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Editor-in-Chief

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Learning objectives for this issue:

1. Describe the key differences between borderline personality disorder and bipolar disorder. 2. Understand how you can use dialectical behavior therapy (DBT) to treat patients with a variety of conditions. 3. Explain some of the changes taking place in how personality disorders are diagnosed. 4. Understand some of the current findings in the literature regarding psychiatric treatment.

Dialectical Behavior Therapy: A Primer

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Dr. Sonkiss has disclosed that he has no relevant relationships or financial interests in any commercial companies pertaining to this educational activity.

A young woman with borderline personality disorder (BPD) calls your office for the third time in one week and reports she's been cutting again. You are discharging a middle-aged alcoholic to residential treatment in another state, and you are afraid he might relapse on the plane. You are asked to consult on an orthopedic

patient whose outrageous demands have the whole medical team in an uproar. In each of these situations, what should you do?

While there are many ways to manage scenarios like these, dialectical behavior therapy (DBT) offers some particularly useful tools for psychiatrists and other clinicians. Marsha Linehan developed DBT to help patients with BPD (Linehan MM, *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York, NY: The Guilford Press;1993), and over the past two decades it has received strong empirical support. But DBT is by no means limited to treating borderline patients:

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Differentiating Borderline Personality Disorder from Bipolar Disorder

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Dr. Grosjean has disclosed that she has no relevant relationships or financial interests in any commercial companies pertaining to this educational activity.

Borderline personality disorder (BPD) and bipolar disorder frequently co-occur (numbers range from 8% to 18%), although they are distinct clinical entities (Paris J et al, *Compr Psychiatry* 2007;48(2):145-154). A proper diagnosis guides the most effective treatment, but you've probably faced the difficult challenge of diagnosing these conditions, which share several clinical features.

BPD can be described by four types of psychopathology: affective disturbance, impulsivity, cognitive problems, and intense, unstable relationships. What's most important—in addition to seeing that your patient meets DSM-IV criteria for BPD—is to establish that patterns of affective instability, impulsivity, and unstable

relationships have been consistent over time. Thus, obtaining a detailed history is crucial. Also, the key features we see in BPD, such as dissociation, paranoia, and cognitive problems, are often affected by the patient's environment and, particularly, his or her relationships. A patient might have a history of rapid and sudden deterioration when relationships change—such as threatening suicide after a breakup or severe mood swings when separated from her family. Generally, the more intense or significant the relationship is, the greater the risk of chronic stress and mood dysregulation.

Many of the same features are seen in patients with bipolar disorder, such as dysphoria, hyperactivity, impulsivity, suicidality, and psychotic symptoms. As a result, borderline patients with this cluster of symptoms are often misdiagnosed with bipolar disorder, possibly because of the effectiveness of psychopharmacological treatments for such symptoms. In fact, a more thorough assessment might show that these patients actually suffer from a

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a growing evidence base supports its use for treating substance-use disorders, eating disorders, depression, PTSD, and even impulsive violence in prison populations. Clinicians who are familiar with DBT have begun to realize they can successfully apply many of its techniques in everyday clinical practice.

So what is DBT? DBT combines principles of Zen mindfulness, cognitive behavioral therapy, and supportive therapy. But DBT is not simply a hodgepodge of unrelated ideas. Mindfulness training is used specifically to help patients tolerate emotional distress without resorting to self-harm. Cognitive behavioral techniques are used to prevent catastrophizing thought distortions that can lead to the emotional turmoil often seen in BPD. And supportive therapy is used to keep patients engaged in treatment long enough to learn and apply the techniques. The term “dialectic,” with its

aura of arcane, Hegelian philosophy, may confuse clinicians about its relevance—it is simply a method of resolving ambivalence through the synthesis of opposing positions. A classic example in DBT is that the patient must learn to accept herself exactly as she is, yet she must also change the behavior that makes her life intolerable.

Though seemingly abstract, DBT’s dialectic offers psychiatrists a practical tool they can use every time they meet with a “difficult” patient. Regardless of their behavior, DBT therapists always assume their patients are doing the best they can at any given moment. Sound like therapeutic nihilism? Far from it. DBT therapists also assume their patients can and will learn to do better, and by adopting these opposing viewpoints simultaneously, they help patients accept themselves in the moment while working hard to change. When I take a dialectical approach, I find it reduces my frustration with patients who might otherwise seem manipulative. It also helps patients overcome black-and-white thinking that can lead to feelings of guilt and hopelessness when they harm themselves, relapse into substance use, or fail to make desired improvements in behavior.

