GOOD PSYCHIATRIC MANAGEMENT
A Pragmatic Approach to Managing Borderline Personality Disorder in the Busy Outpatient Clinic

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Dr. Sean Stanley and Dr. Neisha D’Souza report no conflict of interest.
Learning Objectives

1) Discuss the diagnosis of borderline personality disorder (BPD) to patients and establish reasonable expectations for change.

2) Identify the relationship between symptoms and interpersonal context in BPD.

3) Identify distinctive characteristics of Good Psychiatric Management (GPM)

4) Utilize some basic principles of GPM in your own clinical practice.
<table>
<thead>
<tr>
<th>Statement</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I had a choice, I would prefer to avoid caring for a BPD patient.</td>
<td></td>
</tr>
<tr>
<td>I feel professionally competent to care for BPD patients.</td>
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<tr>
<td>BPD is an illness that causes symptoms that are distressing to the BPD individual.</td>
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<tr>
<td>I believe the BPD patient has low self-esteem.</td>
<td></td>
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<tr>
<td>I feel I can make a positive difference in the lives of BPD patients.</td>
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<tr>
<td>The prognosis for BPD treatment is hopeless.</td>
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<tr>
<td>Some psychotherapies are very effective in helping patients with BPD</td>
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</tr>
<tr>
<td>I would like more training in the management and treatment of BPD patients.</td>
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</tr>
</tbody>
</table>
Making the Diagnosis
DSM 5 Diagnostic Criteria

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.
Borderline Personality Disorder

• Median population prevalence 1.6% (Torgersen 2009) but may be as high as 5.9% (Grant et al. 2008).

• Prevalence
  • Primary care 6%, outpatient MH clinics 10%, psychiatric inpatient 20%.

• Male/female distribution of BPD is fairly equal (Grant BF. Et al. 2008;69(4):533-545.).

• Diagnosed predominantly in females (DSM 5).

• Heritability as high as 0.68 in twin studies (Torgerson et. Al 2001).

• Functional outcome improves with remission.

• Economic and health care burden.
## Mental Health Comorbidities

<table>
<thead>
<tr>
<th>Comorbid with BPD</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive D/O</td>
<td>50%</td>
</tr>
<tr>
<td>Bipolar D/O (Type I and Type 2)</td>
<td>15%</td>
</tr>
<tr>
<td>Panic D/O</td>
<td>50%</td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder</td>
<td>30%</td>
</tr>
<tr>
<td>Substance Use D/O, active</td>
<td>35%</td>
</tr>
<tr>
<td>Antisocial PD</td>
<td>25%</td>
</tr>
<tr>
<td>Narcissistic PD</td>
<td>15%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>20%</td>
</tr>
</tbody>
</table>

Adapted from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*, 2014
## Selecting the Primary Diagnostic Target

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Manage the BPD first?</th>
<th>Will remit if BPD does</th>
<th>Unable to use BPD tx</th>
<th>Recurrence ↓ if BPD remits</th>
<th>Will remit if BPD does</th>
<th>Too vigilant to attach/tolerate challenge</th>
<th>If able to use BPD tx</th>
<th>Is treatment for secondary gain</th>
<th>Overall ↓ response to BPD tx comp to others, but can improve</th>
<th>Unable to use BPD tx</th>
<th>If physical health stable, then OK to use BPD tx</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDD, mild-mod</td>
<td>YES</td>
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<tr>
<td>MDD, severe</td>
<td>No</td>
<td>Will remit BPD does</td>
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<td>Unable to use BPD tx</td>
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<tr>
<td>Bipolar Disorder I, Manic</td>
<td>No</td>
<td>Unable to use BPD tx</td>
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<tr>
<td>Bipolar Disorder I, Not-Manic</td>
<td>YES</td>
<td>Recurrence ↓ if BPD remits</td>
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<td>Bipolar Disorder II</td>
<td>YES</td>
<td>Will remit if BPD does</td>
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<tr>
<td>Panic Disorder</td>
<td>YES</td>
<td>Will remit if BPD does</td>
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<td>PTSD, Early onset, complex</td>
<td>No</td>
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<td>PTSD, Adult onset</td>
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<td>Substance Use DO, active</td>
<td>No</td>
<td>If 3-6 mo sober, may make BPD tx OK</td>
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<td>Antisocial PD</td>
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<td>Narcissistic PD</td>
<td>YES</td>
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<tr>
<td>Anorexia</td>
<td>No</td>
<td>Unable to use BPD tx</td>
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<td>Bulimia</td>
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Adapted from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder, 2014*
MYTHS About the Treatment of BPD

