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Brief Psychiatric Treatment for Borderline Personality Disorder as a First Step of Care: Adapting General Psychiatric Management to a 10 Session Intervention

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Abstract (234/250 words)

The considerable demand versus supply gap of evidence-based treatments for borderline personality disorder (BPD) indicates the need for modular steps of care to tailor fit between individual patients' needs along the trajectory of their clinical course and effective interventions. These trajectories may or may not include lengthy specialized psychotherapies. Good psychiatric management (GPM) for BPD is being practiced by an increasing number of mental health professionals as a basic starting block of mental health services in the community. It remains an open question what duration of GPM is optimal, what the content of a shortened version of GPM may be, and how such brief treatment may be integrated into larger long-term treatment plans for patients with BPD. The present practice review elaborates on a brief version of GPM, addresses its conceptual background and the notion of stepped care in the treatment of BPD, and discusses the clinical tasks and contents of brief psychiatric management in 10 sessions (or lasting four months). It also summarizes the moderate evidence base of brief forms of GPM: two randomized controlled trials (RCTs) of 10-session GPM, and one RCT of a 6-session GPM psychoeducational group, have found medium-to-large effects in reducing BPD symptoms. Finally, this review offers two clinical vignettes of patients either stepping up or down the intensity of their treatment to illustrate how to implement brief GPM, and suggests open avenues for future development and clinical practice.

Keywords: Good Psychiatric Management; Borderline Personality Disorder; Brief Treatment; Clinical Practice; Stepped Care

Brief Psychiatric Treatment for Borderline Personality Disorder as a First Step of Care: Adapting Good Psychiatric Management to a 10 Session Intervention

Borderline personality disorder (BPD) is among the most prevalent diagnoses in clinical settings, especially emergency rooms and inpatient hospital units (Paris, 2013; Zimmerman, Chelminski & Young, 2008). Despite its high frequency, the BPD diagnosis is often missed or not disclosed (Zimmerman, et al., 2010; Zimmerman & Morgan, 2013), since these urgent encounters result in temporizing measures to manage risk of self-destructive behavior, not definitive treatment plans to address their major causes. While patients rarely identify their chief complaint in terms problems related to personality disorders, diagnosing BPD is essential because it influences the course of treatment (Zimmerman & Morgan, 2013). Since BPD is associated with a severe mental health burden, the later the diagnosis is identified, the greater the costs for patients, families, clinicians, and society.

Suicide attempts, the most urgent cause for initiating care, are associated with identity disturbance, frantic efforts to avoid abandonment, and emptiness for those with BPD, and these features are not routinely the focus of assessment and treatment planning (Yen et al., 2021). These characterological features underlie the more obvious acute behavioral symptoms that garner significant clinical attention and resources, and also affect psychosocial functioning, which remains impaired even after symptomatic remission (Gunderson et al., 2011; Zanarini et al., 2014). Symptoms of BPD that occur at age 14 predict poor academic and occupational attainment and greater welfare reliance up to 20 years later (Winograd, Cohen & Chen, 2008). These permanent diversions from developmental life experiences potentiate disability (Moran et al., 2016; Choi-Kain & Sharp, forthcoming). In fact, the majority of costs attributable to BPD are due to indirect costs (van Asselt et al., 2007). Conservative estimates calculate a quarter of the

total societal cost of BPD is due to work disability (Wagner et al., 2014). Moreover, the reduction of life expectancy is estimated to range between 13 and 25 years, when compared to the general population (Cailhol et al., 2017).

Discussion of diagnosis and treatment is essential to the treatment of BPD and is common to all BPD treatments shown superior to treatment as usual (Storebø et al., 2020). Despite its high prevalence in clinical settings, evidence-based practice for BPD is limited in community settings, due to the intensity and costs of both the treatments and the training required to administer them. These factors contribute to pervasive gaps between supply and demand in even the most well-resourced countries (Iliakis et al., 2019), so that indicated empirically supported treatments are rarely available at critical junctures. To address this public health problem, a "good enough" treatment for BPD must be available to fill in this gap (Choi-Kain, Albert & Gunderson, 2016).

Research has shown that structured, generalist interventions perform almost as well as specialized treatments (McMain et al., 2009). General Psychiatric Management, manualized by Paul Links based on Gunderson's *BPD: A Clinical Guide* (Gunderson, 2009), was studied in a randomized controlled trial (RCT) that showed it had comparable effects on all outcome measures to Dialectical Behavior Therapy (DBT) after one year of psychotherapy, and these improvements were maintained after 2 years (McMain et al., 2012). Gunderson re-manualized General Psychiatric Management into the *Handbook of Good Psychiatric Management* (GPM) to be accessible to a general readership of mental health professionals. GPM finds its inspiration in psychoanalytic and cognitive behavioral understandings of BPD. GPM's conceptual foundations are grounded in scientific findings on BPD's etiology, psychopathology, course, process, and treatments. This basic knowledge can be helpful to patients and clinicians across clinical contexts, irrespective of the interventions delivered. Built on core principles that require flexible,

pragmatic and eclectic interventions, GPM employs an active, curious, and thoughtful therapeutic stance common to all effective therapies for BPD. GPM's low intensity and flexibility allow it to be easily adapted to acute settings such as emergency rooms (Hong, 2016) and inpatient hospital units, as well as shorter outpatient formats that can supplement existing triage options for BPD in models of care that guide the efficient allocation of resources.

