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Chapter 1

An Overview of Good Psychiatric Management

Origins and Directions

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We developed this book because most clinicians will need to treat patients with borderline personality disorder (BPD) and can use help in doing so. Patients with BPD represent about 1 in every 4–5 psychiatric hospitalizations and a similar fraction of outpatient clinic visits (Chanen et al. 2008; Korzekwa et al. 2008; Zimmerman et al. 2008), about 1 in 10 visits in

the emergency department (Chaput and Lebel 2007; Tomko et al. 2014), and 1 in 20 visits to primary care providers (Gross et al. 2002). Not only are these patients a major presence in virtually all clinical care sites, but they are frequently experienced as impatient, needy, and burdensome, especially when they perceive that their particular needs are not being addressed. This book is intended to provide helpful how-to advice and wisdom about how their care can best be managed. The word *managed* is key: This book is not about lengthy intensive interventions; it is about management strategies, such as calming, encouraging, advising, and otherwise facilitating getting your patients with BPD in a position to pursue productive lives.

This book's management perspective contrasts with that of the majority of books about the treatment of patients with BPD, which emphasize lengthy complex psychotherapies aimed at bringing about deep psychological changes. Such therapies are for specialists. In this book, our focus is on the majority of patients who are not seeking such psychotherapies and on the majority of clinicians who are not primarily psychotherapists or BPD specialists. This book is addressed to health professionals who simply want to take better care of the patients with BPD who come under their care, with the goal of helping these patients move on with their lives.

To make this book readable, understandable, and most of all useful, our authors have included case vignettes in most chapters to illustrate common problems that clinicians can expect to encounter in usual practice. Each vignette is interrupted with "decision points," demonstrating occasions within the therapy in which a clinician is faced with making an intervention and often needs to consider a variety of options. We provide options that occur to us and then discuss and rate their relative merits. We want readers to consider and rate these options alongside us. Instead of aiming for readers to learn the right answer, this is an exercise in active learning. Decisions made in clinical reality rarely fit the supposedly clear answers provided as multiple-choice options. Do not be surprised if you disagree with our ratings or if you think of other options that might be preferable. We will not be. We want you to learn how to think in good psychiatric management (GPM) terms—that is, practical, thoughtful, and realistic ways—about the care of patients with BPD. We do not aim to create followers who remain tightly adherent to our ideas.

There is strong reason to believe that with shorter-term, less demanding interventions, the majority of patients with BPD can and will get better, as well as or nearly as well as those patients who receive their care from specialists (Choi-Kain et al. 2017; Gunderson 2016). Longitudinal studies of the past 20 years convincingly show that most patients with BPD go on to re-

mission or even to recovery in the absence of intensive specialized evidence-based treatments (Gunderson et al. 2011; Zanarini et al. 2012). There is still growing evidence establishing the value of less intensive nonspecialist interventions (Gunderson 2016). Just as GPM established its value in a comparison to dialectical behavior therapy (DBT), a similar once-weekly model called structured clinical management (Bateman and Krawitz 2013) established its value against standard mentalization-based treatment (MBT) (Bateman and Fonagy 2009). Thus, structured clinical management (SCM) and GPM, less-intensive generalist treatments developed expressly for BPD, have proven effective in two large randomized controlled trials (Bateman and Fonagy 2009; McMain et al. 2009). Specifically, SCM proved effective in reducing BPD symptoms—most notably self-harm—within the first 6 months of treatment but was outpaced by MBT at 18 months (Bateman and Fonagy 2009). GPM performed as well as DBT across a range of outcomes, spanning BPD symptoms, interpersonal functioning, anger, and depression (McMain et al. 2009). As important as the GPM and structured clinical management findings are the results of the DBT-dismantling study, which showed that its group component seems to carry much of the effectiveness (Linehan et al. 2015). Notably, the onerous requirement of around-the-clock, over-the-weekend coverage seems to be dispensable. In addition to these studies, a large psychopharmacological trial (Crawford et al. 2018) recently demonstrated that although lamotrigine failed to show an advantage over placebo, both arms of the study had robust clinically significant improvements—larger than would be expected from treatment as usual. The obvious conclusion to be drawn from findings of Crawford et al. (2018) is that the regular attention of motivated psychiatrists to monitoring changes in signs and symptoms of BPD had a powerful and positive effect on outcome (Gunderson and Choi-Kain 2018).