BPD patients resist treatment

- Most actively seek relief from subjective pain
- Non-compliance is likely when treatment is ineffective
BPD patients rarely get better

Even without extended or stable treatment, remission rates are
~10% in 6 months
~25% in 1 year
~50% in 2 years

Once patients have remitted, relapse is unusual.
MYTHS About the Treatment of BPD

BPD gets better only if given extended, intensive treatments by experts.

- Such treatment is only required by a subsample.
- Intensive treatment may result in regression.
Gunderson Insights

https://www.youtube.com/watch?v=lPcvh_dDScE&index=20&list=PL_L7KEOxOeQ-fgpNYcWPPiXEHWlXkcyN4

https://youtu.be/8nHplUGbohY?list=PL_L7KEOxOeQ-fgpNYcWPPiXEHWlXkcyN4
PRACTICE GAPS

• Under and misdiagnosis remains common
• Treatment of BPD is not done consistently or well
• Lack of training
• There is a shortage of adequately trained BPD treaters
Evidence-Based Treatments
<table>
<thead>
<tr>
<th>Description</th>
<th>Dialectical Behavioral Therapy</th>
<th>Mentalization-based treatment</th>
<th>Transference-focused psychotherapy</th>
<th>General Psychiatric Management</th>
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<tr>
<td>Description</td>
<td>CBT modified with dialectics and validation Skills training.</td>
<td>Therapist assumes curious stance of “not knowing” and promotes capacity to think about oneself and others in terms of meaningful mental states</td>
<td>Psychoanalytically based, promotes integration of split-object representation to stabilize tendencies for unstable relationships and aggression</td>
<td>Diagnosis Disclosure Psychoeducation Case-mgmt approach mixing dynamic and behavioral models, Focus on interpersonal and situations stressors Family Education and interventions</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>Essential</td>
<td>Essential</td>
<td>None</td>
<td>Encouraged</td>
</tr>
<tr>
<td>Individual Therapy</td>
<td>Once weekly</td>
<td>Once weekly</td>
<td>Twice weekly</td>
<td>Once weekly/PRN</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>Family Connections</td>
<td>MBT-Family, Multi-family group therapy</td>
<td>None</td>
<td>Family Psychoeducation</td>
</tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Basic training requirements</th>
<th>Two, 5-day workshops separated by 6 months and self-study</th>
<th>3-day workshop</th>
<th>Two, 3-day workshops 1 year supervision</th>
<th>1-day workshop</th>
</tr>
</thead>
</table>

| Cost                      | $$$$$                                                   | $$            | $$$                                   | $              |

| Clinical face-to-face time | 1H/week individual 2H/week group 24/7 skills coaching | 1H/week individual 2H/week group | 2/week individual | 1H/week individual if person is responding |

| Therapist supervision         | 2H/week group                                          | 1H/week group | 1H/week supervision | 1.5H/week group consultation |

<p>| Cost                      | $$$$$                                                   | $$            | $$$                                   | $              |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Therapies</th>
<th>Duration</th>
<th>Outcome</th>
<th>Takeaways</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarkin et al, 2007</td>
<td>TFP (n=23)</td>
<td>1 yr</td>
<td>• All patients improved significantly</td>
<td>• TFP better in more domains than DBT or SP</td>
</tr>
<tr>
<td>McMain et al, 2009</td>
<td>DBT (n=90)</td>
<td>1 yr</td>
<td>• All patients improved significantly</td>
<td>• GPM was modestly better with more comorbidity</td>
</tr>
<tr>
<td>Bateman &amp; Fonagy, 2009</td>
<td>MBT (n=71)</td>
<td>1.5 yr</td>
<td>• All patients improved significantly</td>
<td>• MBT better with more comorbidity</td>
</tr>
</tbody>
</table>

