A Clinical Application of GPM: A 10-Session Brief Psychiatric Intervention

Patrick Charbon, Ueli Kramer, Jessica Droz, Stéphane Kolly

General Psychiatry Service, Department of Psychiatry, University of Lausanne, Switzerland

Introduction

For many years, borderline personality disorder (BPD) has been considered a long-term debilitating disorder with little improvement expected from treatment. In the '90s, this changed when dialectical behavior therapy (DBT) showed evidence of therapeutic effects after a one-year period (Linehan et al., 1993). Other therapeutic modalities (transference-focused and mentalization-based treatments) have since shown evidence of efficacy as well (e.g., Clarkin et al, 2001, Bateman et Fonagy, 2001). Most of these studies have demonstrated effects using multiple intensive sessions per week over the course of one or more years, so they are quite intensive and demanding on both the clinician and the patient. The time frame of one year is more pragmatic because of research funding and feasibility. In fact, it is probable that certain types of progress should be expected within this relatively brief time frame, whereas other types of progress may necessitate a lengthier treatment (Choi-Kain et al., 2010; Shea et al., 2009; Zanarini et al., 2010). Symptoms related to impulsivity remit in a shorter time frame than affective temperamental symptoms (Zanarini et al., 2016).

A limitation of these evidence-based treatments is the fact that they require highly skilled and trained therapists, as much as highly motivated patients and therapists, making them difficult to implement and only accessible to select patients and therapists. Accessibility and generalizability are priorities of treatments using GPM principles (Gunderson, 2016).

Short-term treatments for BPD have been used across different contexts using several therapeutic models. A particularly well-studied population for brief treatments is adolescents (Chanen et al.,2007, 2008, 2013). This population is at higher risk of poor psychosocial functioning than patients with Axis I pathology (Chanen et al.,2007). Furthermore, for many BPD patients' heavy use of psychiatric resources (2 or more sessions per week) and medications may have already started by the time they reach their twenties (Zanarini et al, 2001). Early and time-limited interventions for sub-syndromal or full-blown BPD have demonstrated a reduction in psychopathology, including parasuicide, and improvement at a 24-month followup (Chanen and McCutcheon, 2013).

Brief treatments lasting between 1-3 months for adult BPD show a partial regression of symptoms across different domains (i.e. mood, emotion dysregulation, subjective stress, parasuicidality, maladaptive behaviour), but functional impairment and a low quality of life persist (Gratz et al., 2006). A brief version of the DBT skills group component over 20 weeks demonstrated sustained (i.e., over 32 weeks) reductions in anger and distress tolerance, and improvement in emotional regulation (McMain et al., 2017). A 3-week intensive suicidality-focused DBT treatment for suicidal patients had a significant effect on the reduction of hopelessness (McQuillan et al., 2005), thus showing that short time focused interventions may be helpful in reducing impulsivity-related symptoms, as well as in improving some aspects of the patient's relationships. This is not surprising, as impulsivity and relational difficulties can be diminished with detailed diagnostic disclosure and psychoeducation (Zanarini and Frankenburg, 2008).

A 10-Session Brief GPM Intervention: From Diagnosis to Psychotherapy

This chapter describes our experience of GPM brief interventions for BPD in a psychiatric outpatient university clinic in Lausanne, Switzerland.

Switzerland has a strong tradition of integrating psychiatry with psychotherapy. Since the ‘50s, the title of a psychiatrist is both “psychiatrist and psychotherapist” and requires a double training. This integrative tradition also applies to integration of different theories and approaches. Most institutional consultation centers offer a great variety of psychotherapeutic approaches (psychodynamic, cognitive, behavioral, family-systemic and humanistic). Our team is interdisciplinary and composed of nurses, social workers, medical residents and psychologists. Psychologists and medical doctors learn psychotherapy and psychiatry in our department. As a public outpatient clinic, it serves the general population. Our short-term GPM-based service is integrated in a non-BPD specialized general setting and our work has to be intelligible for other specialized partners in the institution.

GPM fits in perfectly with this context because it is transmittable and accessible to residents, nurses and social workers and thus is a useful tool to provide coherence to a multidisciplinary team (Kramer et al., 2017). In Switzerland it corresponds to the concept of Integrated Psychotherapeutic Psychiatric Treatment (IPPT), which is commonly used and accepted by insurances and medical administrations. IPPT includes pragmatic interventions, which draw inspiration from psychotherapy theories and psychiatric guidelines. As such, it clearly differentiates itself from formal psychotherapy. IPPT represents the frame, whereas GPM can be a specialized clinical content. As GPM is diagnostically oriented, it is easily accepted in a general psychiatric context, where it becomes a useful tool to foster both a psychosocial and a relational understanding.

Because of the high number of psychotherapists who do private practice in the region, the patients are referred because they require a specialized treatment or an interdisciplinary or crisis intervention. Given this context, the consulting patients tend to suffer from a mix of psychiatric problems and social impairments. Most of them are referred to the outpatient clinic by a first-line service (emergency service, psychiatric first line facilities, hospital, other

specialized services, etc.). We treat patients between 18 and 65 years old. Some patients with BPD that come to our clinic have been previously informed about a personality disorder diagnosis (or a suspicion thereof) usually without much explanation about the diagnostic itself or its impact on their life.