Resource optimization requires that patients receive a treatment tailored to their condition. While the most well-known treatments for BPD are long-term (Storebø et al., 2020; Cristea et al., 2017), 48% (*n* = 36) of the 75 studies included in the current Cochrane meta-analysis on psychological treatments for BPD are shorter than or equal to six months (Storebø et al., 2020).

Brief treatments make clinical sense in the context of *stepped care* models (Paris, 2015; Grenyer, 2014; Laporte et al., 2018), which aim to assign every patient to the most adequate therapeutic resource available. The stepped care model is based on the assumption that long-term therapy is not the only indicated treatment for BPD, and that in many cases, a shorter-term intervention will at least have initial benefits (Huxley et al., 2019), especially if more immediately available during acute clinical states. Given limited clinical resources, therapeutic indications should be based on the extent to which the patient will benefit or not from an initial dose of treatment versus from a longer-term treatment.

Many stepped care models have been proposed by leading experts in the field (Choi-Kain, Albert & Gunderson, 2016; Paris, 2013; Chanen, Berk & Thompson, 2016; Grenyer et al., 2018). One stepped care model which incorporates consideration of stages of illness starts early by responding to preclinical cases with mental health literacy and supportive counselling for patients and relatives. GPM could be offered as a way to increase awareness of early symptoms

and provide basic tools to manage core interpersonal hypersensitivities more proactively so that more self-reliant as well as prosocial behavior is encouraged to replace symptomatic responses to stressors. It may be speculated that when early intervention is possible, patients may benefit the most of GPM, prior to the accumulation of increasing comorbidities, developmental arrests from needing to be exempted from usual life activities, and chronic disability set in (Choi-Kain et al., 2016; Gunderson & Links, 2014). More research is needed to clarify the effects of early and basic intervention on the clinical trajectory of individuals with BPD. For partial responders, or non-responders to the brief GPM, defined in terms of continued need for acute services such as inpatient or emergency room visits, continuous GPM and medication management may be the method of choice, helping them to prepare for a specialized treatment later, or any other treatment option as needed (residential or outpatient intensive care for more severe cases). Available group therapy interventions including DBT, STEPPS, MBT, or substance use disorder self-help groups can be added at this stage as adjunctive treatments to enhance social support as well as attention to key clinical concerns. For patients who do not respond to any treatment, including specialist or residential options, a step down to supportive and clinical case management can be useful. At any stage, patients can step down to GPM on an infrequent basis as primary psychiatric care as needed (Choi-Kain, Albert & Gunderson, 2016).

Stepped care models such as this one can be adapted to any setting (individual, groups, first line or specialized clinicians) and provide a general framework for intervention. Generalist treatments like GPM are therefore *not* understood as an option competing directly with specialized evidence-based psychotherapies. Specialized therapies remain a treatment of choice, but may be too intensive for early intervention, some patients, and some clinical settings. Stepped care provides a step-by-step adjustment of treatment intensity starting with the lowest

dosage, increasing until response in terms of ability to remain in an outpatient status and life activities that normally provide needed structure, roles, and regulation of the patients with BPD in their daily living. When scientific study can clarify how dosage can be properly adjusted for different stages of illness or clinical profiles, a staged approach by be possible to provide more precision to the prescription of the various evidence-based approaches available.

A brief variant of GPM for BPD is conceived as a 10-session treatment (or lasting about four months with weekly sessions). Treatment goals include 1) disclosure of BPD diagnosis; 2) relating how BPD's core feature of interpersonal hypersensitivity plays out in the patient's actions and relationships; 3) psychoeducation about its symptoms, course, and treatments; and 4) generation of motivation and commitment for change either with ongoing therapy or without. The treatment also aims to prevent iatrogenic and unnecessary treatments, such as repeated hospitalization to manage safety. The purported mechanism of 10-session GPM is the provision of sustainable hope required for efforts to change and reclaim one's life, consistent with the goal of remoralization during the initial phase of any effective psychotherapy (Howard et al., 1986).