*TFP – Transference-Focused Psychotherapy
*DBT – Dialectical Behavioral Therapy
*MBT – Mentalization-Based Treatment
*GPM – Good Psychiatric Management
*SCM – Structured Clinical Management
*SP – Supportive Psychotherapy

**Evidentiary Base for the Generalist Model of Tx for BPD**

Interpersonal Hypersensitivity
GPM’s Model of Interpersonal Coherence

from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*, 2014
Diagnostic Disclosure and Psychoeducation
“Individuals suffering from BPD are born with a genetic predisposition to be very sensitive to signs of rejection and to be emotional, and they have low frustration tolerance. They have grown up feeling that their parents did not give them the attention they needed or that they were untrustworthy or abusive. As adolescents or young adults they can take efforts to find somebody who can repair for the childhood care they missed. When they think they found it, they engage in emotionally intense, exclusive relationships, placing unrealistic expectations on the other person. People around them are expected to fill the void and provide what is painfully missed. While initially satisfying for both the individual with BPD and the other person, who is at this stage often idealized, these relationships are hard to maintain, stormy and painful, often leading to frustration and rejection, or to real separation.”

https://youtu.be/3CPPoIw0rtQ?list=PL_L7KEOxOeQ-fgpNYcWPPiXEHWIXkcyN4

from Ridolfy, ME, Gunderson, JG. Psychoeducation for patients with Borderline Personality Disorder.
Explanation in Relation to Traumatic Events

“While some borderline patients have clear traumatic childhood experience (neglecting or abusive family), in many cases there is not a frankly traumatic environment, and siblings and even twins [of patients] often report a more positive perception about caregiving. Moreover, Borderline Personality Disorder can develop without traumatic experiences, and traumatic experiences do not always lead to development of Borderline Personality Disorder... the exact causes of the disorder still need to be identified. What is clear is that neither borderline patients nor their parents are responsible for the disorder.”

from Ridolfy, ME, Gunderson, JG. Psychoeducation for patients with Borderline Personality Disorder.
“Borderline Personality Disorder is significantly heritable. This means families need to customize their caregiving to accommodate the handicaps due to their family member’s genetic disposition”

“Borderline Personality Disorder is a disorder that is very sensitive to environmental stress, especially interpersonal stressors (anger, rejection) or the lack of structure (inconsistent, unpredictable, ambiguous) – this means that patients get relief from structured and supportive environments.”

“Neurobiological correlates involve elevated cortisol [increased stress response] and opioid deficits [decreased stress calming].”

“The brains of people with Borderline Personality Disorder have hyperreactive amygdala (easily excited) and underactive prefrontal cortex (less cognitive/thinking inhibitions). Almost all effective therapies enhance prefrontal cortical activity, imposing thinking to evaluate perceptions and to control behaviors and feelings.”

Discussing Treatments and Prognosis

“There are multiple forms of empirically validated treatments for BPD. All of them decrease self-harm, anger, depression, and use of hospital, EDs, and medications. These treatments usually require 1-3 hours/week for a year or more by therapists with extensive training and ongoing supervision.”

“The vast majority of BPD patients improve without these intensive therapies. Good Psychiatric Management is usually sufficient. Treatment with intensive BPD-specific therapies should be sought for patients who don’t respond.”
Family Psychoeducation
Family: Avoid Pitfalls and Keep Perspective

• **Go slowly**: change is difficult to achieve and fraught with fears. Temper your expectations. Set realistic goals that are attainable. Solve big problems in small steps. Work on one thing at a time.

• **Be cautious/Keep things cool**: avoid suggesting ‘great progress’ or ‘you can do it’ encouragement (progress evokes fears of abandonment); avoid “big”, long-term goals (lead to discouragement and feelings of failure); appreciation and disagreement are both normal – tone them down;

• **Maintain family routines as much as possible** : stay in touch with family and friends - there’s more to life than problems, don’t give up on the good times

• **Find time to talk**: Chats about light or neutral matters are helpful. Schedule time to do this.