Over the past years, by trying to respond to an increasing demand in the community for appropriate treatment, we have started offering a brief intervention for all outpatients as part of a stepped care approach. Generally speaking, brief interventions may represent a useful public health intervention by giving access to more available time limited treatments. They give the opportunity for more patients to be treated in a "good enough" initial treatment. This seems to have specific advantages regarding BPD patients.

More specifically, for BPD patients, a time-limited therapeutic proposition has the advantage of focusing on treatment goals and avoiding treatments that go on-and-on without a clear frame. This prevents the scattering of therapeutic efforts and unrealistic expectations like the therapist being constantly available, which can then become responsible for the lack of change. Instead, time-limited interventions imply an anticipated separation and thus activates abandonment anxiety and rejection sensitivity that will be manifest during the 10 sessions, and which can then be addressed and discussed within the framework of interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008).

A structured 10-Session Intervention helps BPD patients to move from a state of chaotic painful feelings, often caused by perceived rejection from caretakers, to a state where more comprehension of their problems is possible. They can then formulate a more coherent therapeutic plan, which generally is associated with a greater motivation to change. Our 10-Session Intervention also helps to establish a BPD diagnosis in situations where many clinicians avoid it because they believe it is premature to disclose a BPD diagnosis during a

relational crisis. Moreover, Axis I diagnoses are often mistakenly thought to be the main diagnosis. This includes patients whose Axis I symptoms are seen as resistant to treatment. Failure to give the diagnosis of BPD is often the result of insufficient information or fear of stigma (Sisti et al., 2016).

What Is the 10-Session Intervention?

The 10-Session Intervention is a GPM-inspired, time-limited, personality disorder-oriented intervention that can be used either as a specialized assessment or a brief therapy. Its goal is to actively involve the patient in understanding the diagnostic process, to progressively introduce psychoeducation, and to promote mentalisation. In that way the diagnostic process shifts from the imposition of a medical "expert" point of view to the proposal of an active collaboration and thinking about each patient's actual problems and needs.

Structured tools (SCID-II) are used to foster the patient's awareness and active collaboration. Comorbidities are discussed, first as they may require specific treatment, and secondly because they may represent a future threat to the treatment. Psychoeducation and the patient's integration of the links between symptoms and his life problems help to motivate and structure the request for a future treatment. Developing an interpersonal alliance, containing abandonment anxiety, exploring problems, and psychoeducation can be done without being excessively supportive. On the contrary, perception of problems may foster the process of collaboration and the crucial therapeutic alliance.

Referring to interpersonal hypersensitivity (Gunderson & Lyons-Ruth, 2008), one can predict that a brief intervention, by the fact that it is explicitly time limited, will evoke feelings of abandonment and/or rejection and, in turn, may eventually activate pathological attachment

processes, manifested as excessive calls, suicidal threats, and the like. As these behaviors appear and get activated, we think, they become accessible to early change if the therapist constructively addresses them. Our experience showed us that this intervention is per se a short-term specialized treatment and should be developed in that direction. We differentiate between two different types 10-Session Interventions with distinct clinical consequences: The 10-Session Assessment and the 10-Session Therapy. Both involve once weekly sessions. The first is the most commonly used, while the second type is a more recent development.

The 10-Session Assessment

The 10-Session Assessment is a time-limited global evaluation for BPD patients with impeded social functioning or longer-evolving symptoms. It aims at establishing a well-informed treatment plan, integrating diagnostics in a therapeutically-oriented hierarchy and establishing a therapeutic frame that takes into account comorbid diagnoses, relational contexts and existing therapeutic networks. It fosters a better comprehension of the role of BPD pathology in resistance to well-administered treatments of comorbid pathology and more generally to factors adverse to therapeutic progress.

It is indicated for patients with a heavy or complex BPD pathology with comorbidities, frequently misdiagnosed as an Axis I disorder, thus preventing an expected good evolution in comorbid pathology. It then aims at preventing inadequate or excessive use of highly specialized treatments and promotes selective use of long-term resources. It is useful at preventing negligence of comorbidity that can threaten a psychotherapeutic treatment. It is also aimed at giving a precise indication of treatment needs and goals.

The 10-Session Assessment helps orientation to an adapted treatment, according to the stepped care model (Appendix B; Choi-Kain et al., 2016), favoring adequate use of limited therapeutic resources. It is easy to implement in a medically oriented psychiatric institution and

can be understood as a pre-treatment that can prepare the patient for longer-term treatment, when indicated.

Vignette 1: “Colleen” – 10-Session Assessment

Colleen is a 30 year old patient who was discharged from her first inpatient treatment a week prior to her outpatient consultation with her current therapist. She was never diagnosed with a psychiatric disorder before, but presented with several years of consumption of marijuana. She had split up with her boyfriend six months before the consultation and said that she had just gone through a “rough” year. She was admitted to the hospital because of suicidal threats in the context of intense arguments with her ex-boyfriend. When she smoked marijuana, she reported increased well-being and release of internal tensions, but also reduction of sleep, increased mental and body activity, along with increased impulsivity and irritability in the interpersonal context (mostly with her boyfriend). Based on this clinical presentation, Colleen received the diagnosis of bipolar affective disorder, which the patient initially rejected, but then accepted in a quite convinced, almost rigid, manner.

