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General psychiatric management for adolescents (GPM-A) with borderline personality disorder

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While borderline personality disorder (BPD) has its onset in youth and is highly prevalent in young people, diagnosis and treatment are frequently delayed, leading to disruptions in development. The few treatments for this population are specialized, resource-intensive, and not widely implemented. Generalist treatments could broadly increase early intervention and access to care, at a less intensive level, when symptoms are milder and developmental arrests can be avoided. One generalist treatment for adults with BPD, General Psychiatric Management, has been adapted for adolescents (GPM-A). GPM-A can be flexibly implemented in different settings, and emphasizes psychoeducation, medicalization of the disorder, life-building activities, and conservative prescribing. This paper introduces GPM-A and proposes it serve as a primary intervention for adolescents with BPD.

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Introduction

Commonly considered to be only diagnosable in adulthood, borderline personality disorder (BPD) is in fact a valid and reliable diagnosis in adolescence, with comparable severity to BPD in adulthood [1,2]. Yet the stigma against diagnosing BPD in adolescence persists, with less than 10% of clinicians doing this in practice [3•]. Delaying well-informed BPD care decreases the likelihood of interventions that work, potentially worsening long-term outcomes.

A few evidence-based treatments (EBTs) for adults with BPD have been adapted for and trialed in adolescent populations. Mentalization-Based Treatment for Adolescents (MBT-A) [4–6], Dialectical Behavior Therapy for Adolescents (DBT-A) [7–12], Emotion Regulation Training (ERT) [13,14] and Cognitive Analytic Therapy (CAT) [15,16] have been shown to reduce BPD symptoms, as well as self-harm, suicidal ideation, and depression.

However, these psychotherapies require specialized intensive training, which restricts their implementation [17,18]. More feasible alternatives are needed to address the significant public health needs of the adolescent BPD population. Good Clinical Care, the pared-down, non-expert comparator in the CAT trial, showed equivalent reductions in psychopathology, parasuicidal behavior, and global functioning [14]. Standard psychodynamic or cognitive behavioral therapy matched DBT-A's improvements in suicidal ideation, hopelessness, depression, borderline symptoms and functioning at the 3-year follow up, with only self-harm outcomes remaining superior in the DBT-A group [10]. Another DBT-A trial found no advantage over a less intensive supportive therapy in any outcome, including suicide attempts and self-harm episodes, by the 12-month follow up [9]. These results suggest that high quality, structured and informed care are comparable to specialized treatments like CAT and DBT-A despite requiring less expertise and fewer resources.

Less intensive approaches have therefore shown promise as effective and likely more viable alternatives to the specialist BPD treatments for adolescents. This motivated the development of General Psychiatric Management for Adolescents (GPM-A) as a generalist treatment for this population that draws from common factors to be "good enough" for most young people at a critical period of transition and change.

General Psychiatric Management for Adolescents (GPM-A)

GPM-A is adapted from GPM [19••,20•], an evidence-based treatment for adults with BPD that has been demonstrated to be as effective as comprehensive DBT [21,22]. GPM's efficacy was a surprising finding to the field. McMain's trial compared DBT to a similarly BPD-focused, informed, structured, and manualized treatment, which only differed from DBT in its lack of DBT skills training groups and coaching. That manualization, called General Psychiatric Management by its developer Paul Links, used John Gunderson's landmark

textbook *Borderline Personality Disorder: A Clinical Guide* [23]. After McMain and colleague's trial entered the literature, Gunderson and Links re-manualized GPM as "Good" Psychiatric Management, distilling the essential features of the approach in a way most mental health clinicians can learn. Like GPM, GPM-A is informed by clinical expertise, research, and common elements of effective treatments adapted for adolescents with BPD: (1) including those with subthreshold (3+) symptoms; (2) translating materials into age-specific, relatable language; (3) increasing family involvement; (4) shortening treatment duration; and (5) focusing on developmental concerns.

