Training in Good Psychiatric Management for Borderline Personality Disorder in Residency: An Aide to Learning Supportive Psychotherapy for Challenging-to-Treat Patients

Joel Bernanke and Benjamin McCommon

Abstract: Given many competing demands, psychotherapy training to competency is difficult during psychiatric residency. Good Psychiatric Management for borderline personality disorder (GPM) offers an evidence-based, simplified, psychodynamically informed framework for the outpatient management of patients with borderline personality disorder, one of the most challenging disorders psychiatric residents must learn to treat. In this article, we provide an overview of GPM, and show that training in GPM meets a requirement for training in supportive psychotherapy; builds on psychodynamic psychotherapy training; and applies to other severe personality disorders, especially narcissistic personality disorder. We describe the interpersonal hypersensitivity model used in GPM as a straightforward way for clinicians to collaborate with patients in organizing approaches to psychoeducation, treatment goals, case management, use of multiple treatment modalities, and safety. A modification of the interpersonal hypersensitivity model that includes *intra*-personal hypersensitivity can be used to address narcissistic problems often present in borderline personality disorder. We argue that these features make GPM ideally suited for psychiatry residents in treating their most challenging patients, provide clinical examples to illustrate these points, and report the key lessons learned by a psychiatry resident after a year of GPM supervision.

Keywords: borderline personality disorder, narcissistic personality disorder, supportive psychotherapy, case management, psychotherapy training

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The Accreditation Council for Graduate Medical Education (ACGME) requires psychiatry residents to be trained in, at a minimum, supportive psychotherapy, cognitive-behavioral therapy, and psychodynamic psychotherapy (Accreditation Council for Graduate Medical Education, 2017). Given the many other demands placed on psychiatry residents, these ambitious goals mean that attaining competency in any psychotherapy modality is difficult, if not impossible, by graduation. The ACGME does not provide detailed training goals for any of the required modalities, nor do they require that residents have experience treating patients with certain diagnoses, such as personality disorders, with specific modalities.

This limited guidance potentially leaves psychiatry residents unprepared to manage one of the most common and challenging diagnoses they are likely to see: borderline personality disorder (BPD). Depending on the diagnostic rules used, the lifetime prevalence of BPD in the United States is 2.4% to 5.9%, though individuals with BPD make up a much larger portion of outpatient clinic populations, with estimates ranging from 9% to 42% (Grant et al., 2008; Tomko, Trull, Wood, & Sher, 2014; Zimmerman, Rothschild, & Chelminski, 2005). The difficulties of treating patients with BPD, and training psychiatry residents to do so, are numerous, and stem from the absence of standardized approaches to assessment, diagnostic disclosure, treatment planning, safety, pharmacotherapy, and management of transference and countertransference (Occhiogrosso & Auchincloss, 2012).

Though data are scarce, the majority of patients with BPD are likely either untreated or inappropriately treated for their condition (Hermens, van Splunteren, van den Bosch, & Verheul, 2011). Several evidence-based treatments for BPD, including dialectical behavioral therapy, transference-focused therapy, and mentalization-based therapy, require extensive training and frequent patient contact that might hinder their widespread adoption (Gunderson, 2016). In some cases, the burden of training, staffing, and supporting these approaches has led to program closure (Bales et al., 2017). Unfortunately, it seems likely that many patients with BPD will never gain access to these treatments.

Inspired in part by this unmet public health need, Good Psychiatric Management for BPD (GPM) was developed as a simplified, psychodynamically informed framework for the outpatient management of patients with BPD (Gunderson & Links, 2014). GPM is one of several evidence-supported treatments that emphasize a simplified, structured approach to BPD by generalist clinicians (Bateman & Fonagy, 2009; Clar-

kin, Levy, Lenzenweger, & Kernberg, 2007). GPM requires less training and patient contact than other evidence-based treatments for BPD yet appears to be equally effective (Choi-Kain, Albert, & Gunderson, 2016; McMain et al., 2009). This converging evidence provides hope that generalist clinicians can provide effective treatment for many patients with BPD, reserving more intensive specialized treatments for treatment-refractory cases (Choi-Kain, Finch, Masland, Jenkins, & Unruh, 2017).