Colleen came to the first interview and declared that she had “Bipolar Disorder” and was told she needed to see a psychiatrist for the monitoring of her Lamotrigine treatment. She declared that she was not interested in “spending too much time talking about her life”. To this, the therapist expressed some astonishment and invited her to elaborate a bit on her life, Colleen started to cry. She mentioned being at the end of her rope and now being psychiatrically ill to top it all, everything seemed lost. She had lost her job and her boyfriend in the context of the interpersonal crisis that had led her to the inpatient treatment. She said: “I am 30 and I feel that I have no future. Who will want to be together with me, as a partner? With someone who suffers from Bipolar and will have to take a medication all her life? My girlfriends all have stable

relationships and somehow it did not work out for me. Frankly, I still think about killing myself."

A 10-Session Assessment was offered to Coleen at the end of the initial session. The therapist made the following suggestion.

Clinician: *I can see that your suffering is immense. There are still areas we have not completely understood. How is it that you were able to function quite well over the years in a quite stable relationship and then, when this relationship is over, you stumble and get diagnosed with "Bipolar Disorder"? I want both of us to keep searching for the best explanation of your psychological difficulties and I am not sure for now what the best "diagnosis" is. We will use these 10 sessions to clarify this. Is that OK for you?*

The process of assessment was informed by GPM principles and involved a specific focus on the differential diagnosis between bipolar disorder and BPD. Two sessions (out of 10) were dedicated to clarify the symptoms and psychiatric anamnesis to find out that the so-called "manic" symptoms were induced by heavy marijuana consumption, which had increased as a consequence of feeling rejected by her ex-boyfriend. In subsequent sessions, it emerged that Colleen in reality presented with the clinical features of BPD, with intense fear of abandonment, identity problems, marked impulsivity patterns, suicidal threats, and several affective symptoms. This was discussed as part of the final session of the brief intervention, while at the same time acknowledging the work of the inpatient team who seemed to have misdiagnosed the patient's condition. This represented a particularly challenging clinical dilemma.

The therapist said in the final session:

Clinician: *You know, a diagnosis helps us to bring together and understand all the problems you describe. Based on your descriptions, we can say that the acceleration of your thoughts and behaviors were induced by your marijuana consumption. You smoked much more during these past months, because you had an internal feeling of not existing anymore, of having no future and of being left alone by your boyfriend, and by everybody else including your parents and your girlfriends. Is this correct?*

Colleen: *Yes, absolutely*

Clinician: *So it is unclear whether the diagnosis of bipolar you were given is accurate.*

Colleen: *So are you saying that I am not bipolar? I can't believe it. Everybody tells me I'm bipolar. And that I need to take that medication all my life now.*

Clinician: *Yes, I understand that my colleagues at hospital made the hypothesis that you may suffer from bipolar disorder. But remember, we took several sessions here to really find out what the core problems are and they turned out to be inconsistent with bipolar disorder.*

Colleen: *I am completely confused* (cries) *I am lost now.*

Clinician: *Yes, this seems a bit confusing and I understand that you want to know what you suffer from. (Here the therapist went over all her borderline symptoms again in detail and concludes). So based on all of this, BPD would actually better summarize these problems. Have you already heard of this?"*

Colleen: *No, I am not sure.*

Clinician: *Well, it is a condition that may explain the problems you present, in particular why you are so sensitive to interpersonal rejection. It may also explain why it is so important for you to know what diagnosis you have, so you feel more confident about whom you are really.*

Collen: *Yes*

Clinician: *And this condition is treatable. I want us now to think about what this may mean for your treatment from today on. The central treatment for overcoming problems related with BPD is psychotherapy, not medication. I will refer you to a colleague who offers specialized treatments for BPD and he, with you, will decide what themes you have to work on to get better and whether or not the Lamotrigine is still the appropriate medication. For now, I'd suggest you continue Lamotrigine until you talk about it with him.*

Colleen: *You know what, I have talked to all these people, psychiatrists and nurses, at the hospital, everybody was trying to convince me that I am bipolar, but deep inside, I knew this is not me. Then I come to see you. You understand me and give me hope. I know that I can trust you now and that I can always come back to you if I have questions. Thank you so much.*

Clinician: *You are very welcome.*

In conclusion, Colleen left the session relieved and started a structured psychotherapy two months later. Based on the reports of her new therapist, we know that Colleen worked very hard in her psychotherapy, was committed to change and, per medical decision, stopped taking Lamotrigine medication no later than 3 weeks later. She found a new job and worked through

her abandonment issues and was able to reclaim her life. No further inpatient treatment was necessary.

PLACE TABLE 1 ABOUT HERE

The 10-Session Therapy

The 10-Session Therapy is a time-limited intervention for BPD patients with moderate, mild or subsyndromal symptoms and relatively good social functioning. It can be used as a brief structured intervention during a crisis when short-term intervention could be expected to prevent a symptomatic exacerbation.