• **Manage Crises**: Self-destructive acts require attention, but don’t panic. **Listen**. People need to have negative feelings heard. Using words to express fear, loneliness, inadequacy, anger, or needs is good. **Avoid defensiveness**. However unfair, say little and don’t fight. Allow yourself to be hurt. Admit to what truths there are in the criticisms. Make sure professionals know about behaviors.
Family: Give Resources

Books for families:
- Stop Walking on Eggshells: coping when someone you care about who has Borderline Personality Disorder, Mason & Krager, 1998
- Borderline Personality Disorder demystified: An essential guide for understanding and living with BPD, Friedel, 2004
- Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families, Gunderson & Hoffman, 2005
- Sometimes I Act Crazy: Living with Borderline Personality Disorder, Kriesman & Straus, 2006

Websites:
- National Educational Alliance for Borderline Personality Disorder (NEA-BPD) www.borderlinepersonalitydisorder.com/
- Treatment and Research Advancements: Association for Personality Disorder (TARA APD) www.tara4bpd.org
- BPD Demystified www.BPDdemystified.com
- National Alliance on Mental Illness (NAMI) www.NAMI.org
- BPD Central www.BPDcentral.com
- DBT self-help www.DBTselfhelp.com

Videos on the web:
- NEA-BPD videos on multiple topics http://www.borderlinepersonalitydisorder.com/bpd-videos-by-topic/
- First person accounts of BPD in videos feat Amanda Wang on youtube.
- “If only we’d have known” – 5 videos on BPD, causes, diagnoses, treating, coping with – www.bpdvideo.com
GPM: The Basic Principles
Basic Principles of GPM Treatment

1. Offer Psychoeducation

2. Be active, not reactive (model emotions with a contained, active mind)

3. Be thoughtful (model use of frontal lobes)

4. The relationship is real and professional (preventing ambiguity [triggers BPD]
   and projection)

5. Convey that change is expected (there is hope for improvement)

6. Foster Accountability (expectations of action towards improvement)

7. Maintain Focus on Life Situations Outside of treatment (importance of patient
   and their role in life)

8. Be Flexible, Pragmatic, and eclectic (model flexibility and learning over time)
GPM: The Therapeutic Approach
“I’d be glad to meet with you weekly, but I’m reluctant to meet more often until we see whether I can be useful. We’ll both know that by observing whether you feel better and whether these problems in your behavior (like anger or self-harm), and relationships (like distrust of control) are getting better.
Forming the Alliance

- Building a Contractual Alliance (1-3 mo)
- Building a Relational Alliance (1-12 mo)
- Being Trustable Build Narrative Support efforts to engage in life
- Becoming Non-Borderline (2+ yr)

Diagnosis
Prognosis
Psycho-edu

Gradual Successes
Finding a role
Finding rational supports
Support

• Foster trust
• Be reliable, listen, be interested, show concern
• Actively, supportively psychoeducate
• Roll with situational changes – advise, exhort, assist
• Actively address negative emotions in the relationship
• Grow patient’s capacity to tolerate difference and navigate self/others’ emotion
Help Build a Narrative

• “I’d like you to be able to make sense of yourself and your life”
• “How does this relate to past experience?” or “…to last session?”
• “Have you noticed a pattern?”
• Formal use of chain analyses
• Make use of autobiography and recent life events to build change experiments
Process of Change

• Enhances Cognitive Learning – “think first”
• Enhances Social Capital – “get a life”
• Provides Corrective Experiences
  I. Therapist as trustworthy caretaker
  II. Therapist as role model
GPM: The Place of Medications
## Evidence for Medications in Treating BPD

<table>
<thead>
<tr>
<th>Med type</th>
<th>Mood Instability</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Anger</th>
<th>Impulsivity</th>
<th>Cognitive /Perceptual</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs</td>
<td>?</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>+</td>
<td>-</td>
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<tr>
<td>TCAs</td>
<td>-</td>
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<td>-</td>
<td>+</td>
<td>?</td>
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<tr>
<td>Mood Stabilizers</td>
<td>+</td>
<td>?/+</td>
<td>?</td>
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<tr>
<td>Antipsychotics</td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>+</td>
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<tr>
<td>Anxiolytics</td>
<td>?</td>
<td>-</td>
<td>?</td>
<td>-</td>
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<td>?</td>
</tr>
</tbody>
</table>

from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*, 2014
Assess

Mild symptoms

- No request
- Request

  - No medication
  - ?SSRI

Severe Symptoms

- Affective Mood Stabilizer
- Impulsive /Anger SGA/MoodStab
- Cognitive/Perceptual SGA

