING

Review diary card

- Behavior monitoring from previous week
- Personalized to individual patient

Day	Date	Self- Harm (Urge) 0-5	Self-Harm (Behav)	SI (Urge) 0-5	SI (Behav)	Alcohol (Urge) 0-5	Alcohol (Behav)	Drugs (Urge) 0-5	Drugs (Behav)	Med Misuse (Urge) 0-5	Medi Misuse (Behav)	Binge (Urge) 0-5	Binge (Behav)	Sadness 0-5	Fear 0-5	Anger 0-5	Shame 0-5	Joy 0-5
M																		
T																		
W																		

Create session agenda

- Organize session according to hierarchy of treatment targets:
  1. Life-threatening behaviors
  2. Treatment-interfering behaviors
  3. Quality-of-life interfering behaviors

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TABLE FROM CHOI-KAIN & SONLEY, 2021

TOP 10 DBT SKILLS

Skill	Category
1) STOP	Distress Tolerance
2) TIPP	Distress Tolerance
3) Distraction (ACCEPTS)	Distress Tolerance
4) "What" skills (observe, describe, and participate)	Mindfulness
5) "How" skills (non-judgmentally, one-mindfully, effectively)	Mindfulness
6) Wise Mind	Mindfulness
7) Observing, Describing and Naming Emotions	Emotion Regulation
8) Check the Facts and Problem Solving or Opposite Action	Emotion Regulation
9) ABC PLEASE	Emotion Regulation
10) DEAR MAN GIVE FAST	Interpersonal
Bonus Skills: Radical Acceptance and Mindfulness of Current Emotions	Distress Tolerance

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TABLE FROM MCMAIN & SONLEY, 2021

DISTRESS TOLERANCE SKILLS

STOP

- 1. Stop
- 2. Take a step back
- 3. Observe
- 4. Proceed Mindfully

First skill to use when becoming emotionally dysregulated

Notice the dysregulation and think rather than reacting

TIPP

- 1. Temperature
- 2. Intense exercise
- 3. Paced breathing
- 4. Progressive muscle relaxation

Most helpful for patients at an emotional breaking point

Reduces distress during fight-or-flight response

ACCEPTS (Distraction)

- 1. Activities
- 2. Contributing
- 3. Comparisons
- 4. Emotions
- 5. Pushing away
- 6. Thoughts
- 7. Sensations

