Handbook of Good Psychiatric Management for Borderline Personality Disorder

by John G. Gunderson, MD, with Paul Links, MD, MSc. American Psychiatric Publishing, Washington, DC, 2014, 168 pages, $55.00 (paper, includes video illustrated online).

Many readers would agree that the main characteristic of a handbook on any topic must be a clear, concrete, pragmatic, even quasi-dogmatic approach to the subject under study. The demands of busy practitioners, the expectations of anxiety-prone trainees, and the complex needs of all kinds of patients may fully justify such categorical features. This little volume, however, while fulfilling those norms, goes subtly but effectively beyond them to generate in the reader curiosity, interest about conceptual details, and a desire to ask more and new questions. At least 2 reasons for this peculiar reaction to the book are possible: the solid presence of an author like John Gunderson, who is profoundly identified with his topic (and efficiently assisted by Paul Links) and ready to inquire further into an endless area of clinical knowledge, and the introduction of Good Psychiatric Management (GPM), an evidence-based modality of treatment, into the field of borderline personality disorder (BPD).

The handbook's preface is both a recognition of the challenge that BPD patients represent (the authors call it a case of "collective countertransference" [p VII]) and a call for action. The latter is an invitation to "embrace" the challenge, to overcome the myths surrounding the diagnosis, to accept the blossoming of "internal splits," to learn how to handle the "negative fears of being controlled or seduced" (p VIII), and to listen, validate, and empathize with the BPD patient's underlying hypersensitivity, born out of crucial interpersonal experiences. The main purpose of the manual is to have "good enough" treaters of BPD, a statement that sounds neither arrogant nor modest, just right.

Section I cogently summarizes what GPM is: an eclectic approach that advocates "commonsensical and simple to implement" (p 3) interventions by "warm, reliable, interested and unintimidated" (p 4) therapists willing to deal with different management aspects of BPD. GPM acknowledges neurobiological (genetic and psychopharmacologic) components as well as psychosocial perspectives of pathogenic relevance in BPD. While its goal is to help patients achieve satisfactory and meaningful lives, GPM is not a guide for long-term psychotherapy (and therefore not a competitor of well-established BPD treatment techniques), but a basically short-term supportive process that combines case management, psychoeducation, and flexible multimodal interventions and, ultimately, "can do as well as their more celebrated index treatment comparators" (p 6) such as dialectical behavior therapy, according to various empirical validations.

Sections II to IV carry the most substantial "how-to" details of the manual. They describe and explain further the GPM theory, the treatment guidelines per se: steps such as "Making the Diagnosis" and "Getting Started"; specific actions such as "Managing Suicidality and Nonsuicidal Self-Harm"; "Pharmacotherapy and Comorbidity"; and unique management dispositions such as "Split Treatments." A critical objective is the creation of a "holding environment" as a goal of a productive clinician-patient relationship, the building of a "containing" patient's belief that he or she is incontestably cared for. Among 7 central characteristics of the GPM operator, being "uncertain" is the most fascinating because it acts "as a container for the patient's polarized black-or-white thinking, and provides a model for his or her introjection" (p 15). Eight basic principles round up the therapist's multiple roles (coach, advisor, observer, interpreter) and allow him or her to handle the establishment of an alliance and details such as intersession availability, safety, anger, medications, and family involvement.

The would-be GPM "treater" (an almost neologism used to avoid the term *therapist*) of BPD patients will enjoy reading (and practicing) items of the subsection "How Change Occurs" that go from learning to "think first" to conducting "corrective experiences" through "social rehabilitation" aimed at resuming necessary interpersonal functions. The disclosure of the diagnosis "anchors the patient's and clinician's expectations" (p 21), a reminder of realism and pragmatism. This feature is exemplified by the practical acceptance of "the fantasy of being in communication…a form of transitional relatedness" due to electronic messaging (p 29). All this may lead to some inconsistencies, such as the use of "you can do" exhortations, or how the therapist's silence can confer security to a patient avid of it. In turn, the chapter "Split Treatments," which delineates a relatively novel suggestion in the management of BPD, opens even more a pluralistic focus, yet creates doubts or uncertainties about "primary" and "secondary" management roles, indications for the differently framed modalities, matters of emphasis and effectiveness, or the potential emergence of behavioral traits interfering with the improvement process. Literature about the value of this approach is called for.

Chapter 8 ("Case Illustrations"), in Section III, is perhaps the most original and attractive of the book. Well-elaborated clinical vignettes open up "Decision Points" to which alternative responses (in the manner of graded multiple-choice formulations) are offered, followed by a conscientious discussion section. The tables, here and throughout the book, are well conceived and extremely useful resources. Every reader, no doubt, will test himself or herself, and as each case focuses on different aspects of the pathology, all 7 cases will undoubtedly be topics of clinical training presentations and discussions. And, no doubt, the access to the video demonstration links will be crowded.

The "conceptual details" referred to in the first paragraph of this review relate to reflections and questions resulting from the richness of the theme and its text. One wonders if GPM is indeed a substantial management tactic for *all* clinical conditions in psychiatry, not only BPD, as it gathers "common ingredients" much in the pioneering line of Jerome Frank. The eclectic approach seems to miss pharmacogenomic and cultural considerations as examples at the 2 borders of the spectrum. The GPM and the handbook itself must be great points of reference for future research efforts in areas as different as the demonstration of BPD's "deficient pre-frontal cortex gaining control over their unruly amygdala" (p 19), the avoidance of "dichotomous stances" about the use of medications (p 48), or the management of the stigmatizing role that the term *borderline* seems to be playing in the contemporary social scene. Clearly, all this adds to the great value of a practical handbook that is also a wealthy source of clinical wisdom and original thinking.

Renato D. Alarcón, MD, MPH
alarcon.renato@mayo.edu

Author affiliation: Mayo Clinic College of Medicine, Rochester, Minnesota.

Potential conflicts of interest: None reported.

J Clin Psychiatry 2016;77(2):e171
dx.doi.org/10.4088/JCP.15bk10200