Further, GPM's flexibility is compatible with recent expert opinion advising a "contextual" perspective to the long-term treatment of patients with BPD with an emphasis on the importance of the relationship between patient and therapist, especially the basic experience of having a person in one's life who will listen in a caring way over long stretches of time (Stone, 2017). Less emphasized is the use of any particular specialized treatment for BPD, as long as treatment is structured, flexible, and focused on positive change that enhances morale. This has been described as "psychodynamically informed long-term clinical management" (Friedman & Downey, 2016).

In this article, after providing an overview of GPM, we show that training in GPM fulfills the requirement for training in supportive psychotherapy during psychiatric residency; builds on training in psychodynamic psychotherapy (and is compatible with cognitive-behavioral and skills-based therapy training); and applies to other severe personality disorders, especially narcissistic personality disorder. We argue that these features make GPM ideally suited for psychiatry residents, provide clinical examples to illustrate these points, and report the key lessons learned by a psychiatry resident after a year of GPM supervision.

OVERVIEW OF GOOD PSYCHIATRIC MANAGEMENT FOR BORDERLINE PERSONALITY DISORDER

GPM, which is based on the practice guideline for BPD issued by the American Psychiatric Association in 2001, offers a model of interpersonal hypersensitivity that guides particular approaches to the following elements of BPD treatment: case management, psychoeducation, treatment goals, use of multiple modalities, and duration and intensity of treatment (American Psychiatric Association, 2001; Gunderson & Links, 2014). Additionally, GPM provides guidelines for the assessment and management of self-injurious and suicidal thoughts and behaviors.

The Interpersonal Hypersensitivity Model

GPM is underpinned by a model of interpersonal hypersensitivity, which is used by clinicians and patients to understand symptoms and problems in functioning and to identify interventions that are likely to be helpful (Gunderson & Lyons-Ruth, 2008). In the model, interpersonal events result in movement through a cycle of self-states: (1) "connectedness," (2) "feeling threatened," (3) "aloneness," and (4) "despair." "Connectedness" is fostered by idealization and fragile because of rejection sensitivity. "Feeling threatened" occurs when interpersonal stresses such as perceptions of separation, criticism, or hostility lead to devaluation, anxiety, anger, self-injury, and help seeking, requiring support from others to return to "connectedness." "Aloneness" results if others withdraw support, resulting in dissociation, paranoia, impulsivity, and help rejection. "Aloneness" can proceed to "despair," characterized by anhedonia and suicidal thoughts and behaviors, possibly requiring a holding environment such as an emergency room or rescue by others to return to fragile "connectedness." This simplified model allows the clinician to collaborate with the patient in examining typical self-states in BPD with attention to alternative ways of thinking and behaviors that are more likely to promote support from others (and less likely to lead to withdrawal from others).

Case Management

Case management is meant to address the severe psychosocial stressors that are common in BPD and can render any psychotherapy ineffective, and examples include support for activities of daily living, work, family relationships, healthy eating, and budgeting (Gunderson & Links, 2014). Clinicians practicing GPM can also make use of more rigorous case management protocols developed for other serious psychiatric disorders, such as Assertive Community Treatment (ACT) for schizophrenia. In ACT, case management includes help with: social skills and family connections; education and employment; problems in mental and physical health; and activities and instrumental activities of daily living, such as laundry, shopping, cooking, grooming, and transportation (Phillips et al., 2001).

A common challenge in implementing case management for patients with BPD is that patients might prioritize discussions of intimate relationships over problems with more basic needs, such as housing or em-

ployment. The model of interpersonal hypersensitivity gives clinicians a way to understand this and begin to impart this understanding to patients: the patient's desire for connectedness, however fragile, can override other concerns and make it difficult to work toward conditions of a better life that are likely needed prior to improvements in relationships.