Evidence base of brief psychiatric treatment for BPD

The evidence base for brief psychiatric treatments for BPD is moderate and needs further research (Storebø et al., 2020; Cristea et al., 2017). Since the landmark study by McMain et al. (2009; 2012) showing one year of DBT failed to show superiority over one year of GPM (see Table 1), reports from two subsequent small RCTs of the briefer 10-session version of GPM have been published (Kramer et al., 2011; Kramer et al., 2014). Both trials by Kramer et al. assessed the effects of adding Motive-Oriented Therapeutic Relationship (MOTR), a case formulation method focused on contextualizing motives that underlie the patient's behaviors or experiences, by comparing 10-session GPM alone to 10-session GPM+MOTR. The first pilot

study showed better outcomes for general symptoms for the GPM+MOTR group (Kramer et al., 2011), and the second larger study confirmed this effect in a larger trial, also finding that BPD symptoms decreased comparably between the two conditions (Kramer et al., 2014). These results suggested that the MOTR increased overall symptom relief within four months of treatment, over and above the basic GPM approach, which was not the case for the core symptoms of BPD. Brief GPM could therefore be considered as good enough to address these specific borderline symptoms, and additional therapeutic components may not be essential to produce this specific effect. At the 6-12 month follow up, effects of brief GPM were maintained, while all between-condition effects disappeared (Kramer et al., 2017). Adherence to GPM principles, measured by the GPM Adherence Scale (GPMAS) (Kolla et al., 2009), explained 16% and 23% of the general and borderline symptom improvement of 10 session GPM, respectively (Kolly et al., 2016). Of note, these trials were conceived and conducted as add-on RCTs aiming at the study of the effects of case formulation, so conclusions with regard to the effectiveness of the MOTR are limited.

Further research is needed to establish the effectiveness of brief GPM using RCTs. Currently, an ongoing trial addresses two research questions investigating the effectiveness of brief GPM (in 4 months) as it is compared to an equally brief non-specific psychiatric contact (which is not focused on BPD), as well as the neurobehavioral mechanisms of change (i.e., changes in neurofunctional activation in networks associated with emotion and socio-cognitive processing; Kramer et al., 2018; Kramer et al., 2020). This study will not only contribute to more firmly establish modules of evidence-based treatments for BPD, but may also help inform clinicians to formulate intermediate treatment plans that are consistent with a mechanism-based, and research-informed intervention.

Apart from the 10-session GPM format, a 6-session GPM-based psychoeducational group has been compared to a waitlist in a controlled trial (Ridolfi et al., 2019). Participants in the group received six 90-minute sessions weekly, with each session including time for didactic content and for mutual support and feedback. The six topics covered were (1) diagnosis of BPD and symptoms, (2) origins of BPD, (3) co-occurring disorders, (4) course, (5) treatment, and (6) role of medications. The intervention was associated with significant improvement on all sectors of BPD (affective, cognitive, impulsive and interpersonal), and significantly greater gains than the waitlist on every sector except impulsivity, both post-treatment and at the two-month follow-up. Forty-six percent (n = 22) of the psychoeducational group were full responders (decrease of ≥50% from baseline BPD symptoms), as compared to 6% (n = 3) in the waitlist group. Both 10-session individual and 6-session group GPM were rooted in basic principles that are broadly applicable to all patients with BPD, either as pre-treatment or definitive basic care. Of note, the treatment arms included in these studies were led by experts in treating BPD. These experts trained study clinicians who held different degrees ranging from nurses and social workers to psychologists and psychiatrists. Clinicians in these trials, consistent with most other major RCT's verifying the efficacy of BPD's most widely accepted therapies, have typically chosen to work in specialized programs treating BPD. It remains unclear what the interaction between being experienced or interested in treating BPD and adherent delivery of GPM is. This limits generalizability of these results to generalist non-experts practicing in usual settings and calls for more research in these clinical contexts.

We conclude that more research is needed, for example by comparing brief versions of GPM to evidence-based treatment of BPD, such as brief DBT or STEPPS. It would also be important to test the role of training on the delivery of GPM, as it is assumed that therapists with minimal levels of training in psychiatry and psychotherapy will benefit from GPM training and will be able to propose an effective treatment for BPD.

Basic principles of Good Psychiatric Management

GPM relies on fundamental principles guiding good clinical practice, tailored to the specific features of BPD (Gunderson & Links, 2014) (see Table 2). GPM encourages clinicians to use a curious, active, "think first" therapeutic stance to emphasize the patient's role as a collaborator in treatment. GPM calls on patients to manage relationships and solve problems effectively, rather than relying on clinicians to unilaterally take measures such as hospitalization or medications to alleviate distress. These unilateral measures, often the only resources clinicians sometimes can access, leave patients with BPD dependent on the healthcare system, unable to overcome their functional deficits.

The use of GPM principles has many advantages. Training requirements for GPM require fewer hours and lower levels of specialization than specialist therapies, so wider dissemination is possible. GPM's can be flexibly adapted to the clinician's level of practice and experience, helping younger clinicians face difficult interactions, and more seasoned clinicians to address recurring challenges consistently. GPM utilizes a medicalized attitude towards care, relying on common factors connected to different therapeutic attitudes from psychodynamic and cognitive-behavioral backgrounds. GPM rests on common mechanisms of change across all psychotherapeutic modalities which include enhancing patients' motivation to change, expectation that therapy can be helpful, a good therapeutic alliance, increased awareness of their

problems, corrective experiences, and enhanced ongoing reality testing (Goldfried, 1982). GPM does not rely on psychotherapeutic techniques in a strict sense. It is also highly adaptable to different clinical situations and settings. Therapists specialized in domains other than personality disorders (addiction, eating disorder, etc.) can apply GPM's principles and offer an integrated BPD intervention. GPM may also be delivered by health workers who do not work in psychiatry, but encounter patients with BPD in their practice (e.g., emergency room, general practitioners, etc.) GPM helps clinicians to expect patients to demonstrate their BPD symptoms in the course of treatment. This expectation of symptomatic presentations can help overcome stereotypes and negative connotations of patients with BPD as being “clingy” or “difficult”.