At its core, GPM-A is flexible and pragmatic. It eclectically integrates ideas from DBT, MBT, and transference-focused psychotherapy without requiring their intensive training and elaborate techniques. GPM-A is distinct in that it primarily relies on general principles of good psychiatric management that all mental health professionals learn — e.g., making a diagnosis, goal setting, managing issues of safety — such that the approach should already be familiar to clinicians.

Drawing from psychodynamic and cognitive-behavioral principles, GPM-A combines supportive psychotherapy with case management to improve the adolescent's understanding of the self, responses to stress, and problem-solving skills. The principles of GPM and GPM-A have considerable overlap, but there are special considerations for adolescents (summarized in Table 1). Many psychiatric illnesses are emerging at this critical developmental period and GPM-A's focus on interpersonal concerns and managing oneself is relevant to any teenager at risk for developing psychiatric difficulties. Evidence suggests there is a general psychopathology ('p') factor underlying all psychiatric disorders [24] and that BPD represents a general factor that underlies personality pathology especially in its severest forms [25]. Early stabilization of a young person's psychiatric vulnerabilities and functioning can lend them resilience, no matter which psychiatric syndrome develops. In addition, its emphasis on functioning outside of therapy also makes it compatible with the Alternative Model of Personality Disorders (AMPD), which formulates personality pathology in terms of maladaptive self- and interpersonal functioning (Criterion A). This makes GPM-A a good general approach for any personality-related difficulties that develop in adolescence.

Diagnosis

An essential first step in GPM-A is making and sharing the BPD diagnosis. Many clinicians feel ill-prepared, uncertain, or anxious about taking this step, due to misinformation and lack of proper training. However, intervention earlier in the development of the disorder is crucial, as BPD in adolescence is associated with lower functioning and poorer long-term outcomes [26•,27]. As such, GPM-A encourages early identification to minimize interference with normal development.

The diagnosis can be made collaboratively by simply going through the DSM-5 criteria with the adolescent. This way, they can give their own input on whether these criteria resonate with their experience. Even adolescents who do not meet full criteria suffer from poorer quality of life and psychological distress [28], and can benefit from being aware of their cognitive biases and interpersonal patterns, so lowering the diagnostic cutoff to three symptoms offers some clinical utility.

For adolescents, learning about the diagnosis can medicalize their experience to convey they are not alone in trying to cope with their serious vulnerabilities, and

Table 1

Principles of GPM and GPM-A.

Principles of GPM
1. Be active (responsive, curious), not reactive — challenge passivity, avoidance, silences, and diversions; you are 'the container' (cautious, thoughtful, 'hold' projections)
2. Support via listening, interest, and selective validation — seeing the patient's description as legitimate and understandable (by you AND by the patient)
3. Focus on 'getting a life' — school/work is first priority, then dating
4. The relationship is real (dyadic) and professional — disclose selectively (e.g. 'you scared me', 'that would make me angry'), avoid 'talking down' to patient
5. Change is expected — getting worse prompts questions about the therapy's value
6. Accountability — patients need to be active collaborators within treatment, in assuming control of their life (agency).
Principles with Specific Emphasis in GPM-A
1. Include BPD diagnosis in routine clinical assessment — provide understandable age-appropriate formulations, even when symptoms are subthreshold (3+ criteria)
2. Psychoeducation — for patients, families, schools and peers
3. Family involvement — naturally increased for adolescents, balance between connectedness and autonomy
4. Stepped down care — keep treatment time-limited and focused on reintegration in school and relationships

Adapted from Gunderson, Masland and Choi-Kain [20•].

that there are people who can help. It can also decrease blaming others, especially parents, and anchor expectations about the disorder's course and medications' effectiveness. For clinicians, diagnostic disclosure can foster an alliance, facilitate communication with colleagues, and discourage ineffective interventions such as polypharmacy and lengthy hospitalization.