Psychoeducation

Psychoeducation in GPM is designed to enhance the therapeutic alliance; introduce realistic expectations for treatment, including the instillation and maintenance of hope; and reduce stigma and shame. Psychoeducation begins with diagnostic disclosure, conceptualized as a collaborative process involving a joint review of the diagnostic criteria for BPD. Patient acceptance of the diagnosis is not required; GPM can be targeted to the specific symptoms of BPD that the patient is interested in addressing. In that case, GPM can be described as a treatment developed for BPD that is useful for certain symptoms, even if all features of the disorder are not present. After diagnostic disclosure, there is a discussion of the challenges of treating comorbid conditions without also addressing BPD (or features of BPD), a review of the limited effectiveness of medications for BPD, and a discussion of the potentially reduced effectiveness of medications for comorbid conditions.

Next, the clinician conveys to the patient, in simplified language, genetic, developmental, environmental, and neurobiological contributions to the etiology of BPD, including findings from recent research. This includes the significant heritability of BPD, with genetic factors estimated to account for 35% to 45% of the variance in the emergence of BPD (Distel et al., 2009). People with BPD report high rates of childhood trauma, including sexual abuse, emotional abuse, and neglect (Battle et al., 2004). In general, patients who were not the victims of frank trauma are encouraged not to blame their parents or themselves for their development of BPD; instead of "bad parents" or "bad children," the "fit" (or relative lack thereof) of particular parents with particular children is emphasized. Finally, neurobiological findings show increased amygdala activation among patients with BPD in response to facial expressions and decreased ventromedial prefrontal cortex activity during a self-control task when feeling sad (Donegan et al., 2003; Silbersweig et al., 2007). This can be summarized as an imbalance between overactive amygdala ("fearful and emotional brain") and underactive prefrontal cortex ("thinking brain").

Psychoeducation in GPM also includes the expected course of BPD, both with and without treatment. Longitudinal studies show that nearly 70% of patients with BPD no longer meet diagnostic criteria for BPD after six years, even without BPD-specific treatments (Zanarini, Frankenburg, Hennen, & Silk, 2003). After 16 years, however, only 40% of untreated patients have sustained good work and relationship functioning (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012). Treatment with GPM can be described as an evidence-based approach designed to diminish the time to symptom remission and improve the chances of gaining good work and relationship functioning. As part of providing realistic hope, psychoeducation is given about other evidence-based treatment approaches for BPD in case improvement from GPM is insufficient.

Treatment Goals

As noted earlier, the primary goals of treatment with GPM target life outside of therapy, namely improvement in work and relationships, with improvement in work expected before improvement in relationships. These long-term goals are facilitated by the near-term goals of symptom reduction and improved self-control. GPM encourages patients and clinicians to collaborate on setting incremental, realistic goals and on monitoring progress toward these goals. Working toward setting goals is an acceptable first goal.

Use of Multiple Modalities

Although the GPM manual places more emphasis on case management and less on individual psychotherapy, GPM has been described as "case management, dynamically informed psychotherapy, and symptom-targeted medication management" (McMain et al., 2009). Additionally, GPM encourages the flexible use of family involvement; cognitive, behavioral, and skills-based psychotherapy techniques; and group psychotherapy. Group psychotherapy, ranging from general supportive groups to 12-step programs, is likely to be available and affordable to patients, and is seen in GPM as an important opportunity to work on communication and interpersonal difficulties.

Clinicians who can prescribe can do so within the GPM framework and those who cannot should refer their patients for medication evalu-

ation as needed. GPM encourages a collaborative, evidence-based, symptom-targeted approach to medication management. Prescribers should counsel patients on the risks and benefits of using—and not using—medications in light of the patient's symptoms and goals. Prescribers and patients should monitor medication efficacy together and discontinue medications without benefit. Self-discontinuation or misuse of medication can be explored through chain analysis and the interpersonal hypersensitivity model. Additionally, clinicians should discuss any incompatibility of these behaviors with the agreed-on approach to safety and the implication of these behaviors for the treatment.

