Good Psychiatric Management of Borderline Personality Disorder

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Victoria Division of Family Practice Psychiatry Roundtable

Dr. Karen Palmer

Disclosure

- I have nothing to disclose

Learning Objectives

- Recognize and diagnose Borderline Personality Disorder (BPD)
- Learn how to prioritize BPD and comorbid conditions in developing a treatment plan
- Discuss the model of interpersonal hypersensitivity and the importance of understanding the centrality of relationships in treating BPD
- Discuss the basic principles of Good Psychiatric Management (GPM), as outlined by Dr. John Gunderson

Epidemiology

- General Population:
  - BPD affects 1-3% of the general population
  - Lifetime incidence is 5.9%
  - Socioeconomic status has a greater effect on prevalence than race or gender

Epidemiology continued

- Clinical Settings:
  - 6% of primary care office visits
  - 8-18% of outpatient mental health services
  - 20-25% of inpatient mental health services
  - 56% of emergency room visits

Comorbidity

- BPD is highly comorbid:
  - Any mood disorder – 96%
  - MDD – 71-83%
  - Any anxiety disorder – 88%
  - Panic Disorder – 34-56%
  - PTSD– 47-56%
  - Substance Use disorder - 50-65%
  - Eating Disorder - 7-26%

How do you prioritize treatment?

- **Prioritize BPD** in the context of Depression, Generalized Anxiety Disorder, Social Phobia, Narcissistic Personality Disorder
- **Prioritize the comorbid disorder** in the context of Bipolar Disorder, Eating Disorder and significant substance use

- Prioritizing BPD diagnosis early improves treatment outcomes and reduces health care costs.

BPD Diagnosis

1. Frantic efforts to avoid real or perceived abandonment
2. Unstable interpersonal relationships
3. Identity disturbance
4. Impulsivity
5. Recurrent suicidal behavior, gestures or threats or self-injurious behavior
6. Affective instability
7. Chronic feelings of emptiness or boredom
8. Intense, inappropriate anger
9. Transient stress-related paranoid ideation or severe dissociative symptoms

Treatment of BPD

- There are several empirically validated treatments for BPD, including Dialectical Behavioural Therapy, Mentalization Based-Psychotherapy, and Transference-focused Psychotherapy
- But they are delivered by specialists, expensive and generally not available in the public system

Good Psychiatric Management

- Good Psychiatric Management (GPM) is a evidence based, effective model of care for BPD that can be delivered by generalists.
- GPM is low resource and principle driven.
- GPM was developed by Dr. John Gunderson at McLean's Hospital (affiliated with Harvard University).

Key Features of the GPM Model of Treatment

- Establish the diagnosis and **share diagnosis with patient**: this helps patients feel seen and understood and enables them to make sense of their symptoms and thereby enhances the therapeutic alliance
- Provide **psychoeducation about BPD**: BPD is a treatable disorder and not a moral flaw, there is reason to be hopeful. The interpersonal coherence model helps make symptoms understandable
- Maintain an ongoing focus on **accountability and change**: this promotes recovery and helps with identity consolidation. Functional gains are prioritized over "feeling better."
- Encourage the patient to **build a life**: this increases agency and autonomy, increases life satisfaction, improves resilience and reduces relapse. **Work before love**.