Used for situations a person cannot resolve and must tolerate

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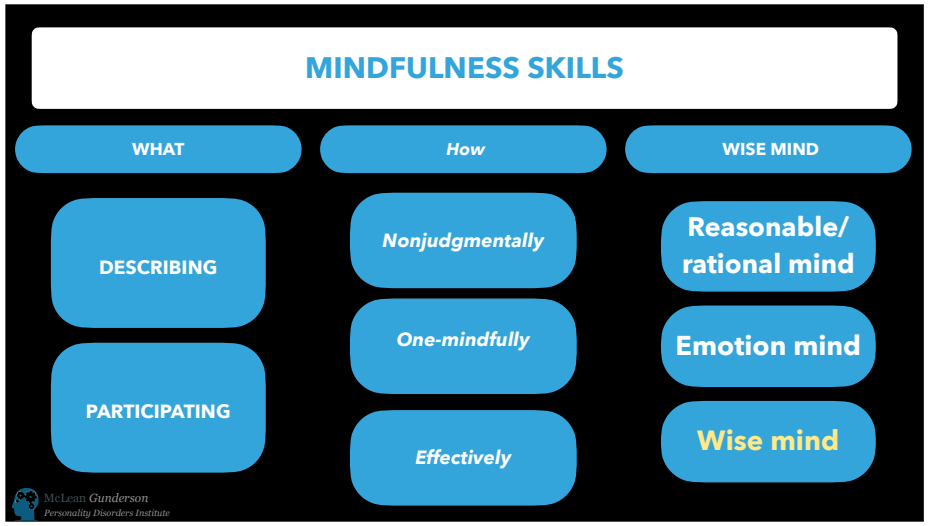
MINDFULNESS SKILLS
WHAT
How
WISE MIND
DESCRIBING
PARTICIPATING
Nonjudgmentally
One-mindfully
Effectively
Reasonable/ rational mind
Emotion mind
Wise mind
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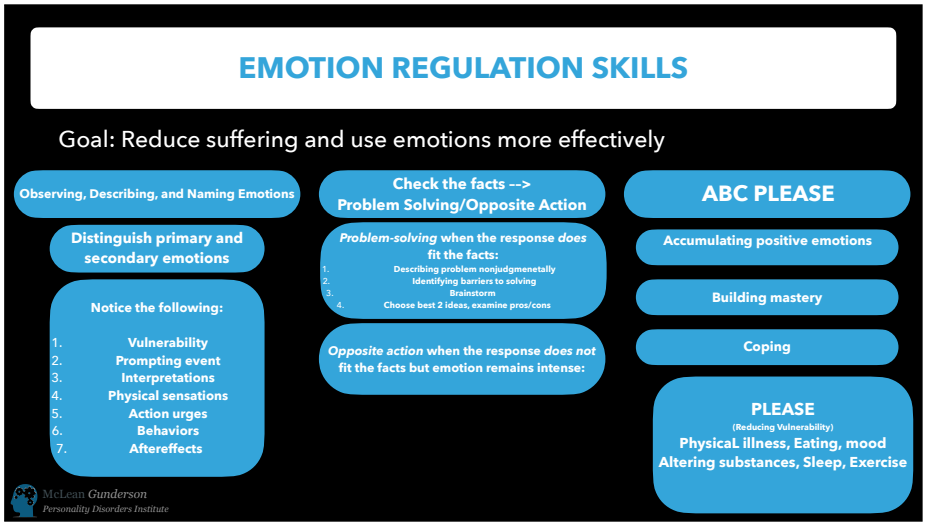
EMOTION REGULATION SKILLS
Goal: Reduce suffering and use emotions more effectively
Observing, Describing, and Naming Emotions
Distinguish primary and secondary emotions
Notice the following:
1. Vulnerability
2. Prompting event
3. Interpretations
4. Physical sensations
5. Action urges
6. Behaviors
7. Aftereffects
Check the facts --> Problem Solving/Opposite Action
Problem-solving when the response does fit the facts:
1. Describing problem nonjudgmenetally
2. Identifying barriers to solving
3. Brainstorm
4. Choose best 2 ideas, examine pros/cons
Opposite action when the response does not fit the facts but emotion remains intense:
ABC PLEASE
Accumulating positive emotions
Building mastery
Coping
PLEASE
(Reducing Vulnerability)
PhysicaL illness, Eating, mood
Altering substances, Sleep, Exercise
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PROBLEM SOLVING AND OPPOSITE ACTION

Check the facts --> Problem Solving/Opposite Action

***Problem-solving* when the response *does* fit the facts:**

1. Describing problem nonjudgmenetally
2. Identifying barriers to solving
3. Brainstorm
4. Choose best 2 ideas, examine pros/cons

***Opposite action* when the response *does not* fit the facts but emotion remains intense:**

Emotion	Action Urge	Opposite Action
Fear	Avoid	Approach
Anger	Attack	Avoid (gently), Be nice
Sadness	Withdraw	Get active, See people
Shame	Hide/Avoid/Repair	Disclose, Approach, Appear confident, No apologies
Guilt	Stop behavior/Repair	Repeat behavior, No apologies, Self-validate
Envy	Obtain/Destroy	Count blessings, Help others
Jealousy	Control	Let go of control, Share what you have
Disgust	Avoid	Approach, Be nice

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INTERPERSONAL EFFECTIVENESS SKILLS

Skills for making requests to another person

DEAR MAN		GIVE	FAST
Describe	Mindful	Gentle	Fair
Express	Appear confident	Interested	No Apologies
Assert	Negotiate	Validate	Sticking to values
Reinforce		Easy manner	Truthful

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THE DIALECTICAL ATTITUDE REDUCES SPLITTING

Radical acceptance

Fully accepting reality as it is.

Mindfulness

Paying attention *intentionally* and *nonjudgmentally*.