A Menu of DBT Skills

Much of DBT involves teaching patients new “skills” to replace maladaptive behavior. A psychiatrist familiar with DBT skills can select one or two to fit a patient’s needs and teach them on the fly. (For a complete explanation of DBT skills along with training exercises and worksheets, see Linehan MM, referenced previously.)

Mindfulness skills are the cornerstone of DBT and are based on Zen mindfulness. A key principle is that there are three basic mindsets in any situation: *emotion mind*, *reasonable mind*, and *wise mind*. Although emotion mind can lead to impulsive decisions and reasonable mind can fail when you need it most, both are considered valid. But true to its dialectical roots, DBT teaches that wise mind emerges from the synthesis of reason and emotion, and it is considered the most effective for solving problems and surviving crises.

Emotion regulation skills are easy to teach and very effective for patients whose intense, labile moods often lead them into trouble. For example, the acronym “PLEASE Master” reminds patients to take care of their physical health (by treating **Physical iLlness**, **Eating**, **Avoiding** drugs, **Sleeping**, and **Exercising**) and to do at least one thing each day to “Master” competence and self-respect. These precautions reduce the likelihood of self-harm, and in my experience they also work well for patients struggling with addiction and the triggers that can lead to relapse.

Distress tolerance skills are also known as crisis survival strategies. I most often recommend pleasurable distraction—which can be as simple as reading a book or watching a movie—in consultation-liaison settings where severe medical problems lead to pain, anxiety, and loss. With patients who cut or burn themselves, I often recommend squeezing ice cubes or snapping a rubber band against the skin as an equally painful but harmless alternative.

Interpersonal effectiveness skills are best taught when patients are not

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EDITORIAL INFORMATION

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Dialectical Behavioral Therapy Skills

Skill	Purpose	Techniques
<i>Mindfulness</i>	Relaxation and awareness	Observing, describing, and participating in the moment
<i>Emotion Regulation</i>	Reducing vulnerability to <i>emotion mind</i>	Labeling emotions, learning how they relate to actions, and taking care of yourself
<i>Distress Tolerance</i>	Enduring unavoidable distress	Distracting yourself with pleasurable activities and intense sensations
<i>Interpersonal Effectiveness</i>	Getting what you want from others without sacrificing self-respect	Prioritizing goals, being assertive, and negotiating effectively

in crisis. I introduce these skills to inpatients that have work or relationship problems once they get well enough to participate in their discharge plans. They're also helpful for medical patients who are having trouble getting along with hospital staff.

The Contingency Management Process

Many borderline patients have learned that hurting themselves is the only way they can get help, and DBT is designed to reverse the unwitting reinforcement of "crisis behavior" that can occur in traditional modes of treatment. Through a process called contingency management, DBT therapists examine how patients somehow end up having their adaptive behaviors punished while their maladaptive behaviors get rewarded. Once you identify these dysfunctional patterns, you then use behavioral principles to create a new reinforcement schedule.

For example, instead of receiving an emergent appointment after an episode of cutting, a DBT patient who self-harms will typically be denied access to his or her therapist for 24 hours (someone else fills in, so the patient is never actually abandoned). On the other hand, adaptive behavior—such as applying DBT skills instead of self-harming—is rewarded by the therapist being available for telephone consultation outside of office hours.

In everyday practice, contingency management can be as effective as it is counter-intuitive. In outpatient settings, consider offering walk-in hours or more frequent appointments for borderline patients, ensuring they have access to care before their troubles reach a crisis stage. Try to resist the temptation to hospitalize after every instance of self-harm. On the other hand, in rare cases, some patients may benefit from brief, occasional admissions "whether they need it or not" when faced with ongoing personal crises. Fixed reinforcement schedules like this one translate readily to other inpatient and consultation-liaison settings, where demanding patients can disrupt entire wards. If patients are told the call button is only for emergencies, their behavior can escalate rapidly. But a short visit from a nurse or psych tech every 30 to 60 minutes—during which validation should be offered—is a better approach.