GPM also gives guidance to psychiatrists providing medication management who are in split treatments with non-psychiatrist clinicians providing psychotherapy. GPM emphasizes regular communication between clinicians to minimize splitting and to establish effective collaboration. Clinicians are encouraged to delineate their respective treatment responsibilities, agree on a safety plan, monitor treatment progress, and discuss treatment changes. Psychiatrists with GPM training can help non-psychiatrist psychotherapists in split treatments to understand the limited role of medications in BPD and the importance of addressing interpersonal hypersensitivity and case management needs.

Many patients with BPD have suffered trauma. For patients with significant stress disorder symptoms, GPM encourages clinicians to refer for evidence-based treatment or to deliver such treatments themselves. In both cases, clinicians are encouraged to maintain the overall GPM framework. When symptoms are less severe, or when trauma-specific treatment is not available (or refused by the patient), GPM encourages clinicians to take the same goal-oriented, multi-modal, efficacy-driven approach to these symptoms as BPD-related symptoms.

Duration and Intensity of Treatment

Research supports the effectiveness of a weekly, yearlong treatment, but GPM does not require a specific duration or intensity of treatment (Gunderson & Links, 2014; McMain et al., 2009). GPM is considered open ended and can be started and stopped as needed, with flexibility to increase or decrease from once-weekly treatment based on treatment goals and efficacy. Efficacy is monitored on an ongoing basis by both the patient and the clinician. GPM provides guidance on expectable progress with treatment, which should be shared with the patient: (1) reduced depression, anxiety, and subjective distress in the

first few weeks; (2) behavioral improvement in the first few months; (3) improvement in work and relationships after six or more months. If expected progress is completely absent at any of these stages, this prompts a review of the treatment, initially by the patient and clinician, but possibly by a consultant if needed.

Management of Self-injurious and Suicidal Thoughts and Behaviors

Suicidal and self-injurious thoughts and behaviors are common among patients with BPD and BPD traits, and the risk of suicide is estimated to be 3% to 10% (Black, Blum, Pfohl, & Hale, 2004; Yen et al., 2004). In a recent large national cohort, the rate of completed suicide in the year after deliberate self-harm was found to be 37 times higher than in the general population (Olfson et al., 2017). GPM provides a systematic approach to managing suicidality and non-suicidal self-harm with an emphasis on reduction of such behaviors. GPM's approach is consistent with the limited psychiatry malpractice data available, as well as recommended medicolegal practices intended to further reduce legal risk, including diagnostic disclosure, safety assessment, family involvement, and maintenance of appropriate clinical boundaries (Goodman, Roiff, Oakes, & Paris, 2012; Gutheil, 2004, 2005; Reich & Schatzberg, 2014).

During evaluation, clinicians should ask patients about self-injurious and suicidal thoughts and behaviors; make note of their frequency, intensity, duration, lethality, and context; and document the patient's acute and chronic suicide risk factors. As in other areas, GPM encourages psychoeducation, genuine interest and concern by the clinician, and a collaborative approach that fosters patients' agency. Clinicians can explain to the patient that these thoughts and behaviors may increase the risk of serious injury and suicide, but that partnering with family and treatment are likely to help. They should add that these thoughts and behaviors likely occur in reaction to interpersonal stressors and, if possible, connect them to the model of interpersonal hypersensitivity. Finally, clinicians and patients should collaborate to set expectation for both parties about how to address safety concerns in and out of therapy sessions.

When a patient reports self-injurious or suicidal thoughts or behaviors, GPM recommends that clinicians express concern, and give the patient the opportunity to volunteer more information and express his or her feelings. GPM recommends against unilateral action by the clini-

cian, when possible; instead, clinicians should encourage patients to be explicit about whether and what help they would like. If a patient is interested in exploring what happened, chain analysis—making particular note of interpersonal stressors—can help patients identify precipitants. Reluctance to discuss safety should prompt exploration of inconsistencies with the agreed upon process and implications for the therapeutic relationship. Clinicians should attempt to identify acute changes in the patient's condition and the presence or absence of suicidal intent; concerns about imminent risk should be directly addressed with the patient and patient's family whenever possible. Consultation should be used liberally, and emergency department referral and hospitalization sparingly (Krawitz et al., 2004).