Psychoeducation: GPM-A's Theory

Psychoeducation, or the process of providing information for patients and loved ones to better understand and cope with a disorder, can in and of itself help improve BPD symptoms [29,30]. It is akin to mental health literacy: conceptualizations about psychological disorders that can help them be recognized, managed, or prevented [31]. In the same way that someone with diabetes learns to recognize signs of complications, self-manage their symptoms, and seek help from doctors, adolescents with BPD can also benefit from this type of education. Understanding what drives one's behaviors and knowing that others share the same struggle can bring relief, and hearing a clinician understand one's symptoms and provide helpful expert knowledge can foster trust.

GPM-A's theory proposes the symptoms of BPD are triggered by patients' interpersonal contexts: they are idealizing and collaborative when connected to others, angry and devaluing when threatened by rejection, and impulsive and self-destructive when alone and in despair [19••]. Adolescents with BPD should know that, partly due to their genetics, they were born with a predisposition to be more sensitive than others and to react more strongly and emotionally to interpersonal events [32–34]. When others respond negatively, the adolescent's hypersensitivity may intensify, and when others rush to "rescue" them, their dependency may be reinforced. This symptom of *splitting* makes it difficult for caregivers to respond in ways the adolescent would find helpful.

The good news is that while BPD traits tend to rise in teenage years, they often decrease with time [35••,36]. The adolescent can take hope that their symptoms will remit in due course, facilitated by their treatment. In the meantime, with this knowledge, they can better monitor how interpersonal events trigger their symptoms, and they can increase awareness of their hypersensitivity's influence on their behavior and its effects on others.

Psychoeducational interventions aimed at families, schools, and peers can also help improve attitudes toward BPD and increase their skills, optimism, confidence and knowledge when interacting with people with the disorder [37–39].

"Getting a Life": School Before Dating

GPM-A focuses on the here and now rather than exploring a long developmental history and abstract, psychodynamic discussions. GPM-A therefore aims to help the adolescent "get a life" outside of treatment that is functional and purposeful. The primary tasks of adolescence include developing a sense of self, engaging in school and extracurricular activities, connecting with peers, managing emotions, and increasing resilience and autonomy. Clinicians and adolescents can collaboratively identify concrete steps to meet shared realistic goals. Although teenagers may be excited to explore romantic relationships or intense exclusive friendships to feel valued and liked, early relationship intensity can lead to risk for increased BPD symptoms [40] especially for a young person who has interpersonal hypersensitivity. Structured academic activities can help buffer the influence of interpersonal hypersensitivity by providing roles, tasks, and specific contexts with boundaries, predictable interactions, and opportunities to build identity and self-esteem. This emphasis on work or school before dating allows the treatment to also foster attention to functioning and not simply symptom reduction.

In GPM-A, progress toward reaching these goals determines treatment duration and intensity. Duration depends on when the adolescent is "back on track" developmentally. If adolescents are not progressing, they are respected in their growing independence by being held accountable. For example, GPM-A clinicians may suggest decreasing frequency of sessions or increasing unwelcome parental supervision as contingencies.

Managing Safety

Adolescence is a time of heightened risk for suicidality and self-harm, particularly for those with BPD [41]. Clinicians should respond without overreacting, but with supportive concern and a balanced assessment of the actual degree of risk. On one hand, adolescents with BPD are at a chronically elevated risk for suicide and may need to be hospitalized if the situation seems dangerous based on behaviors, history, and exacerbations of risk (e.g. comorbidity, substance use, negative interpersonal events). On the other hand, adolescents may be driven by impulsivity or trying to communicate distress without serious lethal intentions, and hospitalization may reinforce this as a method of communication [42].

GPM-A clinicians can predict interpersonal events and high distress can cause these behaviors. Patients are encouraged to put self-harm in the context of larger life difficulties and address interpersonal stressors. With heightened self-awareness, the teenager can brainstorm ways to cope with intense emotions and impulsivity as part of a safety plan. Particularly when working with adolescents, clinicians must be clear that they will need to disclose safety concerns to the family, who can help in safety planning, remind the adolescent to use skills, and reduce access to lethal means.

