Awards Acceptance Speech of Dr Ken Silk

 September 18, 2013

 ISSPD 25th Anniversary

Those of you who know me, know that I like to make jokes, often not very good ones, but like many of the patients that we see, I seem to not be able to learn from my own mistakes. So I thought that I might begin by saying, while I have always aspired to be a comedian, I never thought that I would be the opening act for Sir Michael Rutter. In that context I am thrilled and honored not only to be the recipient of this wonderful award, but also it is a great honor to share this stage, so to speak, with Sir Michael Rutter.

Charlie Nemeroff once told this story about the time he was to be inducted into the Institute of Medicine and like all good comedians, I will steal this story or narrative from him. As he and his wife were getting dressed for the induction ceremony dinner, he turned to his wife and said, “In your wildest dreams, did you ever think that I would be inducted into the Institute of Medicine?” and she turned to him and said, “Charlie, you have never been in my wildest dreams”. That said, in my wildest dreams I never thought that I would receive an award such as this from, in my opinion, a prominent international organization.

Those of us who practice psychotherapy, whatever the brand of psychotherapy we practice, know that patients come to us with their own narrative, their own understanding of who they are and how they arrived at the place they think themselves to be at that particular time. And part of our job, and perhaps even the main aspect of our job, is to help them achieve, and if not achieve, then at least to consider, that an alternate narrative also exists for them. By achieving that alternate narrative, a different or expanded or more complex way of understanding themselves, whether through learning better emotion regulation or understanding the early schema or cognitive assumptions that repeatedly infiltrate so many aspects of their lives or appreciate better that they project onto others feelings and attributes that perhaps do not belong to those others or that they fail to understand the complexity of their own and others’ reactions and responses, these people improve their interactions with others and soften their own perceptions of themselves. Life and human interactions with all its complexities and ambivalences and emotional reactions becomes a tiny bit easier for them. And so I will talk very briefly about my own understanding or appreciation of the field of personality disorders – my own narrative about where we were and where perhaps we as a field might be headed. And I will put this essentially in the time frame of the past 25 years, over the course of time that ISSPD has existed. Some of what I am about to say, Erik mentioned yesterday, and my comments at the end reflect comments that Glen Gabbard made yesterday morning. My comments were prepared prior to listening to theirs, and while we may not be correct, at least there is some consensual validation.

Of course, I shall make the same error that many of us make. When talking about the narrative of personality disorders, I will mostly be talking about the narrative of progress in the area of borderline personality disorder. I do this for a number of reasons. First because it is the area that I know best, and second it is because of all the personality disorders, or at least of the diagnoses, for better or worse, that fall under current diagnostic formulations under the larger category of personality disorders, BPD has accumulated far and away the greatest attention and subsequently the greatest number of publications when compared to other individual personality disorder diagnoses.

There are important people involved in personality disorders before 1988: Ted Millon, John Gunderson, Joh Livesley, Otto Kernberg, Roy Grinker, James Masterson, Harold Searles, Svenn Torgeson, Per Vaglum, Allen frances and Peter Tyrer, just to name a few.Let us go back then to 1988 when the first ISSPD meeting was held here in Copenhagen. These were the days of DSM-III or DSM-III-R and the therapy being practiced with these patients was primarily psychodynamic. While there was a smattering of more structured therapies, particularly in the CBT realm, most of these patients were involved in some form of psychodynamic psychotherapy, often multiple times a week, often transference based, and often under the assumption that the therapy was going to take years and include much drama, and with a little luck, there would be some small to medium chance of success. And success was only with a small select group of therapists (a group to which I am sure we all thought we belonged) who possessed the requisite training and skills to achieve that modest success. (I realize I am over-dramatizing the situation but I hope you will allow me that license.) Stigma was high, therapy was long and painful, and emotional reactions in both the patient and the therapist were intense. Therapy seemed to be filled with acting out (probably in both patient and therapists), regressions (probably in both patient and therapists), and repeated hospitalizations.