Once a crisis has been stabilized, GPM suggests that clinicians follow up during scheduled appointments. Recommended topics include identifying or reviewing stressors that contributed to the crisis; the effect of the crisis on the clinician; the factors that helped the patient feel better, including feeling cared for or held; the limit of relying on the availability of the clinician to manage crises; and the identification of alternative coping strategies.

GPM as Supportive Psychotherapy

Like GPM, the principal objectives of supportive psychotherapy are to help patients improve their self-esteem, symptoms, and functioning (Douglas, 2008; Pinsker, 1997). Furthermore, many recommended supportive interventions are explicitly endorsed in GPM, while the remainder appear compatible with GPM. Central to both supportive psychotherapy and GPM treatment is the development and maintenance of a holding environment and therapeutic alliance (Brenner, 2012; Douglas, 2008). Toward these aims, both encourage an active approach by the clinician that includes: being real and responsive, offering advice, providing reassurance, self-disclosing when appropriate, attending to and helping contain the patient's negative feelings, and monitoring for and quickly repairing ruptures in the alliance (Douglas, 2008).

In addition to these shared recommendations about the therapist's priorities and stance, supportive psychotherapy and GPM overlap in their approach to therapy sessions. Supportive psychotherapy encourages clinicians to make accurate diagnoses, offer psychoeducation, and collaboratively establish appropriate and realistic goals for treatment. GPM tailors these guidelines to patients with BPD, recommending disclosure of and psychoeducation about the BPD diagnosis, discussion of

comorbidity, guidance about the role of medication, selection of goals focused on life outside of treatment, and discussion of expectable improvements. To help patients achieve their goals, supportive psychotherapy recommends that, in addition to the stance and interventions mentioned above, therapists help their patients learn to self-assess and manage difficult emotions, disorganized thinking, and limited insight (Douglas, 2008). GPM offers more specific strategies for achieving these same aims, including helping patients use the interpersonal hypersensitivity model, behavioral chain analysis, and the "think first" strategy to better understand and manage their feelings and behaviors.

Finally, supportive psychotherapy and GPM overlap in their recommendations for dealing with therapeutic challenges, including threats to the alliance, difficulties with attendance, and safety. Supportive psychotherapy encourages clinicians to communicate in a direct and nonthreatening manner, recognize their own feelings in addition to the patients', confront dangerous or damaging behaviors in a collaborative way, and seek consultations or make referrals as needed.

In this light, GPM is essentially comprised of case management and supportive techniques tailored to patients with BPD. The case management hierarchy guides the therapist in identifying and prioritizing goals for each session, while supportive interventions are used to address these topics. Like how residents trained in manualized Transference Focused Psychotherapy (TFP) learn about psychodynamic treatment more broadly, residents trained in GPM are also learning about supportive psychotherapy more broadly (Bernstein, Zimmerman, & Auchincloss, 2015).

Clinical Vignette 1*

Ms. C is a 25-year-old White woman, college educated, living alone, with a history of depressive symptoms, cutting, and thoughts of suicide, prompting an involuntary hospitalization at age 20. She presented to the resident clinic six years ago after moving to town to pursue her artistic career. She had been treated with a variety of psychotherapies and medications, but continued to struggle with dysphoric mood, work advancement, and relationships. Ms. C was transferred to a new third year resident two years ago. At initial evaluation, Ms. C met criteria for major depression, and the resident recommended medication

1. Clinical vignettes are based on composites of real clinical examples with any identifying information changed to preserve confidentiality.

management and supportive psychotherapy. Though Ms. C tentatively agreed to focus on safety, symptom reduction, and general functioning, she became uninterested in taking medications and used sessions almost exclusively to recount her concerns about her relationship with her boyfriend.

During the following year, the resident began working with a GPM-trained supervisor. With the supervisor's support, the resident made and disclosed a BPD diagnosis to Ms. C, who endorsed 6 of 9 diagnostic criteria, and provided psychoeducation about BPD, comorbid depression, and the role of medications. Ms. C found the process validating and relieving. The resident assessed Ms. C to be at chronic risk for self-injury and suicide, but noted that her risk had been somewhat mitigated by treatment to date. Since Ms. C found routine questions about suicidality invasive and distracting, she and the resident agreed that she would bring up any changes in her suicidal thoughts and that the resident would reserve initiating a safety assessment for occasions when he observed clinical deterioration. Next, the resident introduced the model of interpersonal hypersensitivity as a way of understanding Ms. C's relationship concerns.