This book's unspoken mandate for clinicians to use GPM can be criticized on the basis that the empirical support for this model of treatment rests on only one study (McMain et al. 2009, 2012). That study was a well-designed, large, multisite study in which GPM proved to be the equivalent to what was acknowledged to be high-quality DBT, conducted under the supervision of the study's primary investigator. However, it is worth noting that the vast majority of scientific findings are not investigated further in replication studies, with an estimated 1.07% overall replication rate in the field of psychology, for instance (Makel et al. 2012). In other words, the truth is that such a replication, which would be considered significant in the world of research, is unlikely to occur in the present research environment. We believe that the usage of GPM's model really does not and should not depend on the completion of such a study. Its

usage depends on the cumulative research cited here. Moreover, the rationale for learning GPM derives from the absence of any reasonable alternative. Patients with BPD keep arriving in our offices, our clinics, our emergency departments, and our hospitals. These patients deserve to expect that every clinician has been taught how to provide them with basic services from which they have a reasonably good chance of benefiting. GPM meets this need.

GPM developed from clinical experience. Unlike the other evidence-based treatments for BPD, GPM was not preceded by a theory (Gunderson et al. 2018). It evolved gradually over many years since its first iteration in 1984 (Gunderson 1984). What followed were refinements integrated into the American Psychiatric Association's guidelines for the treatment of BPD (American Psychiatric Association Practice Guidelines 2001), culminating in the manualization of the treatment with the help of Paul Links (Gunderson and Links 2014). GPM's evolution was influenced by all the best BPD psychotherapies. Otto Kernberg's object relations theory (Kernberg 1967), Marsha Linehan's cognitive-behavioral paradigm (Linehan 1993), and Peter Fonagy and Anthony Bateman's developmental perspectives (Fonagy and Bateman 2008) all influenced the GPM approach. It first became identified as a distinctive model of therapy in a case report in *The American Journal of Psychiatry*, in which it served to provide a foil against which interventions directed by Kernberg's transference-focused psychotherapy (Clarkin et al. 2007) and Bateman and Fonagy's MBT (Bateman and Fonagy 2006) could be compared (Gunderson et al. 2007). The editor of the journal, Bob Michaels, suggested that the pragmatic eclectic treatment that I (J.G.G.) was providing actually represented a third form of treatment. It turns out he was right, but GPM's claims to legitimacy as a bona fide model for treating BPD needed to wait until GPM integrated BPD's genetic contribution, elaborated a theory of interpersonal hypersensitivity (Gunderson and Lyons-Ruth 2008), and, most importantly, received empirical support from McMain et al. (2009). GPM as it currently stands also integrates medication management. This is done with full recognition that the actual benefits from medications are questionable, although we also recognize that in the prevailing health care systems, almost all patients with BPD will be given medications. It is pragmatic then to do what is possible to make these medications useful rather than to have their prescribing be uninformed or conducted by independent providers.

The specificity of GPM for BPD has two major advantages. The first is that it does not get unduly distracted by signs and symptoms such as im-

pulsive acts or emotional outbursts. Rather, it maintains a focus on the core personality disorder issues related to interpersonal relationships. The centrality of interpersonal relationships in BPD has been recognized in most of the clinical literature. Similarly, the centrality of interpersonal relationships to personality disorders is now usefully recognized in the alternative proposal for personality disorder diagnosis in DSM-5 (American Psychiatric Association 2013). BPD's characteristically troubled and unstable interpersonal relationships best distinguish this disorder from all others (Gunderson and Lyons-Ruth 2008). A second advantage is that treatments for BPD require a focus on its symptoms as a basis for treating other comorbidities instead of vice versa. The history of BPD has been one in which treatments designed for other disorders—for example, psychoanalysis for neuroses, antidepressants for depression, and mood stabilizers for bipolar disorder—have been given to patients with BPD but with harmful results.