Most of the theories concerning the etiology and treatment of personality disorders were quite firmly rooted in psychodynamic tradition. Biological explorations and explanations were just beginning. In 1988 the seminal paper by Siever and Davis presenting an early psychobiological perspective on the personality disorders was 3 years away from publication. Linehan’s book on DBT was 5 years away. But in some way we, in the personality disorders field, could feel better in that we had been legitimized with our own axis that supposedly was to be considered in every initial evaluation before PDNOS or deferred had come into regular usage. Psychopharmacologic treatment was primarily with typical antipsychotic medications but there was this new class of antidepressants called SSRIs that in the next 4-5 years would claim to be so useful for so many different psychiatric maladies that people thought it might be a good idea to just add it to the water supply as we added fluoride, though a full appreciation of the frequency of sexual side effects had not yet become common knowledge. Kramer’s book, *Listening to Prozac,* which suggested that fluoxetine might promote significant personality change was 5 years away from publication. And whatever one’s personal feeling about the inclusion of BPD into the DSM-III diagnostic nomenclature, it identified a construct that the field could study to try to establish whether or not it was a valid and/or useful diagnosis.

It is worth pausing for a moment to appreciate the studies that took place in the late 1980s and early 1990s on the role or the correlation of trauma to the diagnosis of BPD. There was the hope among some of us that if there was a direct relationship between trauma, sexual or psychological, then perhaps the mental health world might begin to view borderline patients’ symptomatology and interpersonal relationships as attempts to grapple with the impact of these early traumatic experiences. These patients then might be seen in a softer kinder light by the mental health profession. But eventually this idea of early trauma and BPD, while still important and relevant, did not open doors to new treatments; it appeared that patients with BPD now presented with two though closely related problems, the BPD behavior and the behavioral response to the trauma itself. I think it was not until Marsha Linehan’s book and her appreciation of emotion dysregulation and invalidation that the field was able to look more calmly and less judgmentally upon these individuals.

In the 1990s, a number of exciting things occurred that were to become foci of interventions and research over the subsequent two decades and that lead up to where I think we are at this time. There is the work of Svenn Torgeson on the epidemiology of personality disorders and his elegant twin studies. Then there was the publication of Linehan’s book on Dialectical Behavior Therapy. This book was to challenge many of the old ways in which we thought about and approached this disorder from a treatment standpoint. This book and its proposed treatment was to radically change the narrative about the disorder. It was no longer not treatable. Patients could get better, and treatment would not have to be a continuous struggle between therapist and patient where it often felt like we the therapist had to drag the patient by some unknown psychological force into a more healthy relationship to the world and to the people who inhabit that world. It was now OK to use the term borderline personality with the patients themselves, for it was no longer something thrown out in a derogatory manner but was part of a psycho-educational approach to the patient. It was actually possible to recruit these patients into a mutually agreed upon treatment endeavor.

DBT was followed by other more structured treatments such as Bateman and Fonagy’s MBT and Davidson’s CBT, Arntz and Young’s Schema –Focused Therapy and Kernberg and Clarkin’s TFT, as well as the General or Good Psychiatric Treatment/Management of McMain/Links/ and Gunderson. STEPPS was developed, thanks to Nancee Bloom and Don Black, as a treatment designed to augment existing treatments. Biologic research into BPD and other personality disorders has exploded, enhanced by greater sophistication in genetics and psychobiological studies in many areas but particularly in the area of neuroimaging led by New York City’s Mount Sinai team of Siever, New, Koenigsberg and in Mannheim and Heidelberg in Germany under Bohus, and Schmahl and Herpertz, studies that have put us on the edge of understanding the actual neurological connections within the brains of these individuals with personality disorders, how their brains process, appreciate, register, assign salience, adapt, relearn, and modify emotional stimuli and their reactions to those stimuli. The follow along work of Zanarini and colleagues at McLean and the CLPS studies that emerged as a collaborative effort from 5 universities in the United States have elucidated the course of BPD, a course that is much less dire, and much more hopeful and optimistic than we first thought. Zanarini’s follow-along period is in its 3rd decade, and the data emerging from this seminal and persistent work is not only of immeasurable value to clinicians worldwide. Again the historical narrative of BPD as a disorder that cannot be treated and does not get better is changed.