After Ms. C was laid off from work, her mood worsened and she had increased urges to cut and recurring thoughts of suicide, which she brought up herself in the session after she revealed that she had been laid off. She said that she would like to avoid medication but was open to involving her mother in a family session, which occurred a week later. The resident made the case for prioritizing getting and keeping a job, and treatment goals accordingly were re-negotiated. The resident then reframed the discussions of how much time and "emotional energy" her dating relationship took in terms of her progress toward finding work, and helped Ms. C identify strategies for putting aside her relationship concerns so she could focus on her job search. She found these techniques helpful both in searching for work and in limiting the intense emotions that emerged from her relationship. Her suicidal thoughts and urges to cut herself diminished over the next several weeks.

GPM as Psychodynamically Informed

Supportive psychotherapy as practiced in GPM is psychodynamically informed. For example, GPM suggests that patients are typically unaware of the feelings, fears, and fantasies that underlie their behavior, and that many of their symptoms and maladaptive behaviors

are the results of attempts to keep intolerable thoughts and feelings out of their awareness (Gunderson & Links, 2014). These concepts are reflected in the interpersonal hypersensitivity model, which tries to make explicit the patient's caretaking fantasy and abandonment fear, and in recommendations throughout the manual that clinicians "expose" anger and other difficult feelings and connect those feelings with maladaptive behavior and symptoms. Additionally, GPM notes how harsh self-criticism can lead to self-judgment, shame, and self-harm. We think these observations and recommendations contain mainstays of psychodynamic theory and treatment: making the unconscious conscious, interpreting immature defenses, and tamping down an overly punitive superego (Cabaniss, Cherry, Douglas, & Schwartz, 2016; Gabbard, 2005).

GPM does not rely on clinicians having a deep conceptual understanding of psychodynamic psychotherapy but rather offers a variety of practical interventions that are grounded in psychodynamic theory. Most centrally, GPM encourages psychoeducation about the potential connections between difficult feelings—specifically fear and anger—and symptoms, and also recommends attempts to "expose" these feelings through direct questioning and behavioral chain analysis. This process involves interventions that psychodynamic therapists would label as confrontations, clarifications, and working through. Here, GPM overlaps with more explicitly psychodynamically conceptualized treatments for BPD, such as TFP (Yeomans, Clarkin, & Kernberg, 2015). However, GPM does not emphasize the elements of psychodynamic psychotherapy that may disrupt fragile alliances, worsen symptoms, or take the focus off the patient's current life outside the treatment, including discussions of resistance, use of free association, and direct and genetic interpretations.

Additionally, GPM offers clinicians psychodynamic concepts to help them manage their relationship with the patient by protecting both the alliance and themselves from being overwhelmed by negative feelings. Clinicians are encouraged to anticipate and address patient's negative feelings toward the therapist, to offer realistic views of their limits as therapists, and to seek consultation with peers to discuss their feelings toward the patients. These maneuvers rest on the concepts of negative transference, idealizing positive transference, and countertransference. GPM, in treating the therapeutic relationship as both real and professional, does not emphasize transference interpretations.

Finally, GPM encourages the use of concepts borrowed from other psychotherapies with deep ties to psychodynamic psychotherapy, such as mentalization and attachment theory (Bateman & Fonagy, 2009). GPM suggests that patients with BPD have an underdeveloped theo-

ry of mind that leads to their misinterpreting the actions of others. It also suggests that insecure attachment during development likely contributes to difficulties with trust during adulthood. GPM encourages therapists to help their patients learn to mentalize, and suggests they use psychoeducation about attachment difficulties to help them understand ongoing interpersonal challenges.