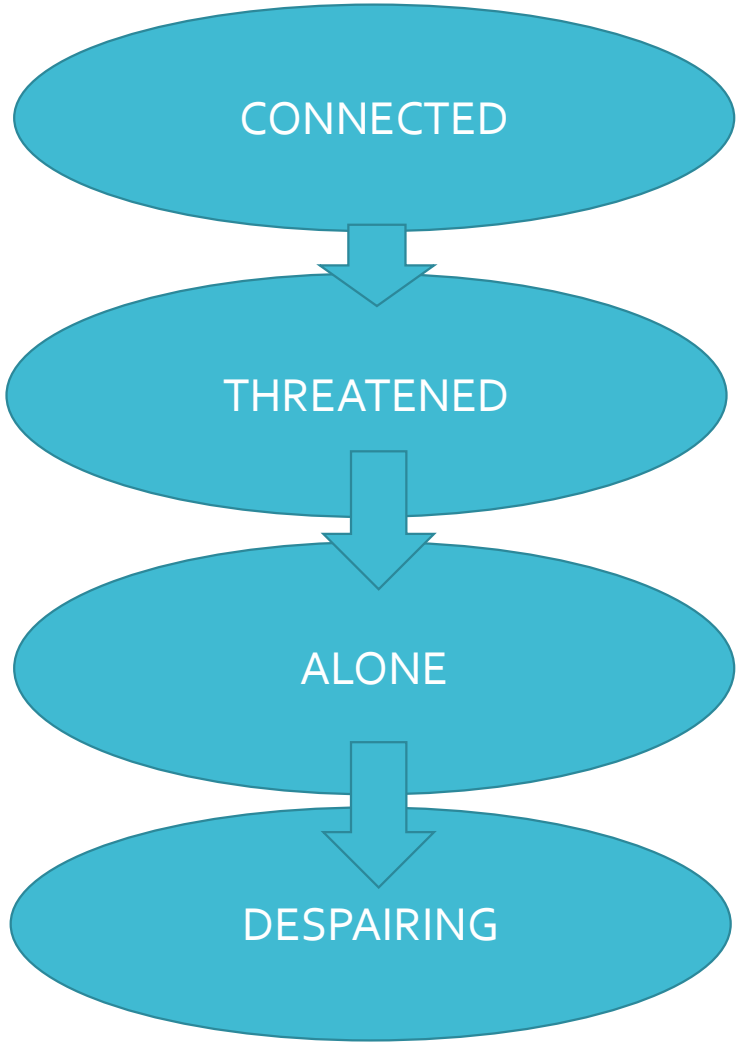
Why is it important to disclose the diagnosis of BPD?

- Reduces feelings of uniqueness and alienation.
- Supports more realistic expectations regarding course and medication response.
- Supports the therapeutic alliance
- Reduces externalization of responsibility and increases collaboration.
- It can be helpful to review the DSM5 criteria with a patient as a way of exploring the diagnosis.
- When discussing the diagnosis I tell patients that it doesn't mean the have a bad personality or are a bad person (rather, it reflects a pattern of relating to the self/other people/world). I also say that it also doesn't mean that it is fixed or permanent.

Basic Psycho-education for BPD

1. BPD is significantly heritable – approx. **55%**
2. BPD is a disorder that is very sensitive to environmental stress, especially interpersonal stressors, and lack of structure.
3. The brains of people with BPD have a hyperactive amygdala and an underactive prefrontal cortex.
4. Most patients have symptom remissions – about 50% by 2 years, 85% by 10 years, and once remitted only 15% have relapses.
5. There are multiple forms of evidence based treatment for BPD.
6. The vast majority of patients with BPD improve significantly without receiving these therapies. Good Psychiatric Management (GPM) is usually sufficient.

Interpersonal Coherence Model of GPM



Clinical Utility of Interpersonal Coherence Model

- Patients' sensitivity to connection and disconnection predicts symptoms and helps guide risk assessment. Behaviours are seen as secondary to mental states.
- It encourages clinicians to connect symptoms onset to interpersonal events so that patients can, over time, develop a sense of agency over their behavior, and experience their behavior as more predictable
- It reminds clinicians of their own role in potentially triggering unexpected responses that would otherwise be experienced as disorienting or overwhelming.

Medications and BPD?

- There are no approved medications for BPD. No medications are uniformly helpful across all symptoms domains.
- There are few RCTs and many of the existing RCTs are underpowered, short in duration and with outcomes that are highly variable.
- Studies are challenging due to risk and the high degree of comorbidity.
- Polypharmacy is very common and approx. 40% of patients with BPD are on 3 or more medications.
- Medications are best limited to treating serious comorbidities.
- The primary treatment for BPD is psychosocial.

Framework for Medications

- Emphasize functionality over feeling better.
- Limit medication changes to when there is an identifiable comorbidity or worsening distress that risks functional impairment.
- Establish the need to continually reassess the efficacy and role of medications by both physician and patient.
- Taper ineffective or duplicate medications.
- Be *very* hesitant to prescribe benzodiazepines as they are disinhibiting and increase suicide risk.

You

- Being thoughtful helps you to be a container for your patient's distress and serves as a role model for thinking first.
- The relationship is both real and professional.
- Being responsive assures patients that you are interested and involved; do not catastrophize. Be active, not reactive.
- **A consistent, reliable, relatable clinician is good enough to help patients with BPD.**

Looking for more?

- Harvard offers an 8h online course that provides excellent training in GPM. It is only $45 USD.

https://cmecatalog.hms.harvard.edu/general-psychiatric-management-borderline-personality-disorder