GPM's formulation of BPD as a disorder of interpersonal hypersensitivity (Gunderson & Links, 2014) explains the rapidly changing symptomatic presentations of patients with BPD. Four types of relational states are conceptualized: connectedness, feeling threatened, aloneness, and despair (see Figure 1). When the patient is connected, they are dependent and receptive to collaboration, but anxiously scanning for signals of pending rejection. Invariably, real or perceived abandonment triggers a threatened state, dominated by anger turned towards oneself in self-harm or towards others in devaluation. While counterintuitive, clinicians can lean in to help the patient sort out what is causing their angry reaction, in hopes that more prosocial actions can be taken. However, often this activated state naturally elicits withdrawal when others recoil in shock, confusion, fear, or frustration. Intolerant of aloneness, the patient with BPD will become more impulsive, paranoid, and dissociated, spiraling ultimately in a state of despair when isolated, feeling worthless without the attention of an engaged other. It is in this state that patients with BPD will contemplate suicide more seriously. As the patient descends into states of aloneness and despair, others around them generally resort to unilateral action to provide

containment such as hospitalization or other interventions. The byproduct of this transaction is that it re-catalyzes support and reconstitute the patient to a connected state. Using this model can foster mentalizing about problematic states in relationships, and consequently it contributes to increased awareness that can empower the patient to interrupt the progression of more severe symptomatic states. The aim of using this GPM model is to find alternatives to suicide attempts and hospitalization so patients can find the social support they need to stabilize.

Fundamentally, this model assumes a centrality of the interpersonal events as triggers for behavior crises. It informs possible ways to move the patient from one state to the next, with relevant therapist responses that can help the patient move back to a connected state. The therapist may use this model as a case formulation and share it with the patient (Choi-Kain & Finch, 2019). GPM's basic lesson direct patients toward more prosocial rather than destructive behavior, and increased self-reliance since the actions of others can be more difficult to control, especially when one is sensitive to the responses of others. As Gunderson famously said to patients, "You don't want your safety to depend on the likes of me" (Gunderson & Links, 2014).

Implementation of 10 sessions of Good Psychiatric Management

Goals of treatment can be adapted to time limitations, clinical resources and patient motivation. A 10-session intervention aims to help the patient recognize and seek future helpful therapeutic interventions and differentiate them from iatrogenic interventions. 10-session treatment aims at formulating an overall clinical management plan for BPD according to the stepped care model. It also helps the clinician-patient dyad to anticipate a crisis and diminish the use of undesirable interventions. Importantly, it fosters the patient's active engagement and responsibility in treatment to promote their dependence on themselves to make good decisions about how they manage their interpersonal vulnerabilities to best meet their goals.

Brief, 10-session GPM can stand on its own as the only treatment the patient receives for the time being. It aims at limiting unsuccessful coping with BPD (i.e., passive fatalism, social avoidance, diminished responsibility), while building courage to face relational and existential events, rather than escape or avoid in a passive, dependent position. GPM's psychoeducation integrates the patient's experience with a coherent narrative, which guides the patient when facing difficulties in professional life and relationships. It emphasizes life events as a source of corrective experiences, providing growth and learning, rather than just a succession of failures.

What happens at the start? The first session is devoted to promoting interest and engagement in the intervention. At the end of the first (or second) session, a 10-session intervention is proposed, if known already either as extended assessment or as time-limited psychotherapy.

What happens in the following sessions? Establishment of the BPD diagnosis is the first step. Evaluation of the different domains of symptomatology (affect regulation, impulsivity, identity, cognition, self-destructive behaviors and interpersonal functions) not only assesses the diagnostic criteria, but carefully evaluates their impact on the patient's daily life. This systematic evaluation prevents underdiagnosis of BPD and provides a direct way of naming problems. Through this process, a diagnostic hierarchy of co-occurring disorders is established, with BPD as a primary focus. Ten-session GPM follows standard practices of general psychiatric assessment (i.e., establish rapport, investigate historic origins of problems, describe problems) with BPD-specific content. The content of the sessions uses diagnostic sharing, psychoeducation, building of a narrative and case formulation, using interpersonal hypersensitivity model of GPM.