The technique of "validation" occupies a special place in the DBT toolbox. This is because patients who are constantly being pushed to change their self-defeating behaviors may experience this as being "invalidating." Essentially, they feel that they are being criticized for being ill. To offer validation, I try to step beyond empathic reflection to let patients know their feelings make sense in the context of their own unique experience, even if I don't agree their behavior is the best way to solve problems. For

example, I might say, "I can see how in that situation, it seemed like overdosing was the only way you could get anyone to listen to you." Validation is effective in a wide range of circumstances, including when borderline patients present in crisis, addicts struggle to maintain sobriety, or medical patients become angry at hospital staff. I even use it when I'm not at work!

DBT adapts well to a multitude of clinical situations. Although not all DBT techniques work for everyone, most psychiatrists and their patients will find something that works for them.

Additional DBT Resources

- For a thorough review of how DBT principles can be applied in general practice, see Dimeff and Koerner, *Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings*, Guilford Press, 2007.
- Behavioral Tech, LLC (www.behavioraltech.com) offers assessment and research tools for clinicians and informational materials for patients.
- DBT Self Help (www.dbtselfhelp.com) is a website with information for patients and families that is written by people who have been through DBT.

personality disorder. In one study, more than one third of those misdiagnosed with bipolar disorder met DSM-IV criteria for BPD (Zimmerman M et al, *Compr Psychiatry* 2010;51(2):99-105).

In BPD, mood changes are generally short-lived, lasting only for a few hours at a time. In contrast, mood changes in bipolar disorder tend to last for days or even weeks or months. Mood shifts in BPD are usually in reaction to an environmental stressor (such as an argument with a loved one or a frustration in the waiting room), whereas mood shifts in bipolar disorder may occur out of the blue.

Some clinicians consider BPD an "ultra-rapid-cycling" form of bipolar disorder, but there's little evidence to support this link (Gunderson JG et al, *Am J Psychiatry* 2006;163(7):1173-1178). Patients with BPD might rapidly cycle through depression, anxiety, and anger, but these mood shifts rarely involve elation; more often, the mood shifts are from feeling upset to feeling just "OK." Likewise, the anxiety or irritability of BPD should not be mistaken for the mania or hypomania of bipolar disorder, which usually involve expansive or elevated mood.

At a more existential level, patients

with BPD—particularly younger patients—often struggle with feelings of emptiness and worthlessness, difficulties with self-image, and fears of abandonment. These are less common in bipolar disorder, where grandiosity and inflated self-esteem are common, especially during mood episodes. And while both conditions may include a history of chaotic relationships, a patient with BPD may describe relationship difficulties as the primary—or sole—source of her/his suffering, while the bipolar patient may see them as an unfortunate *consequence* of his behavior.

Q & A
With
the Expert

This Month's Expert

Diagnosing Personality Disorders: The Latest Trends

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Dr. Zimmerman discloses that he has received research grant support from Eli Lilly to study the validation of a scale. Dr. Balt has reviewed this article and found no evidence of bias in this educational activity.

TCPR: In 2013, the American Psychiatric Association (APA) plans to release the fifth edition of the DSM. We are all aware that there may be some significant changes in personality disorder criteria in the DSM-5, which has created some controversy. Where do the proposed changes stand right now and how might this affect us in the long-term?

Dr. Zimmerman: I don't know what the final version will look like, but there has been an outpouring of criticism from the personality disorder research community. There are questions about changes in the criteria for the existing disorders and concerns about the rationale for deleting certain disorders.

TCPR: Could you summarize the major changes?

Dr. Zimmerman: There is a new system to describe personality dysfunction, and the APA proposes removing schizoid, paranoid, histrionic, and dependent personality disorders, as well as personality disorder NOS. The DSM-5 retains six personality disorder types: schizotypal, avoidant, borderline, antisocial, narcissistic, and obsessive-compulsive.

TCPR: Of course, if you delete a personality disorder from the DSM, it doesn't mean that the person is cured. The person still has a disorder and the difficulties that come along with it. Aren't practicing doctors likely to just continue diagnosing patients as they have been doing all along?