Caring for a self-destructive adolescent can be anxiety-inducing, so seeking consultation and support from colleagues is strongly encouraged. GPM-A clinicians should "never worry alone." Furthermore, they should set clear boundaries and emphasize that the teen's safety should not depend on the clinician's availability.

Multimodal Treatments

There is no medication that has been well-researched or approved by the Federal Drug Administration (FDA) for neither adults nor adolescents with BPD [43,44], yet polypharmacy remains a common problem. Prescribers should be especially conservative when working with adolescents, avoid pharmacotherapy when possible, and ask for the adolescent's help in evaluating any medication's effectiveness [45]. Most importantly, GPM-A clinicians should emphasize that medications are adjunctive to actively collaborating in psychotherapy, which is the necessary ingredient for getting better.

Groups — both therapy and recreational — should be encouraged. They are a cost-effective forum for social learning, and can provide peer support, feedback, exposure, and opportunities to learn others' perspectives. Groups such as Family Connections can also be part of families' treatments, as families often bear a heavy burden: fearfulness, worry, resentment, and alienation [37].

GPM-A clinicians can review Family Guidelines for BPD and hold conjoint sessions [46]. Families are encouraged to go slowly, express concern for self-destructive behaviors, maintain family routines, and foster their child's capacity to ask for the help that the child needs. Especially for adolescents, the support of the family is often crucial for treatment success and involvement will vary with the patient's age. Ideal times to bring in the family include the diagnostic stage, psychoeducational sessions, discussions on limit-setting or important life decisions, troubleshooting problems, and periodic treatment reviews. GPM-A clinicians should monitor the progress of both the adolescent and their family.

Training

In contrast to specialized BPD treatments that require high cost and time commitments, training in GPM-A involves only one eight-hour course that simply capitalizes on what clinicians already know and do, but with greater specificity to BPD [47]. Not only is it familiar to clinicians, but adult GPM training has been shown to reduce avoidance, dislike, and hopelessness about the care of patients with BPD while improving feelings of competence and beliefs in the efficacy of BPD treatments and the capacity to make positive differences, even six months after the training [48,49•]. Improved attitudes toward BPD likely influence how hypersensitive adolescents experience their clinicians, which can affect retention and the therapeutic alliance. Training in GPM-A may increase access to care by fostering generalists' optimism that they can effectively treat adolescent BPD.

Conclusion

Like GPM, GPM-A is not meant to replace more intensive EBTs. However, for the majority of mental health professionals who will never receive training in these treatments, GPM-A provides a framework for treating adolescent BPD and potentially other forms of personality pathology given the notion that BPD may be a prototype of personality functioning with low resilience. As a form of early intervention, its integration of up-to-date scientific understanding with pragmatic clinical management can combat the tendency to wait until symptoms worsen in severity, interrupting adolescent development and causing dependency on clinical care. GPM-A provides lower-level intensity of care if the adolescent does not need, does not want, or cannot access, specialized treatments; or as a precursor to more specialized treatments if the case is more severe. Treatments that expressly address concerns about self, identity, interpersonal sensitivities, and functioning are necessary for most adolescents across psychiatric diagnoses as they undergo this critical developmental stage, and GPM-A has the advantage of being packaged in a way that is accessible to most clinicians. We hope clinicians who are not trained in specialized treatments can still feel confident in their ability to help their younger patients broadly increase their resilience by using these principles as a standard of care.

Conflicts of interest

LCK receives royalties from American Psychiatric Association Publishing for the book Applications of Good Psychiatric Management for Borderline Personality Disorder: A Practical Guide, and from Springer for the book Borderline Personality and Mood Disorders: Comorbidity and Controversy.

Author contributions

Lois Choi-Kain — conceptualization, writing-original draft and review and editing. Gabrielle Ilagan — writing-original draft and review and editing.

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