What happens in the last session? The final session of is a moment of review and synthesis that summarizes the clinical process so far, and a reflection on the patient's evolving

understandings of themselves and their problems. Brief GPM provides a structured outlook on future treatment options. Other clinicians, relatives or family can be invited to this final session. Recommendations should include the general diagnostic hypothesis that links the interpersonal hypersensitivity model to specific problems at hand, integrating BPD with comorbid diagnoses as part of a larger understanding of the patient. From this, a therapeutic plan with its explicit priorities and short- and long-term goals can be made clearer. If needed, further treatment is considered with the GPM clinician assisting the organization of the next steps of care.

Special tools and processes in a brief treatment

Diagnostic sharing. GPM adopts a medical understanding of BPD to provide factual clarity and concrete links to clinical decision making. The medicalized formulation promotes non-judgmental observation and prescription of healthy actions. People with BPD are considered responsible individuals whose actions and engagement have consequences in their lives. Patients decide how to use the clinical guidance to improve their symptoms and functioning.

Psychoeducation. Psychoeducation in GPM is clinically driven. This means that the clinician can use comments focused on the problem as expressed by the patient in the session. Psychoeducation also teaches patients about prognosis and the different validated treatment modalities. Psychoeducation may build the patient's interest and motivation to pursue a specialized treatment according to personal goals.

Shared narrative and case formulation. Once the diagnosis has shared, it is necessary to "tailor" it meaningfully in discussion with the patient. This narrative is a personal history integrating the role of BPD in daily functioning, relational crises, repeated patterns of self-sabotage, perceptions of self, and expectations in one's personal life. GPM's medicalized language helps the clinician convey an understandable case formulation, blending the patient's

developmental history, history of symptoms, and clinical investigation with the clinician's own theoretical and scientific knowledge base. The interpersonal hypersensitivity model is at the core of this narrative-building autobiographical process.

Interpersonal hypersensitivity. Interpersonal hypersensitivity may be used as a GPM-specific BPD case formulation tool that integrates symptoms, patient attachment state, subjective feelings, behavior, and interpersonal habits. 10-session GPM uses the model to identify repetitive relational transactions in the patient's life, and clarify relational transactions both in the patient's life in and out of sessions. The interpersonal hypersensitivity model has two functions: a) it may contribute to holding and regulating overly activated in-session affect in the patient, and b) it may contribute to triggering affect in the here and now and thus be helpful to name and explore central interpersonal themes in relation with the activated affect.

Case: "Step up" to intensive psychotherapy after brief GPM

The following vignette illustrates how a patient with BPD may move from a 10-session GPM to a structured evidence-based psychotherapy:

Caroline, who is 20 years old, is referred by her general practitioner for ongoing depression. She arrives with her mother, who is obviously overwhelmed by the situation and describes how Caroline had been physically aggressive towards her. Since dropping out of school a year ago, Caroline spends most of her time online chatting with friends. Despite her claims of enjoying this activity, she also finds herself in conflicts where she often is rejected or devalued. In response, she is unable to regulate her emotions, then tends to self-harm, or behave aggressively towards others, particularly her mother. In one such situation, Caroline physically attacked her mother. A 10-session GPM begins to help clarify Caroline's interpersonal hypersensitivity as a source of vulnerability to social interactions and her subsequent aggression

towards herself and others. The GPM clinician prompts her to think of a specific interaction to collaboratively analyze using the interpersonal hypersensitivity model. Caroline, who has previously devalued psychiatric treatment in general, admitted these sessions help her understand her core difficulties. In session 8, Caroline asked the clinician what would happen after session 10. The patient said that she wanted to make sure to be able to continue working on her problems, because there would be many more situations to work through in her opinion. She also mentioned she wanted to get back to school, and said treatment could help her to achieve that.

Caroline is diagnosed with BPD, which deeply resonates with her experience of herself. She reports that the diagnosis reframes her sense of herself as bad, to being someone with a medical condition needing treatment. The discussion regarding treatment options led to the selection of further work in an evidence-based therapy, in addition to a skills training group. This treatment allowed her, much later, to stop self-harming and reduce impulsivity, and to get into a professional training to reclaim her life. GPM's systematic work on interpersonal hypersensitivity is a major treatment starting block for Caroline, who entered treatment mistrustful and disengaged. During brief GPM's, Caroline discovered how further treatment could help her, which catalyzed her motivation for profound change.

Case: "Step down" or How much therapy is needed for a patient with multiple symptoms?

The following vignette illustrates the usefulness of a brief psychiatric treatment in a clinical scenario where too many therapists are involved and how it may help to develop a more focused, simplified, effective treatment plan:

Theresa is referred to a 10-session GPM by the inpatient psychiatric unit after being hospitalized eight times in the last six months due to severe suicidal episodes, some of which required surgical interventions and intensive care. Theresa is treated for depression with

medication by her psychiatrist and the medication is administered by a visiting nurse at her home three times a week to minimize risk of overdose. Nonetheless, Theresa sometimes stockpiles her pills and overdoses on them. Theresa also goes to a suicide prevention-focused individual therapy weekly and in addition to a couple and family therapy. Despite this highly intensive psychotherapeutic regimen, Theresa continues to have recurrent suicidal attempts. These attempts mobilize her husband and the family to try to keep her safe in desperate ways. When Theresa's husband is invited to a session, he reports oscillating between the feeling that care providers are not doing enough for his wife, and feelings that nothing can be done for her.