GPM began with a utilitarian once-weekly individual-session format meant specifically for adult patients with BPD. It then became apparent that GPM was well suited for use as an initial intervention at the early stages of the development of BPD, and therefore the use of more intensive specialist care could be reserved for nonresponders (see Appendix B, "Stepped Care Model" [Choi-Kain et al. 2016]). It has been rewarding to learn about the development of other applications of GPM. Those applications populate this book. The first part of this book considers the applications of GPM to general hospital as well as psychiatric inpatient and outpatient treatment settings. The second part considers the use of GPM by different psychiatric and nonpsychiatric providers. The third part considers GPM's implementation in brief format and for narcissistic personality disorder as well as in integration with other evidence-based therapies for BPD. The range of applications described in this book means that you will not necessarily read this book from start to finish. Rather, some chapters will have immediate relevance to your clinical work, whereas others can rest as reserve resources to be read as clinical exposure changes. Our goal is that you will find this book useful and entertaining. We hope it will lend confidence, structure, and specificity to your care of patients with BPD so that your efforts feel rewarding. If that occurs, we predict that the reluctance and usual anxieties many clinicians have when working with patients with BPD will eventually diminish and be replaced with the sort of general good concern you have for any other patient who needs and deserves your care.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Arlington, VA, American Psychiatric Association, 2013

American Psychiatric Association Practice Guidelines: Practice guideline for the treatment of patients with borderline personality disorder. Am J Psychiatry 158 (10 suppl):1–52, 2001 11665545

Batemen A, Fonagy P: Mentalization-Based Treatment for Borderline Personality Disorder: A Practical Guide. New York, Oxford University Press, 2016

Bateman A, Fonagy P: Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry 166(12):1355–1364, 2009 19833787

Bateman AW, Krawitz R (eds): Borderline Personality Disorder: An Evidence-Based Guide for Generalist Mental Health Professionals. Oxford, UK, Oxford University Press, 2013

Chanen AM, Jovev M, Djaja D, et al: Screening for borderline personality disorder in outpatient youth. J Pers Disord 22(4):353–364, 2008 18684049

Chaput YJA, Lebel MJ: Demographic and clinical profiles of patients who make multiple visits to psychiatric emergency services. Psychiatr Serv 58(3):335–341, 2007 17325106

Choi-Kain LW, Albert EB, Gunderson JG: Evidence-based treatments for borderline personality disorder: implementation, integration, and stepped care. Harv Rev Psychiatry 24(5):342–356, 2016 27603742

Choi-Kain LW, Finch EF, Masland SR, et al: What works in the treatment of borderline personality disorder. Curr Behav Neurosci Rep 4(1):21–30, 2017 28331780

Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF: Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry 164(6):922–928, 2007 17541052

Crawford MJ, Sanatinia R, Barrett B, et al: The clinical effectiveness and cost-effectiveness of lamotrigine in borderline personality disorder: a randomized placebo-controlled trial. Am J Psychiatry 175(8):756–764, 2018 29621901

Fonagy P, Bateman A: The development of borderline personality disorder—a mentalizing model. J Pers Disord 22(1):4–21, 2008 18312120

Gross R, Olfson M, Gameroff M, et al: Borderline personality disorder in primary care. Arch Intern Med 162(1):53–60, 2002 11784220

Gunderson JG: Borderline Personality Disorder. Washington DC, American Psychiatric Press, 1984

Gunderson JG: The emergence of a generalist model to meet public health needs for patients with borderline personality disorder. Am J Psychiatry 173(5):452–458, 2016 27133405

Gunderson JG, Choi-Kain LW: Medication management for patients with borderline personality disorder. Am J Psychiatry 175(8):709–711, 2018 30064243