There is an explicit agreement between patient and therapist that the therapy will stop after 10 sessions. The goal of a 10-Session Therapy should be to help patients to better manage interpersonal relations, avoid social isolation and its consequences, and promote a better relational life with the help of psychoeducation focused on interpersonal hypersensitivity. Adequate early short-term therapy may help reduce further relationship-induced problems and avoid use of harmful interventions (e.g., unnecessary medications). It is important to notice that symptoms most susceptible of being responsive to a short-term treatment are those frequently associated with the "bad reputation" of BPD patients, such as self-harm and suicidality.

In this setting, the predictable and imposed end-of-treatment separation is, according to interpersonal hypersensitivity theory, likely to induce abandonment and rejection feelings, revealing emptiness and aloneness experiences. Maladaptive behaviors aimed at restoring attachment are likely to be manifest. This will require constant evaluation to determine if they should be directly addressed to maintain the therapeutic movement, as they could cause a premature end of therapeutic work and thus represent an actual threat to the treatment. Working through these potential relational crisis can help borderline patients link their symptoms to

interpersonal stressors – confirming what they have learned through psychoeducation based on interpersonal hypersensitivity. This can help foster better affective and cognitive integration.

Comorbidities will be explored in a way to help the patient to have a healthier life and seek specialized help if needed. Psychoeducation will be given in a way that can be integrated by the patient and used later.

Exploration and psychoeducation about comorbidities are supportive aspects of the 10-Session GPM Therapy.

Vignette 2: "Paul" – 10-Session Therapy

Paul is a 22-year-old engineering student. He moved out from his parents home two years ago to go to college. His studies are going well and his goal is to later work with his father in his engineering consulting company. He was in a romantic relationship for a year with a young student he met at a party, but when he had a discussion with her about sharing a flat, he had the feeling she started to progressively distance herself from him. He then expressed suicidal ideas and was so angry with her that he insulted her in front her friends. Two days later he apologized but she said she never wanted to see him again.

After that, Paul drank heavily for a few days and realized one morning that he had driven home drunk after a party. Before that, Paul had taken alcohol and cannabis only occasionally. He took some ecstasy one evening but did not want to take any after that. Afraid of his behavior, he made an appointment for psychiatric consultation at a student health clinic.

Paul explained that his girlfriend did not show any signs of joy when he suggested that they could share a flat. He felt rejected when she answered the phone in front of him, while he was expecting her to show feeling towards him. He immediately felt angry towards the friend who was calling her on the phone, feeling that she was more important to his girlfriend than he was.

Paul felt depressed but did not want any medication. He stayed with his parents for a week in a nearby city and rapidly got better. When he came back, he decided to stop meeting the psychologist, arguing that it would divert his attention and energy from his studies and that he wished to prepare his exams. Later on, he passed his exams and had another romantic relationship, though he felt that he did not invest this relationship as much as the previous one. He had been at a concert with a friend and saw his ex-girl friend kissing another student. The next night, he texted her hateful and impolite messages, and wrote a letter where he accused her of being an evil person. He came back to consultation 10 months later and was admitted to our specialized unit. Paul said that he needed help, but was afraid of being put on medication and did not want to be become a psychiatric patient. Nevertheless, he wished he could speak to someone, because when he talks about his problems to friends, and particularly about sad feelings and occasional suicidal thoughts, he feels like they distance themselves from him.

Paul: *When you say that my problem may be borderline personality disorder, I'm afraid. I think BPD is a chronic disease, in the movies it is always the bad guy who has borderline.*

Clinician: *It may be useful for you to have some information about the way BPD is understood today. First, BPD is a disorder that naturally evolves rather well. People with BPD very often have much less symptoms with time. They usually get better when they understand the interpersonal sources of their symptoms. Some people with BPD then organize their life such that they have less relational solicitation and avoid interpersonal stress, that is not such a good outcome.*

Paul: *You know, when I go out with friends, I very often come home earlier, because I know that if I stay longer with them, I may become sad, angry, all sorts of things that I don't want to show my friends, and which may provoke some interpersonal crisis. I want to become more comfortable and better able to enjoy staying with my friends.*

Clinician: *You said before that you did not want to become a psychiatric patient, and I think this is very legitimate. But on the other hand, having a little help can make your life easier. Helping you with your problems does not necessarily require a long-term treatment.*

Paul then proposed a 10-Session Therapy. At the second session, the therapist took a brief personal history.

Clinician *We have now quickly gone through your personal history, but I realize I do not know much about your affective life.*

Paul: *I am not comfortable about speaking of my affective and love life. I am not happy about it. When I feel something for a girl, it is so strong that I cannot speak about it to friends and I keep it to myself. Every time I want to share my feelings with a girl, the same thing happens. As soon as she understands I have a crush, she pushes me away and avoids seeing me. I believe that I am uninteresting and that no girl will ever be interested in me.*

Clinician: *I would like to understand better how it feels to be in this situation when you try to share your strong feelings and feel rejected. [*Paul becomes tense, sweats and seems uncomfortable.]