Yet our psychopharmacologic treatments remain woefully inadequate, marginal at best, and loaded with side effects such a weight gain, metabolic syndrome, polycystic ovarian syndrome, cognitive difficulties, sexual side effects, experiences where patients feel too distant from their feelings. The costs of the taking of these medications appear high, especially in young women of child-bearing age while the benefits as stated above remain marginal at best. And now we have trends throughout psychiatry towards pharmaceutical augmentation and polypharmacy for which we have no evidence except evidence, particularly from Zanarini and Frankenburg, that it increases the chances that the patient will experience more side effects such as weight gain and drug-drug interactions to an extent much greater than it enhances therapeutic effects.

Then what do I think the future holds for study and discovery in the area of personality disorders, and this, I repeat, is my own idea, my own narrative about an area that in the last 25 years has uncovered many interesting and useful concepts and interventions. Yet overall the last 25 years still leaves us hungry for more information to assist us in removing the burden of this particular illness from their weighed down shoulders.

The future for research in personality disorders is probably no different from the future that we hope for in thinking about and trying to improve our understanding of any mental disorder. We hope that we will continue not only to learn how the brains of these people operate and how they differ from the brains of people who do not suffer so painfully from these illnesses, but also to find some way to apply what we learn from these studies to actual treatment interventions that ultimately result in more effective treatment. We will refine our effective treatments and hopefully combine our understanding of biology and neuroimaging to appreciate better how these treatments change the brains of those who receive them and utilize the treatments to help improve our patients’ day to day functioning. We will need to find ways either to generalize our treatments to many more patients or invest in studies of treatment matching to figure out what current evidenced-based treatment works best for what type of patient, though I am painfully aware that treatment matching has had little successful research in the past.

I hope but remain pessimistic about the discovery of pharmacologic agents that will prove to be powerfully effective among these patients. In the 42 years that I have practiced psychiatry, the pharmaceutical industry has promised much as they have delivered mostly “me-too” drugs with complicated and often debilitating side effects.

We need to resist random pharmacotherapy and polypharmacy which in actuality is dangerous. T F Main once said, and I am paraphrasing here, that the astute patient who refuses to get better meets increasing forms of sadism disguised as treatment. Polypharmacy may be one of those forms of sadism.

We need to remember that there are many more patients who fall under personality disorders than just borderline patients and we need to move forward to study them more carefully and design interventions for them.

But I fear none of this will come to pass if we continue to fight among ourselves as to what is the right versus the wrong way to define patients with personality disorders. There is no right way to diagnose a psychiatric patient. There are ways that may be in fashion and they will fall out of fashion only to be replaced by other more fashionable approaches. And I want to emphasize more fashionable, not better or closer to biological truth or genetics, just more fashionable. Because what or who gets lost in all these disagreements is the patient who continues to suffer; and they will continue to suffer no matter what label we give them or what approach we take to diagnose them. For there are many more important things we need to be more sure of before we think we really know the best way to arrive at a diagnosis.

Echoing the spirit of what Dr. Gabbard said yesterday morning, we need to resist simple checklists and strive to continue to listen, as hard as that may be, to our patients. The deterioration of the ability to listen, the financial pressures that make us diagnose first and perhaps listen later, have been and continue to be some of the most disappointing changes and some of the most important challenges that I have witnessed in my years as a psychiatrist.

If we are to move forward and continue to have meetings that bring together the best minds from all over the world who are struggling to understand these perplexing conditions, we cannot let disagreements over diagnosis split us apart. If we think we are right and we already know the answer and we set out to prove we are right, then true curiosity and inquiry ceases. We then stop moving forward and while we may be right, whatever that means, our patients will continue to suffer.

I realize that this is but one person’s narrative about personality disorders over the past 25 years. I know that meetings of ISSPD in the next 25 years will continue to present concepts and data that will lead to further elaborations of each of your own narratives about personality and personality disorders.

Thanks you.