Response

  - Antidepressant
  - Change Class SGA-MS
  - Change SGA

adapted from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*, 2014
GPM: Med Management Strategies

1. Temper Expectations
2. Emphasize need for collaboration
3. Stress necessity for responsible use in order to assess effectiveness
4. Don’t be proactive in all circumstances
   a) Use meds only if pt requests, or if pt severely distressed
   b) If pt requests but not severely distressed, be willing but cautious, use SSRIs
   c) If pt severely distressed, encourage, but don’t push
   d) If pt failing to respond to med, taper it and begin new one (unless pt severely distressed)
“I’d like you to try this medication knowing that whether it will help is not certain and that you will need to help me assess its effectiveness. It will be helpful for you to read as much as you can about the medication and to monitor whether you see improvement in the symptoms that it is intended to affect. Will you do this?”
GPM: Managing Suicidality and Self-Harm
Assessing Risk

Assess Risk

Suicidal

Not Dangerous
  - Outpatient

Dangerous
  - Hospital/Residential

Non-suicidal

Dangerous
  - Infrequent
    - Intensive Outpt, Partial Hospitalization, Outpatient

Not Dangerous
  - Outpatient

Adapted from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*, 2014.
“Suicidality and self-endangering behaviors are usually reactions to interpersonal stress, i.e., the perception of rejection and the fear of being alone. I can help you manage these behaviors, but to diminish their cause we need to help you find better social supports – people to help you with those situations”.
“I’m willing to hospitalize you despite my concern that it will not be helpful. I would do this because I fear you will become more suicidal if I do not. Am I right about that?

We would both be better if we could find an alternative, yes?”
Directing to more intensive treatment

- Hospitalize Reluctantly, but don’t avoid at all costs
- Make stays as short as possible
- Coordinate with inpatient treaters
- Uses:
  - safe asylum
  - enhanced psychoeducation
  - evaluating existing tx
  - considering changes in tx
  - consider changes in tx level
  - developing better safety plans
  - develop stepdown plans
- Use of BPD as primary diagnosis for hospitalization increases focus of treatment on BPD
GPM: Expectable Changes
Assessing Progress

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Expected progress</th>
<th>Introspection</th>
</tr>
</thead>
</table>
| 1.5 mo     | • Has patient’s acute distress diminished?  
• Is the patient actively participating?  
• Do you like each other?                                                                         | 1) Do I know the patient better?  
2) Can I now predict my patient’s reactions?  
3) Am I involved?  
4) Has the patient become more trusting?                                                            |
| 3 mo       | • Has self-injurious behavior decreased?  
• Does the patient remember and apply lessons learned in sessions?  
• Has your understanding and empathy increased?                                                       |                                                                              |
| 6 mo       | • Has the patient assumed/resumed social role/responsibility?  
• Does the patient relate behaviors or emotions to interpersonal events?  
• Has the patient’s trust in you (reliable, well-intentioned, caring) improved?                  |                                                                              |
## Expected Changes Over Time

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Change</th>
<th>Time</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective distress/dysphoria</td>
<td>↓ anxiety &amp; depression</td>
<td>0-1.5 months</td>
<td>• Support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Situational changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ↑ self-awareness</td>
</tr>
<tr>
<td>Behavior</td>
<td>↓ self-harm, rage, promiscuity</td>
<td>2-6 months</td>
<td>• ↑ awareness of internal and interpersonal triggers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ↑ problem-solving strategies</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>↓ devaluation, ↑ assertiveness and positive dependency</td>
<td>6-12 months</td>
<td>• ↑ mentalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ↑ stability of attachment</td>
</tr>
<tr>
<td>Social function</td>
<td>More stability of school/work/domestic responsibilities</td>
<td>6-18 months</td>
<td>• ↓ fear</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• ↓ failure</td>
</tr>
<tr>
<td></td>
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<td>• ↓ abandonment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ↓ coaching</td>
</tr>
</tbody>
</table>

From Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*, 2014
## When to Question When Treatment is Failing