Dr. Zimmerman: I think that clinicians will embrace the changes only when they see data demonstrating why changes should be made. An important clinical piece of information is prognosis. To what degree will changes in DSM-5 allow us to better predict how individuals will do? Will they give us some guidance that we can use to treat patients more effectively?

TCPR: Let's start with one of the more radical changes, which is a proposal to switch from a categorical approach to diagnosis to a dimensional approach. Can you define what this means, and why it is important?

Dr. Zimmerman: The categorical approach to personality disorders is what we are used to, and it follows the medical model approach towards diagnosis and classification—somebody goes to a doctor and gets a diagnosis, such as diabetes or cancer. However, the fact is that most things in medicine—and in mental health—fall along a dimension. For example, take blood pressure. When you measure blood pressure you come up with a number, and based on that number, you make a judgment about whether intervention is warranted. But as human beings, we like to categorize, and as physicians we like to diagnose and treat. So we take that dimensional score and then we categorize it as “hypertension” or “normal.” Over time, as we collect more data, we may well change the cut-off point that we use to say something warrants treatment or not. Similarly in psychopathology, the constructs that we evaluate are not all-or-nothing, but they follow along a dimension of severity scores—whether depressive symptoms, anxiety symptoms, levels of substance use, or likewise dimensions of personality.

TCPR: Where in the assessment of personality disorders for a given patient would “dimensions” come into play?

Dr. Zimmerman: That can be done in different ways. Some argue that we should measure dimensions that have been shown to reflect normal personality. For example, we could rate a person's level of introversion, extraversion, or rigidity, or other dimensions that personality researchers have found to characterize human experience. Particularly high or low scores on these dimensions could then be mapped onto the personality disorders identified in the DSM. This is essentially the approach being suggested for the DSM-5. Another approach would be to take the personality disorder constructs as we currently know them in the DSM and to dimensionalize them. For example, rather than saying that someone does or does not have borderline personality disorder or schizotypal personality disorder, you would make a rating of “how” borderline they are or “how” schizotypal they are.

TCPR: It certainly seems that in the real world of the clinic, psychiatrists are not spending a lot of time figuring out if a patient meets the formal criteria for each personality disorder.

Dr. Zimmerman: I agree that most clinicians are not rigidly applying all of the personality disorder criteria to their patients. In fact, they are rarely assessing them. Instead, we are listening to individuals relate their histories, tell their stories, and we consider patterns that emerge over time. We are thinking things like, what are the typical stressors that come up over and over in my patients' lives? How do they react? How do they cope with those stressors? How are they processing information? How are they

relating to the external world? What difficulties characterize their interpersonal relationships? And based on that, we are identifying certain personality traits that we find have an impact on their relationships, and on how they are coping with and dealing with the world. So in a sense, we naturally think in terms of traits and severity of those traits—which is precisely why the DSM-5 committee has come up with their dimensional system. It makes intuitive sense, though we have very little actual research to either support or reject this approach.

TCPR: Although your group at Brown University has begun to do some of this research.

Dr. Zimmerman: Yes. We recently wrote a paper called, “Does the Presence of One Feature of Borderline Personality Disorder [(BPD)] Have Clinical Significance? Implications for Dimensional Ratings of Personality Disorders.” We wrote it because we had the following question: If dimensional scoring is so important how come there has never been a study that has compared individuals with one criterion versus zero criteria? (Zimmerman M et al, *J Clin Psychiatry* 2012;73(1):8–12). Clinically, this question can have major consequences. For example, what will happen in a child custody battle when the lawyer for one parent accuses the other parent of being a little bit borderline? Does that have any meaning? We did a study on several thousand psychiatric outpatients who were evaluated with a semi-structured diagnostic interview for both Axis I and Axis II disorders. We then searched for patients with any of the criteria for borderline personality disorder. We did an analysis comparing patients who had no criteria for BPD vs those who had exactly one criterion. We had hypothesized that there would be no difference between individuals with zero and one criterion. So we were surprised when the results showed that those with a single criterion had significantly more psychosocial morbidity than those with no criteria.

TCPR: So this study implies that counting up the number of criteria might be useful in determining how ill a patient is. Did you compare patients with other numbers of criteria for BPD?