The diagnosis of BPD is confirmed, and an intervention of once weekly GPM over four months is recommended. At the start of 10 session GPM, Theresa still has a number of different therapists (couple/family therapist, nurse, prevention program, psychiatrist), who all expressed exhaustion from the current treatment. The GPM clinician contacts all these therapists to collect their views on the treatment. When Theresa starts brief GPM, her prior clinical team ends treatment after a final meeting with the patient. The GPM clinician clearly explains to Theresa that she has a choice to act responsibly for her medication or end the pharmacological prescriptions if they are used to attempt suicide. Theresa's own commitment to coming to therapy bolsters her motivation to refrain from abusing medication. The interpersonal hypersensitivity model is used to explain these patterns of interaction with her husband and their children, to explain her loneliness, emptiness and impulsive self-harming behaviors.

After four months, Theresa does not attempt suicide, although she reports situations where she came "close". Having one therapist in 10-session GPM seemed "good enough" for Theresa at this particular junction of her treatment trajectory to reorient the direction and focus

of her care. Long-term once-weekly psychiatric treatment based on GPM principles is offered to Theresa at the final session.

Conclusions

From a public health perspective, effective brief psychiatric treatments for BPD have many advantages, chief among them the immediate cost-effectiveness, its accessibility in underserved communities of clinicians, and its potential integration with ("stepping up to") intensive longer-term psychotherapy, as well as an intervention to limit iatrogenic treatment (such as recurrent emergency department or inpatient visits). GPM can increase collaboration within clinical teams, with feasible training requirements.

At the same time, brief treatment for BPD still has drawbacks and limitations. Brief GPM is not a total panacea and may simply be "sufficient" for treating BPD in some cases, but a first step for others who will need a second step of care, depending on a number of complex clinical factors including acuity, comorbidities, available resources, and patient motivation. Also, we are still unsure about what the training requirements for delivering effective GPM really are, and we call for more research on this topic in a variety of contexts.

The advantages and limitations of brief psychiatric treatments may define its place in various steps of BPD care. While RCTs clarify which psychotherapies are superior to other alternatives in a patient trajectory of care, they do not provide a complete picture of scalable treatments that are realistically implemented to address public health needs for patients with BPD at various stages of illness, symptom severity, and treatment responsiveness. Personalized medicine – and psychiatry – will refine our ability to offer tailored steps of care in empirically supported ways. We hope that in the future, research will determine which patients with BPD

respond best to either a "good-enough" brief, or long-term, treatment, or a high-intensity evidence-based psychotherapy in both brief or long formats.

In conclusion, clinicians may feel overwhelmed when working with patients with BPD. These clinicians may not have access to training in lengthier evidence-based therapies for BPD. Brief interventions offer clear principles to guide a structured, medicalized BPD-tailored approach. Patients often lack guidance on how to make mental healthcare decisions, and those with BPD often experience rejection and abandonment in the mental health system, causing recurrent exacerbation of their illness and chronic disability often paired with therapeutic pessimism. Many of these patients will benefit from brief treatment once they receive it. Research indicates that most patients can expect to improve while in treatment, even when brief (Storebø et al., 2020). Short-term GPM holds promise as a way to provide "good enough" care to a larger number of patients with BPD. Future directions for research include the adaptation of brief GPM to other personality disorders such as narcissistic personality disorder (Choi-Kain & Gunderson, 2019), the integration of brief GPM with other evidence-based treatments such as DBT (Sonley & Choi-Kain, 2020), and the potential of brief GPM as a form of early intervention during adolescence (Choi-Kain & Sharp, 2021).