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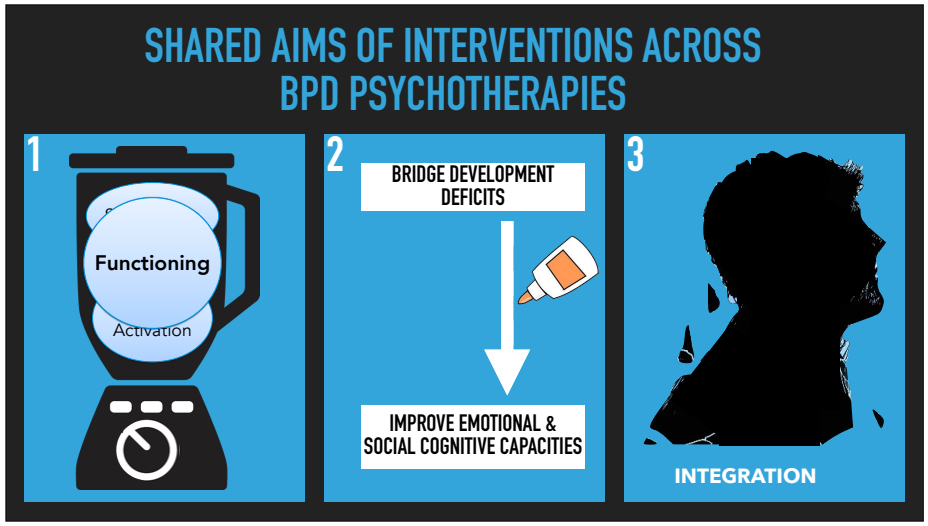
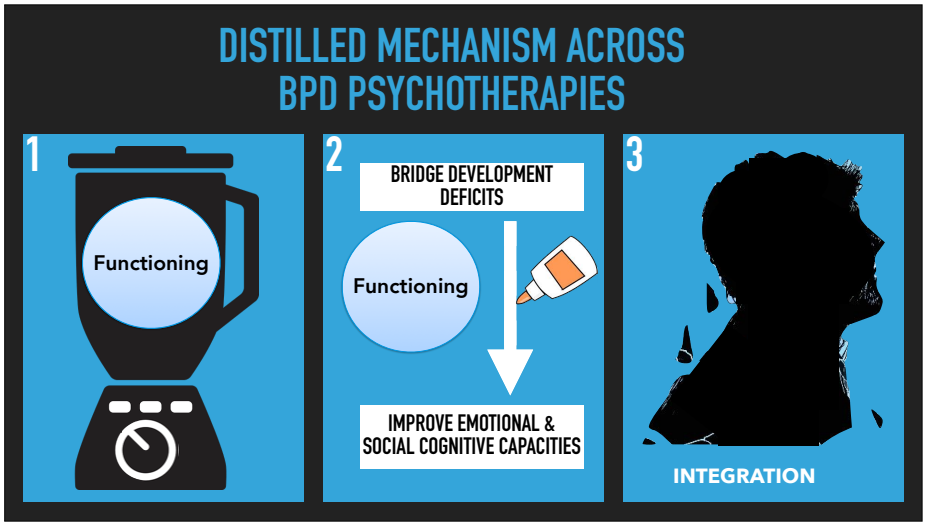
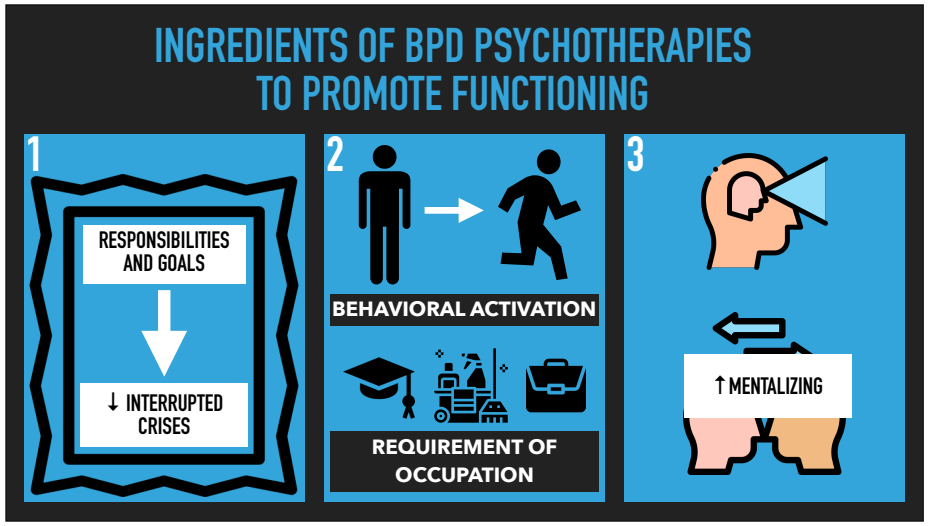
	Severity	Definition	Potential Interventions
5 Chronic persistent	Unremitting & unresponsive disorder	Unresponsive to interventions from previous stages	Low frequency GPM or Supportive therapy Rehabilitative focus Case management (e.g. state/public services)
4 Severe	Remitting & relapsing	+ severe self-harm + suicide attempts with moderate to high risk	DBT or MBT (where available) v. GPM Consider higher level of care DBT skills, STEPPS group & Family
3 Sustained moderate	Sustained threshold level symptoms	Unresponsive to basic treatment + self-harm + suicidal ideation	DBT or MBT (where available) v.GPM DBT skills or STEPPS group Carer intervention
2 Early-mild	1st episode of threshold BPD	+ self-harm - suicidality	GPM DBT skills, STEPPS, support groups Carer intervention
1 Preclinical	Subthreshold	Interpersonal hypersensitivity Emotional dysregulation	Psychoeducation & health literacy Problem solving Supportive counseling Carer psychoeducation