Clinical Vignette 2

Mr. F is a 33-year-old man, living with his on-and-off boyfriend, who completed a two-year culinary program and works as a line cook in an upscale restaurant, his third job in the past two years. He presented to the resident clinic three years ago, was diagnosed with major depression and BPD at initial evaluation, but was not interested in psychotherapy. He was started on fluoxetine and was transferred to a private clinician. He returned to the clinic about 18 months ago seeking combined treatment. He was initially enrolled in the clinic's Dialectical Behavioral Therapy program but never filled out a diary card, stopped attending group, and found skills "annoying," prompting a switch to GPM.

Despite having dated his boyfriend for the majority of the past six years, Mr. F described frequent thoughts of other men and impulses to pursue other relationships, which he had acted on previously. He said these thoughts and behaviors were distressing to him because he said his boyfriend was "the most loving and caring person that I'll ever convince to be with me" and wanted to make the relationship work. When asked about the interactions with his boyfriend that lead to these thoughts, he identified a common chain of events: something his boyfriend said or did would make him angry but he would be too afraid of losing the relationship to address it. He'd then judge himself harshly for thinking "nasty thoughts" about his boyfriend, but would nonetheless experience a surge in thoughts of other men. We discussed effective ways to share his concerns with his boyfriend and talked about how his boyfriend might respond in these conversations. We also identified ways to manage his harsh self-criticism.

GPM for Narcissistic Problems

Comorbidity with other personality disorders is the norm in BPD (Zimmerman et al., 2005). Individuals with BPD may have a lifetime

prevalence of up to 39% for comorbid narcissistic personality disorder, which can further increase the difficulty of treatment (Stinson et al., 2008). Similarly, up to 37% of individuals with narcissistic personality disorder may also meet criteria for BPD at some point in their lifetimes. Based on these figures, we estimate that up to about 2% of the United States population may have both BPD and narcissistic personality disorder, or at least significant features of both.

In the absence of evidence-based treatments for narcissistic personality disorder or narcissistic problems, experts recommend adapting treatments for BPD, a "near-neighbor" disorder (Caligor, Levy, & Yeomans, 2015). GPM can be adapted in this way while preserving the case management and supportive psychotherapy approach. Specifically, the model of interpersonal hypersensitivity can be extended to include *intra*-personal hypersensitivity: a patient with narcissistic problems can reject and attack himself or herself if not meeting high internal standards. Parallel to the *inter*-personal model, this can lead to movement from the self-state of "connectedness" to the self-states of "feeling threatened," "aloneness," and "despair," as described earlier.

While patients with BPD may rely on relationships with idealized others to maintain their sense of self-worth, patients with narcissistic problems may rely on idealized conceptions of themselves to do so. And in the same way that patients with BPD are hypersensitive to the potential loss of these idealized relationships, patients with narcissistic problems are hypersensitive to the potential loss of their idealized selves. This commonly manifests as avoidance of everyday challenges, since anything less than a superior performance might be seen as threatening to their idealized self. Both avoidance and *intra*-personal rejection can result in low self-esteem, abandonment of any standards for behavior, withdrawal, and giving up. Additionally, patients with narcissistic problems are at greater risk of devaluing both social and clinician support, which might cause them to avoid asking for or to dismiss help.

Psychoeducation in GPM can be adapted to narcissistic problems by describing both the *inter-* and *intra*-personal hypersensitivity models. Given the pejorative use of the term "narcissistic" among the general public, patients are often more accepting of being described as having "self-esteem" problems. Low self-esteem can be emphasized if this is the patient's predominant experience, as is often the case, with encouragement to look out for more subtle indications of problematic high self-esteem, such as too high internal standards, which can contribute to the fragility of the state of "connectedness." Clinicians can explain that patients may tend to feel good, even superior, if they perceive themselves to be perfectly meeting their high internal standards, but as

soon as they feel any threat to meeting these standards, they can attack themselves as worthless and feel as terrible as when they experience rejection as coming from other people.