Paul: *In fact I feel very angry when that happens to me.*

(Pause)

You are going to think that I am crazy, or that I am a bad person. Probably you think, "Oh that guy is a nasty person with girls"... What are you thinking of me?

Clinician: *I think I may understand what you are talking about, that you can have very strong feelings, sometimes so strong that you don't really know what to do with them, and that when you share these feelings you feel rejected, so much that you become furious with the person whom you feel rejected by. And I am wondering if what you are speaking about is not happening right now between you and me, that you feel rejected by me, because you think I could have bad ideas about you.*

Paul: *This is what is happening now, I think you see me as a bad person.*

Clinician: *That strongly reminds me of something we understand about painful relations borderline persons can experience. It is called interpersonal hypersensitivity, and I think it could help you understand how these feelings happen in your life, as its has happened right now between you and me.*

PLACE TABLE 2 ABOUT HERE

Suggested Interventions Within the 10-Session Therapy

Some specific interventions are offered in this section. Clinicians should not expect to comply word-by-word with these formulations, but they may be helpful for some therapists as guides.

How do we present the 10-Session Intervention to other professionals? The 10-Session Intervention is a specialized asssment / therapy that is aimed at documenting and informing the patient about his personality disorder and its consequences, as well as assessing eventual co-

morbidity. It is also aimed at helping the patient have enough time during the intervention to understand and link the diagnosis of personality disorder with its life consequences. A 10-Session Intervention is time limited. It can be the only intervention, or lead to specialized treatment in our unit or in private practice.

How do we present the 10-Session Intervention to patients ? This intervention is not a usual medical process where patients are passive and receive the diagnosis as a result of the doctor's work. Here you yourself will be the investigator, and we will help you with that work through some structured and some less structured procedures. It is aimed at exploring your personality functioning, and the influence it may have on your life, the way you think, your behavior and your relationships.

Content of the 10-Session Intervention: Session by Session

The 10-Session Intervention is a once a week multimodal approach with a Primary Clinician (MDs and psychologists). It contains some structured content (MINI, SCID-II), some partly structured content (psychoeducation) and some less structured content (first session, exploration of relational conflicts).

First session. The aim of the first session is to meet the patient and explore his difficulties. It is constructed around supportive and open-ended questions. The clinician actively investigates problems, with a focus on patterns of relational problems (private life, work, previous treatments). Repetitive ruptures may be the sign of a major threat to the pursuit of sessions, and should be addressed. At the end of this session, a first rendition of the clinician's formulation of the patient's problems is offered, and the frame of the 10-Session

Intervention and its content is set. If the proposition is a 10-Session Therapy, the number of sessions will be announced as being exactly 10.

Further sessions. Further sessions follow GPM guidelines and are mostly centered on real life, relational crises, treatment breakdowns and major changes in interests and goals. We use the interpersonal hypersensitivity as a frame for investigation, and later on, for restitution and psychoeducation. Comorbidities and medical problems are rigorously investigated; a structured psychiatric interview (MINI) may be used. It is important to investigate particularly subjects some patients try to put aside, such as addictions, relational or economic problems, and important not to share the patient's denial of theses aspects. When useful, other professionals can participate in the investigation. We extensively use specialized resources (social worker, psychiatric nurses), including resources outside the unit (addressing addiction, attention hyperactivity deficit disorder, trauma, migration, and so forth). Families and relatives are frequently invited as a part of the process. Diagnostic disclosure and discussion are mandatory, integrated with discussion about the relationship between their personality disorder and comorbidities and their effects on life. We discuss it with the patient and sometimes the relatives (as for a young patient living with his parents or dependent on them). The goal is not only to deliver a medical diagnosis, but also build an individualized working hypothesis that integrates in a meaningful way BPD diagnostic, co-morbidities and problems in real life. This formulation must most of all make sense for the patient.

Focus on real life – We are interested in outside daily life, as it will provide a lot of information on social functioning (work, disability, schema use, autonomy) and interpersonal issues (conflicts, relational stressors and resources). A review of the financial difficulties with a social worker helps us understand real life problems and eventually provide specialized support.

Psychoeducation – Psychoeducation is used as a productive way to help the patient understand and reduce symptoms. It can be used in a supportive way, as something the patient can learn in a short time and be useful for real life. It gives sense to apparent clinical manifestation by throwing light on interpersonal and attachment conflicts. It helps establish hope that recovery is possible, even likely.

PLACE TABLE 3 ABOUT HERE

Psychoeducation may also include explorations which show the importance of negative affects on real life, show how "symptoms" can be used to justify a passive life, or how externalizing problems or responsibilities on others is self-defeating. It helps prevent excessive hope on "passive" pharmacological treatment and helps to actively engage the patient in treatment.

Change is expected – Some amelioration is expected quite early during intervention. We observe whether early psychoeducation is (or not) used by the patient to promote some change, revealing either motivation or resistance that should then be addressed. It is difficult to evaluate motivation for change in a few sessions and this is a point where 10 sessions may be a period just long enough to evaluate whether a patient makes use of psychoeducation, and what his potential is for active engagement in a future treatment.