Dr. Zimmerman: We did that in a prior paper, in which we limited our analysis only to patients who had met criteria for BPD. We wanted to know if the severity of BPD, reflected by the number of criteria met, was associated with psychosocial morbidity. Surprisingly, we found that there was no association—there was no difference between groups in terms of pathology, whether you met five or six or seven or eight or nine criteria. Once you met the threshold for borderline personality disorder all the groups looked the same (Asnaani A et al, *J Personal Dis* 2007;21:615–625). The bottom line is that there is evidence for both the dimensional view and the categorical view of personality disorders.

TCPR: What is the role of a structured interview in personality disorder assessment? Should we be using such instruments in our practices?

Dr. Zimmerman: Four or five studies have compared what happens when clinicians use semi-structured interviews vs standard unstructured clinical interviews (Zimmerman M and Mattia JJ, *Am J Psychiatry* 1999;156:1570–1574). And every study finds the same thing, which is no big surprise: when you administer a semi-structured interview you make many more diagnoses. When you ask questions for two to three hours you tend to get more positive information than if you are asking questions for 45 minutes to an hour. Time constraints in the real world mean that diagnostic information gets missed.

TCPR: The current DSM-5 criteria for personality disorders will require that we look for “self and interpersonal deficiencies” in order to diagnose PDs. Can you explain how we can best assess for these?

Dr. Zimmerman: There’s really no standardized way to measure these deficiencies, so clinicians should listen to patients tell their stories and describe what is going on in their lives over time. Patients describe their problems and how they deal with them. In the context of those descriptions, you hear about the impact on interpersonal relationships and the level of distress that is caused by their approach of dealing with others and dealing with the world. But the key is that they cause distress. Sometimes we see personality traits that should not be misconstrued as personality pathology.

TCPR: Finally, can you describe your work in the MIDAS project, which provides much of the data for your studies, and some of the take-home messages from your experience?

Dr. Zimmerman: MIDAS (Methods to Improve Diagnostic Assessment and Services) is an ongoing study at Rhode Island Hospital in which more than 3,500 psychiatric outpatients have been evaluated with semi-structured diagnostic interviews. Though we have not yet collected data to demonstrate this, our experience suggests that we can better treat our patients, and achieve better outcomes, the more comprehensively we assess them. I think, increasingly, the psychiatry field has farmed out psychotherapy to other mental health disciplines, and increasingly—certainly not exclusively—psychiatrists are doing pharmacologic management rather than more comprehensive management. And when you are doing psychopharmacology—with or without psychotherapeutic intervention—I think the more you know about the individual the better the care you are able to deliver to the individual. The other significant component of the MIDAS project has been the development of measurement tools for clinicians to better evaluate their patients upon initial presentation and follow-up visits.

TCPR: Thank you, Dr. Zimmerman.



Research Updates IN PSYCHIATRY

Section Editor, Glen Spielmans, PhD

Glen Spielmans, PhD, has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

SUBSTANCE ABUSE

Does Counseling Add to Suboxone's Efficacy?

The combination of buprenorphine and naloxone (Suboxone) has become a popular replacement therapy for heroin dependence. However, it's not yet clear how effective it is for prescription opioid dependence, or whether adjunctive counseling provides any additional benefit over the drug alone.

In a recent study of 653 outpatients who were dependent on prescription opioids, these questions were put to the test. The study involved two phases. Phase 1 was a "brief treatment" trial, in which patients were randomly assigned to either standard medical management (SMM: 15-minute visits every one or two weeks), or SMM plus opioid dependence counseling (ODC). ODC consisted of hour-long visits once or twice per week, focusing on relapse prevention and lifestyle change.

Regardless of which treatment group they were assigned to, all patients were placed on Suboxone, were continued on it for two weeks, were tapered off the medication over two weeks, and were followed off meds for eight weeks. As you might predict, only a small number of patients responded to this rapid-fire protocol—43 of 653 patients (6.6%) were "successful," which was defined as using opioids on no more than four days in a month and having less than two consecutive opioid-positive urine tests. There was no difference in outcome between those who did or did not receive additional ODC.