<table>
<thead>
<tr>
<th>Time in Treatment</th>
<th>Observation</th>
</tr>
</thead>
</table>
| 3 weeks           | - Attendance is Poor.  
                  | - Subjective distress is not better.  
                  | - You do not like the patient. |
| 3 months          | - Patient consistently disparages the therapist.  
                  | - Self-endangering events or activities of daily living worsen.  
                  | - Your empathy or understanding has not improved. |
| 6 months          | - Level of self-endangering behaviors persists.  
                  | - Patient fails to remember or use lessons from prior sessions.  
                  | - Patient has failed to attain or resume some part-time vocational role.  
                  | - Patient fails to recognize significant of adverse interpersonal events such as rejection or separation. |

From Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*, 2014
<table>
<thead>
<tr>
<th>Step</th>
<th>Severity</th>
<th>Definition</th>
<th>Potential Interventions</th>
<th>Intensity</th>
</tr>
</thead>
</table>
| Pre-Clinical    | Subthreshold              | Less self-harm  
Less suicidality                                                            | Psychoeducation for pts and families  
Focus on supportive counseling                                                          | -         |
| Early/Mild      | 1st episode of BPD       | Some self-harm  
Less suicidality                                                        | GPM  
Case Management  
DBT skills group                                                                          | ↑         |
| Sustained       | Sustained threshold level sx | More self-harm  
Unresponsive to basic tx                                                   | GPM with med mgmt.  
DBT skills training  
Single model EBT (DBT, MBT, TFP)                                                       | ↑↑        |
| Moderate        |                           |                                                                           |                                                                                        |           |
| Severe          | Remitting and Relapsing   | Severe self-harm  
Potentially Fatal Suicide attempts                                             | Integration of EBTs  
GPM informed med mgmt.  
Higher level of care (IOP, Hosp) if need                                                 | ↑↑↑       |
| Chronic         | Unremitting               | Unresponsive to interventions from previous stages                         | GPM  
Supportive Therapy                                                                       | ↓ care to ↑ response? |
| Persistent      |                           |                                                                           |                                                                                        |           |

If sx worsening, consider level in stepped care

from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*, 2014
GPM: Expectable Changes
TAKE-AWAYS
• Borderline Personality Disorder (BPD) places a great burden on patients and the healthcare system
• There is currently not enough availability of treatment for all persons with BPD
• Generalist models of treatment of BPD can be as effective as higher-intensity models when used in appropriate subset.
• Good Psychiatric Management provides a model for:
  • Understanding core interpersonal sensitivity and relational patterns in BPD
  • Providing clear psychoeducation to patients with and their families
  • Engaging patient in multimodal lower-intensity treatment that improves interpersonal function over time
  • Knowing when higher-intensity treatments may be indicated
## Attitudes Towards BPD

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I had a choice, I would prefer to avoid caring for a BPD patient.</td>
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<td>I feel professionally competent to care for BPD patients.</td>
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<tr>
<td>BPD is an illness that causes symptoms that are distressing to the BPD individual.</td>
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<tr>
<td>I believe the BPD patient has low self-esteem.</td>
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<td>I feel I can make a positive difference in the lives of BPD patients.</td>
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<tr>
<td>The prognosis for BPD treatment is hopeless.</td>
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<tr>
<td>Some psychotherapies are very effective in helping patients with BPD</td>
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<tr>
<td>I would like more training in the management and treatment of BPD patients.</td>
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</tr>
</tbody>
</table>
Resources for Clinicians


Websites:
- National Educational Alliance for Borderline Personality Disorder (NEA-BPD) www.borderlinepersonalitydisorder.com/
- Treatment and Research Advancements: Association for Personality Disorder (TARA APD) www.tara4bpd.org
- BPD Demystified www.BPDdemystified.com
- National Alliance on Mental Illness (NAMI) www.NAMI.org
- BPD Central www.BPDcentral.com
- DBT self-help www.DBTselfhelp.com

Videos on the web:
- NEA-BPD videos on multiple topics http://www.borderlinepersonalitydisorder.com/bpd-videos-by-topic/
- First person accounts of BPD in videos feat Amanda Wang on youtube.
- “If only we’d have known” – 5 videos on BPD, causes, diagnoses, treating, coping with – www.bpdvideo.com