We clinically observe, in addition to the later reported research, that the most predictable changes in a 10-Session GPM Intervention are an amelioration of self-harm behaviors, a better recognition of interpersonal factors in symptoms, an amelioration of subjective distress, and improved attitude towards treatment interventions.

Formulation of an Integrated Diagnostic and Working Hypothesis

In the 10-Session Assessment, the goal of the formulation of a hypothesis is to give meaning to a further treatment (or give meaning to end of a treatment). We observe that some patients decide to go on with a treatment, inside or outside our institution, and some do not wish more.

In the 10-Session Intervention, the goal is to give the patient a meaningful understanding of his problems, especially of relational problems, in a way he can identify with and use later on with the goal of having a better life. More useful than the diagnosis itself is a working hypothesis, which combines BPD specific contents (such as elements of interpersonal hypersensitivity), its relationship to comorbidities and to current problems, and the recognition of relational triggers in current crises and conflicts. This understanding is both cognitive (through psychoeducation) and emotive (through active exploration of relational problems in personal history or during the intervention).

Last session. The last session of the process consists of a review of the assessment as made by the clinician as well as what the patient had gained in knowledge about himself, with the patient and sometimes his relatives. We take a joint decision to continue or end of intervention. At that point, goals and tools of the further treatment are discussed in detail.

PLACE TABLE 4 ABOUT HERE

Empirical Evidence

A series of studies empirically investigated the question whether a brief version of GPM relieves the initial symptoms as much as a longer-term treatment for BPD. It was observed that the rate of change was greatest during the first four months of treatment (e.g., McMain et al., 2009). In terms of pre-post changes on self-reported general symptoms (i.e., distress, interpersonal and social role domains), borderline symptoms and interpersonal problems, we

observed a medium pre-post effect for the brief 10-Session GPM in two distinct samples (total *N* = 99; Kramer, Berger et al., 2011; Kramer, Kolly et al., 2014). In a randomized controlled trial, we wanted to study whether the add-on component of an individualized case formulation consistent with the Plan Analysis method produced additional pre-post symptom decrease. The main analysis showed that this was the case only for general symptoms, but not for the specific borderline symptoms (and only marginally for interpersonal problems). This result indicated that brief GPM is "good enough" for reducing initial borderline symptoms, but may be improved on the more general levels of change in patient's distress. Interestingly, these differences did not hold up to the analysis at 6 months follow-up, where the general symptom level improved on average to a similar extent in both conditions (Kramer et al., 2017). As such, the pattern of change found in other studies (i.e., McMain et al., 2009) was shown here: strong initial symptom decrease followed by a plateaued evolution over time. It is noteworthy that we found a marginal prediction between the treatment density and symptom decrease after 6 months of follow-up: the fewer sessions per week, the better the outcome. This surprising result may speak to a flexible approach in handling missing sessions in the very beginning of treatment for patients with BPD. Our in-depth process analyses yielded pre-post process ameliorations on the levels of emotional processing (Berthoud et al., 2017), coping effectiveness (Kramer, Keller al., 2017) and in biased thinking (Keller et al., 2018), with some specific advantages in the prediction of outcome for the enhanced intervention component. Finally, we analyzed the therapist adherence to GPM principles, using the GPMAS, and demonstrated high adherence; the level of adherence was linked with the symptom change at the end of brief GPM (Kolly et al., 2016), suggesting that the overall use of GPM stance may be a potential candidate for an effective intervention ingredient.

Conclusion

The 10-session GPM-based intervention can be conveniently integrated in a psychiatric outpatient organization. It is helpful to introduce psychotherapy along with psychiatric procedures. It helps organize care by providing coordination between different professions of different theoretical background. It aims at being cost-effective through offering a good enough treatment for most patients, and avoiding excessive use of highly specialized treatments (and thus augmenting accessibility to patients who need them). It has a strong educational value and helps highly specialized clinicians to work and transmit their experience to patients and trainees in a limited time.

Bibliography:

Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. Am J Psychiatry, 158(1), 36-42. doi:10.1176/appi.ajp.158.1.36

Bender, D. S., Dolan, R. T., Skodol, A. E., Sanislow, C. A., Dyck, I. R., McGlashan, T. H., . . . Gunderson, J. G. (2001). Treatment utilization by patients with personality disorders. Am J Psychiatry, 158(2), 295-302. doi:10.1176/appi.ajp.158.2.295

Berthoud, L. et al. 2017 Berthoud, L., Pascual-Leone, A., Caspar, F., Tissot, H., Keller, S., Rohde, K. B., de Roten, Y., Despland, J.-N., & Kramer, U. (2017). Leaving distress behind: a randomized controlled study on change in emotional processing in borderline personality disorder. *Psychiatry: Interpersonal and Biological Processes*, *80*, 139-154. doi: 10.1080/00332747.2016.1220230

Chanen, A. M., Jackson, H. J., McCutcheon, L. K., Jovev, M., Dudgeon, P., Yuen, H. P., . . . McGorry, P. D. (2008). Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial. Br J Psychiatry, 193(6), 477-484. doi:10.1192/bjp.bp.107.048934

Chanen, A. M., Jovev, M., & Jackson, H. J. (2007). Adaptive functioning and psychiatric symptoms in adolescents with borderline personality disorder. J Clin Psychiatry, 68(2), 297-306.