More than 200 patients dropped out of the study, leaving 360 patients (who failed phase 1) to enter phase 2 of the trial. This involved a more leisurely 12 weeks of Suboxone, a four week taper, and eight weeks of medication-free follow-up. While these patients had good success while taking Suboxone (49.2% success after three months), after eight weeks off the drug their success was a dismal 8.6%, again with no difference between those who received SMM or SMM

plus counseling (Weiss RD et al, *Arch Gen Psychiatry* 2011;68(12):1238–1246).

TCPR's Take: The good news is that this study shows that maintenance Suboxone treatment works pretty well for patients addicted to prescription opioids. (We'll leave it up to readers to decide if four days of drug use per month should really be considered successful treatment, as it is in the study.) But once you taper the medication, expect a high rate of relapse. In this study, adding ODC to Suboxone was not helpful. So does this mean all opioid users should be put on Suboxone indefinitely, with no counseling? Not so fast. All patients in this study had weekly doctor visits of 15 to 20 minutes in length; that's more than in the typical Suboxone practice, so the "no counseling" group may in fact have received significant amounts of therapy of some sort. It's likely that the more closely you follow your Suboxone patients, the better they will do.

RECOVERY

Helping the Severely Mentally Ill to Help Themselves

"Self-management" is a newly popular buzzword among clinicians treating the seriously mentally ill. Self-management programs include psychoeducation for patients about their illness, training to help patients communicate more effectively with their doctors, and instruction on how to advocate for themselves in treatment settings.

One of the more popular self-management programs is Wellness Recovery Action Planning (WRAP). In WRAP, trained peer instructors lead weekly sessions consisting of group exercises, lectures, and voluntary homework. Group topics include such items as maintaining wellness, recognizing symptoms, managing crises, and learning where to obtain credible information about one's condition. In a controlled trial early last year, patients of public mental health clinics who participated in WRAP had fewer psychiatric symptoms and an enhanced quality of

life than those not receiving WRAP training (Cook JA et al, *Schiz Bull* 2011;online ahead of print).

One possible explanation for the efficacy of WRAP is that it facilitates a patient's self-determination and builds self-advocacy skills. To test this hypothesis, the researchers randomized 555 community mental health patients, most of whom had been diagnosed with psychotic or mood disorders (but no substance use disorders), to either a two-month WRAP intervention (276 patients) or to treatment as usual (279 patients). All patients continued to receive medications, case management, and therapy if and when indicated. "Self-advocacy" was measured by the Brashers' Patient Self-Advocacy Score (PSAS). This scale consists of three subscales: education, the patient's willingness to learn about his/her illness; assertiveness, the patient's ability to be assertive during a health-care encounter; and mindful non-adherence, the patient's inclination to disregard a provider's recommendations (while we often consider "non-adherence" an undesirable outcome, in this case, it represents the patient's ability to act autonomously in an informed way) (Brashers et al, *Health Communication* 1999;11(2):97–121).

Patients who received WRAP training had greater self-advocacy scores over time than those assigned to treatment as usual. This was particularly true on the measure of mindful non-adherence; scores on the other subscales did not change significantly. Higher overall self-advocacy scores were significantly correlated with higher levels of hopefulness (correlation coefficient $r = 0.45$), better quality of life ($r = 0.28$), and lower symptom severity, as measured by the Brief Symptom Inventory (BSI) Global Severity Index ($r = -0.23$). (Jonikas JA et al, *Comm Ment Health J* Dec 2011;online ahead of print).

TCPR's Take: WRAP training appears to be a simple and inexpensive way of increasing the assertiveness of the seriously mentally ill. We'd like to see longer term follow-up, but meanwhile we recommend referring patients to such a program if you can find one in your community.

CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by March 31, 2013. As a subscriber to *TCPR*, you already have a username and password to log on www.TheCarlatReport.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning objectives are listed on page 1.

1. What is the remission rate for borderline personality disorders (BPD) with effective psychotherapeutic treatments (Learning Objective #1)?

<input type="checkbox"/> a) As high as 20% in 10 years	<input type="checkbox"/> b) As high as 45% in 10 years
<input type="checkbox"/> c) As high as 85% in 10 years	<input type="checkbox"/> d) As high as 90% in 10 years
2. Which of the following is considered a cornerstone of dialectical behavior therapy (DBT) and is based on Zen principles (LO #2)?