Clinical Vignette 3

Mr. W is a 22-year-old single man, living with his mother, attending community college part time, with a history of a manic episode with psychotic features requiring hospitalization in the context of heavy substance use three years ago. He presented to the clinic two years ago at the urging of his girlfriend's parents. At initial evaluation, the resident recommended combined treatment, including initiation of mood stabilizers and reduction in substance use. Mr. W was reluctant to take medications, saying that he had not experienced any significant mood or psychotic symptoms since he self-discontinued medications after his hospitalization. Similarly, he said that his substance use, which still included near daily alcohol and marijuana use, and occasional cocaine and hallucinogen use, was already reduced compared to one year prior. Mr. W missed about half of his sessions, though he said he liked coming and found it helpful. After a year, the resident made and disclosed a BPD diagnosis.

After a review of treatment goals, Mr. W expressed dissatisfaction with his school performance. He explained that he usually did well for the first few weeks of a class, during which time he often felt "smarter" than his peers. At some point, he would receive what he perceived to be negative feedback, for which he would judge himself harshly. He would start attending class irregularly and turning in assignments late, which made him feel worse. He further explained that, as he struggled in his classes, he would become despondent about his ability to succeed in a career, and that drinking alcohol was one of the few activities that helped him cope with this feeling. The resident described to Mr. W the intrapersonal hypersensitivity model, highlighting how excessively high internal standards often lead to feelings of inferiority, which in turn lead to giving up and despair.

Mr. W said the model was helpful in understanding his feelings and behavior. Yet, he continued to miss about half of his sessions, saying he forgot when they were. The resident recommended reducing the frequency of their sessions to every other week and adjusting the goals for treatment accordingly. Mr. W attended a greater proportion of his sessions for several months but his attendance fell off again after getting a new job and he was ultimately discharged from the clinic for non-attendance.

Lessons Learned

GPM helps psychiatry residents learn supportive limit setting. All patients, but especially patients with personality disorders, can make overwhelming demands of their providers. Both patients and clinicians can experience limit setting as the harsh and arbitrary refusal of the clinician to honor the request of a patient, but the absence of limit setting can result in negative feelings in the clinician that interfere with treatment. GPM's emphasis on collaboration makes limit setting a collaborative process where the clinician and the patient come to an agreement about what conditions are needed for the treatment to be most likely to succeed. In this model, limits are not imposed by the clinician on the patient, but are worked through together for the clinician's and the patient's mutual benefit, since both are ultimately most concerned with the success of the treatment.

GPM's explicit establishment of the case management hierarchy early in treatment can reduce feelings of chaos and provide support for both clinicians and patients. Patients with personality disorder are often prone to rapid decompensation, but all patients benefit from psychoeducation that significant changes in their safety, condition, functioning, or psychosocial circumstances should be brought to attention in treatment, and will likely need to be prioritized, both because they are intrinsically important and to give the therapy the best chance of success.

Finally, the hypersensitivity model provides a helpful, straightforward framework for both clinicians and patients. GPM's guidelines about perennially challenging clinical issues—such as safety, negative transference, and potentially counterproductive interventions—further circumscribe the therapeutic maneuvers psychiatry residents must choose among and master. This improves the resident's confidence and speeds competency.

CONCLUSIONS

GPM training is increasingly accessible, with plans for online availability in 2018 (Choi-Kain, personal communication). In this article, we have shown how the key concepts of and interventions in GPM represent tailored versions of those used in supportive psychotherapy. We have explained how GPM is rooted in psychodynamic concepts. Psychiatry residents with psychodynamic training will have a deeper understanding of GPM interventions, but psychodynamic proficiency

is not necessary to master GPM. We have outlined a simple extension to the interpersonal hypersensitivity model to address the narcissistic problems that are frequently comorbid with BPD. Finally, we have listed some lessons learned from a trial of GPM supervision in psychiatry residency.

Future Directions

While this article has focused on GPM in outpatient psychiatry, GPM is designed to be useful in other treatment settings, such as inpatient psychiatry units, the emergency room, and in consultation to medical and surgical services (Unruh & Gunderson, 2016). Training residents to use GPM in these settings might meet a demonstrated desire for supportive psychotherapy training in these settings by psychiatry program directors (Blumenshine, Lenet, Havel, Arbuckle, & Cabaniss, 2017; Unruh & Gunderson, 2016).

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