Chanen, A. M., & McCutcheon, L. (2013). Prevention and early intervention for borderline personality disorder: current status and recent evidence. Br J Psychiatry Suppl, 54, s24-29. doi:10.1192/bjp.bp.112.119180

Chanen, A. M., McCutcheon, L. K., Jovev, M., Jackson, H. J., & McGorry, P. D. (2007). Prevention and early intervention for borderline personality disorder. Med J Aust, 187(7 Suppl), S18-21.

Choi-Kain, L. W., Albert, E. B., & Gunderson, J. G. (2016). Evidence-Based Treatments for Borderline Personality Disorder: Implementation, Integration, and Stepped Care. Harv Rev Psychiatry, 24(5), 342-356. doi:10.1097/HRP.0000000000000113

Choi-Kain, L. W., Zanarini, M. C., Frankenburg, F. R., Fitzmaurice, G. M., & Reich, D. B. (2010). A longitudinal study of the 10-year course of interpersonal features in borderline personality disorder. J Pers Disord, 24(3), 365-376. doi:10.1521/pedi.2010.24.3.365

Clarkin, J. F., Foelsch, P. A., Levy, K. N., Hull, J. W., Delaney, J. C., & Kernberg, O. F. (2001). The development of a psychodynamic treatment for patients with borderline personality disorder: a preliminary study of behavioral change. J Pers Disord, 15(6), 487-495.

Gratz, K. L., Lacroce, D. M., & Gunderson, J. G. (2006). Measuring changes in symptoms relevant to borderline personality disorder following short-term treatment across partial hospital and intensive outpatient levels of care. J Psychiatr Pract, 12(3), 153-159.

Gunderson, J. G., & Lyons-Ruth, K. (2008). BPD's interpersonal hypersensitivity phenotype: a gene-environment-developmental model. J Pers Disord, 22(1), 22-41. doi:10.1521/pedi.2008.22.1.22

Gunderon, J. G. (2016). The Emergence of a Generalist Model to Meet Public Health Needs for Patients With Borderline Personality Disorder. Am J Psychiatry, 173(5), 452 - 458.

Keller, S., Stelmaszczyk, K., Kolly, S., de Roten, Y., Despland, J.-N., Caspar, F., Drapeau, M., & Kramer, U. (in press). Change in biased thinking in a treatment based on the motive-oriented therapeutic relationship for borderline personality disorder. *Journal of Personality Disorders Special Section Mechanisms of Change in Treatments of Personality Disorders.*

Kolly, S., Despland, J.-N., de Roten, Y., Marquet, P., & Kramer, U. (2016). Therapist adherence to good psychiatric practice in a short-term treatment for borderline personality disorder. *Journal of Nervous and Mental Disease*, *204*(7), 489-493. Doi: 10.1097/NMD.481.

Kramer, U., Berger, T., Kolly, S., Marquet, P., Preisig, M., de Roten, Y., Despland, J.-N., & Caspar, F. (2011). Effects of motive-oriented therapeutic relationship in early-phase treatment of borderline personality disorder: A pilot study of a randomized trial. *Journal of Nervous and Mental Disease, 199*(4), 244-250.

Kramer, U., Charbon, P., Despland, J.-N., & Kolly, S. (in press). "Good enough" training in clinical practice for BPD? A commentary. *Swiss Archives of Neurology, Psychiatry and Psychotherapy, 168*(8).

Kramer, U., Keller, S., Caspar, F., de Roten, Y., Despland, J.-N., & Kolly, S. (2017). Early change in coping strategies in responsive treatments for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 85*(5), 530-535. Doi: 10.1037/ccp0000196.

Kramer, U., Kolly, S., Berthoud, L., Keller, S., Preisig, M., Caspar, F., . . . Despland, J. N. (2014). Effects of motive-oriented therapeutic relationship in a ten-session general psychiatric treatment of borderline personality disorder: a randomized controlled trial. Psychother Psychosom, 83(3), 176-186. doi:10.1159/000358528

Kramer, U., Stulz, N., Berthoud, L., Caspar, F., Marquet, P., Kolly, S., de Roten, Y., & Despland, J.-N. (2017). The shorter the better? A follow-up analysis of 10-session psychiatric treatment including the motive-oriented therapeutic relationship for borderline personality disorder. *Psychotherapy Research, 27*(3), 362-370. doi: 10.1080/10503307.2015.1110635

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Arch Gen Psychiatry, 48(12), 1060-1064.

Linehan, M. M., Heard, H. L., & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. Arch Gen Psychiatry, 50(12), 971-974.

