INTERACTIONS OF BPD WITH MAJOR COMORBIDITIES

Effect	Co-Occurring Disorder					
	MDD	Bipolar	AxD	PTSD	Subst Ab	ED
↓ BPD's Course	MAYBE*	NO	NO	YES	YES	NO
↓ Other D's Course	YES	NO	YES	YES	YES	NO

*BPD is primary cause of persistent MDD, MDD eventually then has negative affects on BPD

Gunderson & Links, 2014

BPD COMORBIDITY: WHICH DISORDER IS PRIMARY

Disorder	BPD Primary?	Rationale
Depression	**Yes**	**Will remit if BPD does**
Bipolar disorder		
manic	**No**	**Unable to use BPD therapy**
not manic	**Both**	**independent courses**
bipolar II	**?**	**More research needed**
GAD & SP	**Yes**	**Will remit if BPD does**
PTSD		
early onset (complex)	**No**	**Too vigilant to attach/be challenged**
adult onset	**Yes**	**BPD predisposes to onset, will remit if BPD does**
Substance use disorder	**No**	**2-6 months sobriety makes BPD tx feasible**
dependency	**No**	**sustained sobriety required**
abuse	**Probably**	**concurrent tx required**
Antisocial PD	**?**	**Is there 2° gain?**
Narcissistic PD	**Yes**	**Will improve if BPD does**
Eating disorder		
anorexia	**No**	**Unable to use BPD treatment**
bulimia	**?**	**Is physical health stable?**

SIX PRINCIPLES OF GPM

1. Be Active (responsive, curious), not reactive

2. Support

3. Focus on life situations – relationships and vocation
   - Work > love

4. The relationship is real (dyadic) and professional -- selective disclosure (e.g., "you scared me", "that would make me angry")

5. Change is expected

6. Accountability – expect patients to be active within treatment, in controlling their life (agency)