SHARED AIMS OF INTERVENTIONS ACROSS BPD PSYCHOTHERAPIES
1
Functioning
Activation
2
BRIDGE DEVELOPMENT DEFICITS
IMPROVE EMOTIONAL & SOCIAL COGNITIVE CAPACITIES
3
INTEGRATION


DISTILLED MECHANISM ACROSS BPD PSYCHOTHERAPIES
1
Functioning
2
BRIDGE DEVELOPMENT DEFICITS
Functioning
IMPROVE EMOTIONAL & SOCIAL COGNITIVE CAPACITIES
3
INTEGRATION


INGREDIENTS OF BPD PSYCHOTHERAPIES
TO PROMOTE FUNCTIONING
1
RESPONSIBILITIES AND GOALS
↓ INTERRUPTED CRISES
2
BEHAVIORAL ACTIVATION
REQUIREMENT OF OCCUPATION
3
↑ MENTALIZING


THANK YOU
GUNDERSONPDI@PARTNERS.ORG
McLean Gunderson
Personality Disorders Institute

GPDI RESEARCH

RECRUITMENT ONGOING

- Contact gundersonpdi@mgb.org for the patient flyer and information letter for clinicians

McLean Gunderson Personality Disorders Institute

Education and Symptom Measurement for Newly Diagnosed Borderline Personality Disorder

Were you diagnosed with borderline personality disorder (BPD) in the past six months? If so, you may be eligible for a research study at McLean Hospital in which you watch educational videos, respond to questionnaires, and complete cognitive tests.

This study is being conducted to investigate how learning new information might impact BPD symptoms over time. The study is two months long, with four main timepoints when you would answer surveys and complete cognitive tests. Each timepoint takes 35-45 minutes.

Participating in this study might benefit you by helping you learn more about topics related to your health. You may also benefit from a better understanding of your own symptoms and cognitive profile.

You will be paid up to $100.00 for participating in the study. The study is recruiting people of all genders, ages 18 and up.

If you are interested, please scan the QR code below to fill out a survey and determine your eligibility:

You can email Julia Jurist with questions about this research study at: gundersonpdi@partners.org.

MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

The purpose of the MHTTC Network is technology transfer - disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office.

Our collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals.
Our services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

SAMHSA
Substance Abuse and Mental Health Services Administration

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