McMain, S. F., Guimond, T., Barnhart, R., Habinski, L., & Streiner, D. L. (2017). A randomized trial of brief dialectical behaviour therapy skills training in suicidal patients suffering from borderline disorder. Acta Psychiatr Scand, 135(2), 138-148. doi:10.1111/acps.12664

McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., & Streiner, D. L. (2009). A randomized trial of dialectical behaviour therapy versus general psychiatric management for borderline personality disorder. Am J Psychiatry, 166(12), 1365-1374. doi:10.1176/appi.ajp.2009.09010039

McQuillan, A., Nicastro, R., Guenot, F., Girard, M., Lissner, C., & Ferrero, F. (2005). Intensive dialectical behaviour therapy for outpatients with borderline personality disorder who are in crisis. Psychiatr Serv, 56(2), 193-197. doi:10.1176/appi.ps.56.2.193

Sisti, D., Segal, A. G., Siegel, A. M., Johnson, R., & Gunderson, J. (2015). Diagnosing, Disclosing, and Documenting Borderline Personality Disorder: A Survey of Psychiatrists' Practices. J Pers Disord, 1-9. doi:10.1521/pedi_2015_29_228

Skodol, A. E., Gunderson, J. G., McGlashan, T. H., Dyck, I. R., Stout, R. L., Bender, D. S., . . . Oldham, J. M. (2002). Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. Am J Psychiatry, 159(2), 276-283. doi:10.1176/appi.ajp.159.2.276

Tracie Shea, M., Edelen, M. O., Pinto, A., Yen, S., Gunderson, J. G., Skodol, A. E., . . . Morey, L. C. (2009). Improvement in borderline personality disorder in relationship to age. Acta Psychiatr Scand, 119(2), 143-148. doi:10.1111/j.1600-0447.2008.01274.x

Zanarini, M. C., & Frankenburg, F. R. (2008). A preliminary, randomized trial of psychoeducation for women with borderline personality disorder. J Pers Disord, 22(3), 284-290. doi:10.1521/pedi.2008.22.3.284

Zanarini, M. C., Frankenburg, F. R., Khera, G. S., & Bleichmar, J. (2001). Treatment histories of borderline inpatients. Compr Psychiatry, 42(2), 144-150. doi:10.1053/comp.2001.19749

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2010). The 10-year course of psychosocial functioning among patients with borderline personality disorder and axis II comparison subjects. Acta Psychiatr Scand, 122(2), 103-109. doi:10.1111/j.1600-0447.2010.01543.x

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. M. (2016). Fluidity of the Subsyndromal Phenomenology of Borderline Personality Disorder Over 16 Years of Prospective Follow-Up. Am J Psychiatry, 173(7), 688-694. doi:10.1176/appi.ajp.2015.15081045

Zimmermann, M., & Mattia, J., I. (1999). Differences Between Clinical and Research Practices in Diagnosing borderline personality disorder. Am J Psychiatry, 156, 1570-1574.

Table 1. Goals of 10-Session Assessment.

Goals of 10-Session Assessment
1 - Diagnostic Identify personality disorders (including when patients have only Axis I treatment without sufficient amelioration) and comorbid pathology, with the use of reality focused multimodal assesment
2 - Psychopathological working hypothesis Produce an articulated frame of work for future treatment, integrating and hierarchizing primary, secondary and comorbid problems (e.g., depression or PTSD).
3 - Personalized treatment indication (Stepped Care) Offer a coherent treatment, integrating diagnosis, motivation, potential obstacles to treatment.
4 - Therapeutic alliance Promote the patient's motivation for change and valuation of treatment

Table 2. Goals of 10-Session Therapy

Goals of 10-Session Therapy
1 - Diagnostic
Comprehension of the problem in medical terms, explanation of false beliefs about BPD
2 - Meaningful psychiatric diagnosis
Links between BPD diagnostic as a medical construct and the patient's real life's problems
3 - Cognitive and affective integration of the diagnosis
Affective and Cognitive integration of interpersonal hypersensitivity's importance in their interpersonal life, outside and inside the therapy
4 - Importance of adequate goals outside therapy (Work and Love)
Comprehension and integration of GPM principles in real life

Table 3. Psychoeducation

Psychoeducation content:
1 - Nature and natural course of BPD
2 - Interpersonal hypersensitivity and its consequences in real life
3 - Importance of change in real life
Have a life, "Work and Love"
4 - What helps and what does not (information on treatments, non-professional help, and useful behaviors to prevent crisis)

5 - Expectations about therapy and about medication

Table 4. Two versions of 10-Session GPM: Assessment and Therapy

	10-Session Assessment	10-Session Therapy
Indications	Patients with acute or long-term symptoms, comorbidities and maladaptive behaviors leading to social functioning impairment	Patients with acute symptoms or crisis symptoms who have enough psychological motivation and don't want to engage in a long psychiatric treatment.
Goals	Propose an adequate treatment as needed	Not become a chronic psychiatric patient
Abandonment fears and rejection sensitivity	Are mostly documented while exploring the disorder's history and actual real life relations	Mostly manifest towards the therapy frame and primary clinician
Work on interpersonal relationships	Exploring relationships in the assessment may be helpful to prevent drop-out. Exploration of real life, work, relations, previous treatments gives examples for	Exploring relationships in the therapy may be helpful to prevent drop-out. Exploring relationships in therapy gives examples for

	psychoeducation about interpersonal hypersensitivity	psychoeducation about interpersonal hypersensitivity
Use of psychoeducation	Foster engagement in future treatment and alliance	Provides a canvas for future self-help or to improve use of care