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Figures and Tables

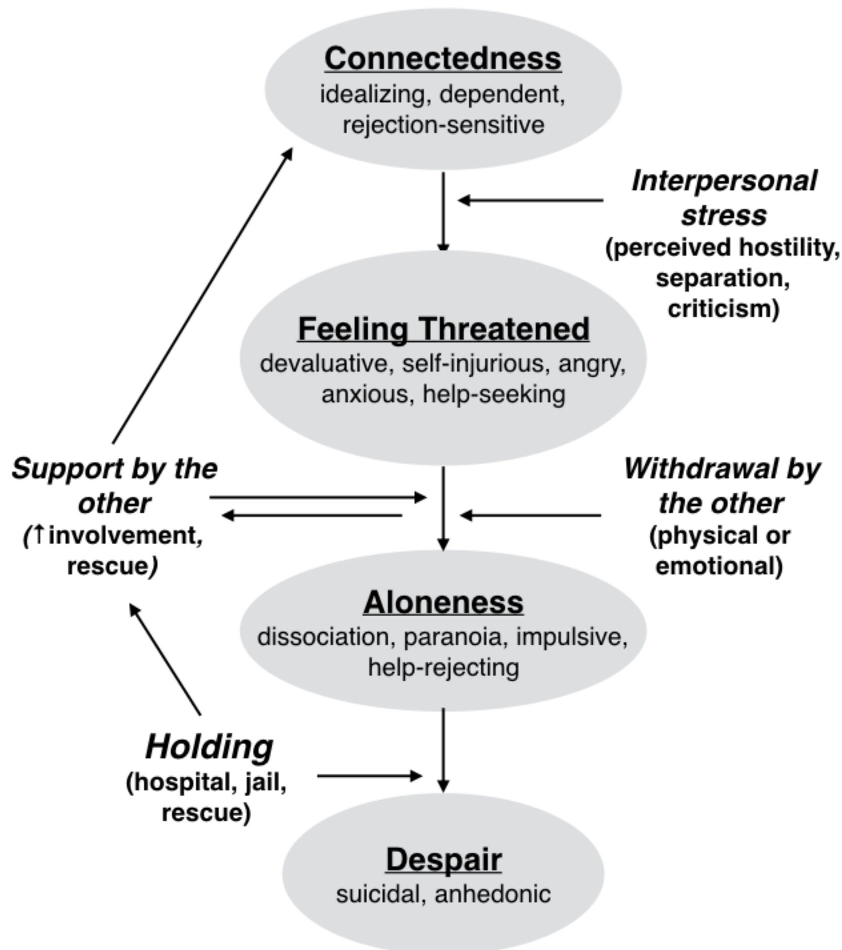

Figure 1. GPM's model of interpersonal coherence describes how individuals with BPD oscillate among four key states, and how others (e.g. loved ones, clinicians) may be able to intervene. Reprinted with permission from Handbook of Good Psychiatric Management for Borderline Personality Disorder, (Copyright ©2014). American Psychiatric Association. All Rights Reserved.

Table 1. Summary of GPM's evidence base.

Reference – Study Design	Study Design	Intervention(s)	Sample	Outcomes	Follow-Up/ Secondary Data Analyses
Treatment Effectiveness					
McMain et al. (2009)	RCT testing 12-month BPD treatments	DBT (n = 90) vs. GPM (n = 90)	Adult outpatients with BPD • M = 30.4 years old • 86% women • 65% not employed	• No significant differences across groups. • Significant improvement in suicidality, NSSI, BPD symptoms, distress, depression, anger, interpersonal functioning in both groups. • ↓ in general health care utilization.	• Dropout: Pts with ↑ Axis I comorbidity had ↑ retention in GPM. In both txs, ↑ comorbidity, anger, and suicide attempts, and ↓ alliance, predicted dropout (Wnuk et al., 2013) • 2-year follow-up: Pts sustained or even made further improvements. 2/3 achieved remission, but over half still had high functional impairment (McMain et al., 2012) • Trajectories: Across txs, pts who rapidly responded to tx but relapsed (vs. pts who sustained gains) had ↑ baseline depression, ED visits, and unemployment (McMain et al., 2018) • Tx selection: Pts with higher psychiatric symptom severity and impulsivity are more likely to benefit more from GPM, while pts with dependent traits, emotional abuse, and social adjustment are more likely to benefit from DBT (Keefe et al., 2020) • PTSD: Both txs ↓ suicide attempts, NSSI, distress, and BPD sx for BPD pts with and without PTSD (Boritz, Barnhart & McMain, 2016))
*Kramer et al. (2011)	Pilot RCT testing effects of adding MOTR to 10-session GPM	MOTR + GPM (n = 11) vs. GPM (n = 14)	Adult outpatients with BPD • M = 30.7 years old • 77% women	• No significant differences in outcomes between groups, except improvement in interpersonal problems (MOTR + GPM > GPM) • MOTR + GPM was associated with ↓ dropouts and ↑ quality of the therapeutic alliance	• N/A