<input type="checkbox"/> a) Mindfulness skills	<input type="checkbox"/> b) Emotion regulation skills
<input type="checkbox"/> c) Distress tolerance skills	<input type="checkbox"/> d) Interpersonal effectiveness skills
3. Under the changes currently proposed in personality disorder (PD) criteria in the DSM-5, how many PD types will remain in the manual (LO #3)?

<input type="checkbox"/> a) Three	<input type="checkbox"/> b) Four
<input type="checkbox"/> c) Five	<input type="checkbox"/> d) Six
4. Weiss RD et al found that in phase two of their study of outpatients who were dependent on prescription opioids, what percentage of patients still had good "success" eight weeks after discontinuing the replacement drug Suboxone?

<input type="checkbox"/> a) 3.2 %	<input type="checkbox"/> b) 8.6 %
<input type="checkbox"/> c) 12.6 %	<input type="checkbox"/> d) 15.3 %
5. Cook JA et al found in a controlled trial that patients of public mental health clinics who participated in Wellness Recovery Action Planning (WRAP) had which of the following results?

<input type="checkbox"/> a) More psychiatric symptoms and poorer quality of life	<input type="checkbox"/> b) Fewer psychiatric symptoms and enhanced quality of life
<input type="checkbox"/> c) No change in symptoms or in quality of life	<input type="checkbox"/> d) Greater disregard for a provider's treatment recommendations

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Differentiating Borderline Personality Disorder from Bipolar Disorder

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A pattern of self-harm and suicidal activity often serves as a cue for diagnosing BPD (but are not necessarily required). But both can be seen in bipolar disorder, too. In BPD, suicide threats and attempts may occur along with anger at perceived abandonment and disappointment. Patients often explain these impulses as a way to be relieved of pain, or to "stop their thinking," more so than to end their lives, per se. Patients with BPD may experience "micropsychotic" phenomena of short duration (lasting hours or at most a few days), including auditory hallucinations, paranoia, and episodes of depersonalization. However, patients generally retain insight, and can acknowledge that "something strange is happening" without strong delusional thought. When psychotic symptoms occur in bipolar disorder, they happen in the context of a

mood episode, they tend to last longer, and patients may be unable to reflect on their behavior.

Accurate diagnosis of BPD and bipolar disorder can be difficult, but it's essential for proper treatment and optimal outcome. Remission rates in BPD can be as high as 85% in 10 years (Gunderson et al, *Arch Gen Psychiatry* 2011;68(8):827–837), particularly with effective psychotherapeutic treatments (Zanarini MC, *Acta Psychiatr Scand* 2009;120(5):373–377). Unfortunately, such treatment is not always available. Some medications can be used in BPD, such as an SSRI for impulsivity, severe and persistent depression and/or suicidality, or an atypical antipsychotic for recurrent dissociative symptoms or disinhibition. However the only consensus seems to be that medications should be used as adjuncts to psycho-

therapy (Silk KR, *J Psychiatric Practice* 2011;17(5):311–319). The long-term use of a mood stabilizer or atypical should be reserved for known cases of bipolar disorder.



Clinicians sometimes think of a BPD diagnosis as pejorative (chronic and untreatable) and may be reluctant to disclose it, but patients and their families often find it helpful to be informed of the diagnosis. Similarly with bipolar disorder, accurate diagnosis often determines prognosis and effective treatment. For the clinician, however, it's imperative that you make the proper diagnosis in these two often overlapping, but fundamentally quite distinct, conditions in order to optimize your patients' outcomes.

Please Join Us in Welcoming our New Editor-in-Chief, Dr. Steve Balt!

After 10 years at the helm of *TCPR*, Dr. Carlat has handed over editor-in-chief duties to Dr. Steve Balt. You might recognize Steve's name from a number of recent articles he has written for *TCPR*. He is a psychiatrist and a research fellow in the Addiction Pharmacology Research Laboratory at California Pacific Medical Center in San Francisco, CA and is a graduate of Weill Medical College at Cornell University. Dr. Balt writes the popular Thought Broadcast blog (www.thoughtbroadcast.com). Steve has expertise in psychopharmacology, cognitive-behavioral therapy, dialectical behavioral therapy, and community psychiatry. We're excited to welcome him aboard!



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