*Kramer et al. (2014)	RCT testing effects of adding MOTR to 10-session GPM	MOTR + GPM (n = 36) vs. GPM (n = 38)	Adult outpatients with BPD • M = 32.7 years old • 69% women • 76% not employed	• MOTR did not result in greater reduction of BPD sx, but did yield stronger therapeutic alliances	• Additional benefits of txs across groups: ↓ in distress and ↑ in adaptive emotions (Berthoud et al., 2017), ↑ capacity to distance oneself from one's own rigid and ineffective beliefs (Maillard et al., 2020), ↓ behavioral coping strategies (e.g. self-destructive behaviors) (Kramer et al., 2017), ↓ negative cognitive errors (Keller et al., 2018) • 6-month follow-up: Gains were sustained and did not differ between conditions,(Kramer et al., 2017), and ↑ in metacognitive capacities were associated with sx reduction (Maillard et al., 2020) • 12-month follow-up: MOTR + GPM pts were more likely to enter structured psychotherapy than GPM pts (Kramer et al., 2017) • Adherence to GPM (Kolla et al., 2009) explained 16% and 23% of the general sx and BPD sx improvement, respectively (Kolly et al., 2016) • SUD: ↑ reduction in BPD sx and ↑ growth in alliance were found in pts with BPD + SUD vs. BPD (Penzenstadler et al., 2018) • Alliance: Pt and therapist ratings of alliance were temporally congruent, but outcomes were not predicted by congruence (Kivity et al., 2020) • Interactions: ↑ activation of social interaction patterns predicted ↑ interpersonal outcomes but ↓ alliance in MOTR + GPM, but not GPM (Signer et al., 2020) • Pt factors: Pt agreeableness at baseline was associated with sx change in GPM but not MOTR + GPM (Zufrey, Caspar & Kramer, 2019)
*Kramer et al. (2018)	Pilot study utilizing fMRI and behavioral tasks	10-session GPM (N = 8)	Female outpatients with BPD • M = 23.1 years old	• Reductions in BPD sx at the trend level • Changes in arousal during behavioral task was linked to changes in BPD sx	• N/A
*Ridolfi et al. (2019)	RCT testing 6-session psycho-educational group (PEG)	PEG based on GPM + TAU (n = 48) vs. Waitlist + TAU (n = 48)	Adult outpatients with BPD • M = 34.5 years old • 55% women	• Significant improvements in affective, cognitive, impulsive, and interpersonal BPD symptoms	• 2 month follow-up: Positive effects of PEG were sustained

			• 42% not employed	• Improvement was ↑ in PEG vs. waitlist, except in impulsivity	
Training Effectiveness					
Keuroghlian et al. (2016)	1-day trainings on BPD treatment	GPM Training (n = 297) vs. Historical data from STEPPS Training (n = 271) (Shanks et al., 2011)	Spectrum of mental health clinicians • M = 17 years of experience • 75% women	• ↓ avoidance or dislike of BPD pts, belief that BPD's prognosis is hopeless • ↑ feelings of competence, of being able to make a positive difference (GPM > STEPPS), belief that psychotherapy can be effective	• N/A

Masland et al. (2018)	1-day training in GPM	GPM Training (n = 52)	Spectrum of mental health clinicians
			• M = 18 years of experience
			• 63.5% women
				• ↓ avoidance of BPD pts
				• ↑ felt competence to care for BPD pts, belief in medical model of BPD, belief that some psychotherapies are effective for BPD, interest in further training, confidence in diagnosing BPD, and willingness to disclose diagnosis to pts
					• 6-month follow-up: Most positive attitude change toward BPD pts was sustained, except the belief that some psychotherapies can be effective for BPD and the desire for more training. The following new effects emerged:
					  • ↓ dislike of BPD pts, belief that BPD prognosis is hopeless, felt difficulty empathizing with BPD pts, and discomfort in sessions with BPD pts compared to others
					  • ↑ felt ability to positively impact BPD pts, willingness to take on new patients with BPD

*Brief forms of GPM

BPD - borderline personality disorder; DBT - Dialectical Behavior Therapy, GPM - Good Psychiatric Management; MOTR - motive-oriented therapeutic relationship; pt - patient; STEPPS - Systems Training for Emotional Predictability and Problem Solving; SUD - substance use disorder; sx - symptoms; TAU - treatment as usual; TOM - theory of mind; tx - treatment; ↓ - decrease; ↑ - increase

Table 2. GPM's Basic Principles (Gunderson & Links, 2014)

Principle	Description
1 – Be active not reactive	A discussion on the BPD diagnosis generally helps the patient commit to treatment. GPM recommends that the diagnosis is openly shared and discussed with the patient. Its complex etiology (including genetic and environmental aspects), clinical course, and treatability are explained. Tailored psychoeducation is necessary for patients, as well as for their loved ones and relatives.
2 – Provide support	The patient may find it difficult to explore and face their core problems, but doing so is important and the patient is actively supported by the clinician in the session.
3 – Focus on life outside treatment	Life challenges are assessed in therapy. These difficulties are experienced by the patient as obstacles to having a meaningful life outside treatment, from which the patient can develop an identity and be connected to others. Therefore, it is recommended to focus on life outside of treatment.
4 – Therapeutic relationship is real and professional	The GPM clinician pays special attention to relational issues in the patient's life. Relational issues between patient and therapist are not GPM's primary focus and are only rarely addressed directly. Instead, the general links between relational events, internal feelings, and behaviors are understood using the interpersonal hypersensitivity model (Figure 1) (Kolly et al., 2016). The therapist provides both a professional relationship and a personal one marked by authenticity when needed.
5 – Change is expected	Change is expected in GPM. Symptomatic amelioration is expected when in treatment. A short-term treatment should already have some effects on certain aspects of BPD symptomatology, since we assume that change starts with session one.
6 – Promote responsibility	Psychoeducation and the clinician's attitude during the sessions promote responsibility. The patient should know that their active participation has an effect on their real-life difficulties and therapeutic outcomes.

BPD - borderline personality disorder; GPM - Good Psychiatric Management