GPM as a framework for a dimensional, trigger-based approach to emotion dysregulation in borderline personality disorder

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Conflit of interest

- None

It always starts with patients...

Mister X, 26

- Referred for diagnostic evaluation for BPD
- Medical history:
  - BPD(reason for referral)
  - ADHD (diagnosed at a specialized center)
  - Adult ASD without ID (diagnosed at a specialized center)
  - BD(diagnosed at a specialized center)
  - Cannabis and alcohol use disorder
  - Bulimia nervosa
  - Complex PTSD (severe childhood trauma)
  - Intimate partner violence
  - DID (recently diagnosed in a private clinic)
- Living situation: In an open relationship, no children. Lives with his girlfriend and another boyfriend in an apartment. Not working. Dropped out of high school due to mental health issues
- Medication: XEROQUEL 600mg, TERCIAN 100mg, TEMESTA 2.5mg

Clinical picture

- Multiple emotional outbursts throughout the day
  - Self-harming and, at times, aggressive behaviors
  - Multiple substance and food-related issues (substances and food)
  - Anger outbursts
  - Recurrent dissociative and paranoid symptoms
- Major interpersonal difficulties
  - Hypersensitivity to rejection and fear of abandonment
  - Difficulties with social cognition
- Post-traumatic symptoms, including hypervigilance and, at times, significant flashbacks

How to treat ?

- ASD Specialist: “ASD must be first”
- BD Specialist: “BD must be stabilized first”
- EMDR Therapist: “We must start by stabilizing the flashbacks”
- Referring Physician: “Above all, BPD must be treated first”…

…

- Patient: “I don’t understand any of this”

Let’s slow down a bit…

Personality disorders

- Personality disorders (PDs) are among the most frequent and disabling psychiatric disorders.
- Among these disorders, the most studied is borderline personality disorder (BPD), which affects approximately 1.6% of the general population
- Treatment is psychotherapeutic (GPM!)
- New development in PD research emphasize that PD should be considered dimensionally
  - Level of Personality Functioning (~BPD) : identity, self-determination, empathy, intimacy
  - Pathological personality traits

Blay et al., 2026 ; Gunderson et al., 2018 ; Sharp & Wall, 2021

Emotion dysregulation

- Among the core psychopathological dimensions of BPD, emotion dysregulation (ED) constitutes a key mechanism.
- In classification, ED has long been mostly accounted in the BPD criteria, and thus mostly viewed through this lense
  - At least 4/9 criteria: self-harm & suicide, affective lability, impulsive behaviors, anger…
- … Even though we now know that it is a transdiagnostic construct, also found
  - Other PDs: NPD, OCPD, ASPD
  - NDDs : ADHD, ASD
  - (c)PTSD
  - BD

Glenn & Klonsky, 2009 ; Blay et al., 2024, 2026 ; Carmassi et al., 2022 ; Sloan et al., 2017

The problem

- Consequently, the presence of ED frequently leads to the attribution of a BPD diagnosis, even when the clinical profile is rooted in other psychopathological dynamics.
  - Hard to distinguish between BPD, other disorders, and true comorbid pictures…

- Potential important consequences
  - Impaired therapeutic relationship due to lack of epistemic epistemic correspondence
  - Missing key issues may lead to treatment drop-out/resistance (e.g., ASD, PN)
  - Delays in prescribing medication and/or failure to prescribe medication (e.g., ADHD, BD)

Blay et al., 2023; Blay et al., 2024; Campbell et al., 2009; Richter et al., 2023; Bemmouna et al., 2022

The need for a dimensional approach

- New dimensional approaches
  - HiTOP (and its super-spectrum of emotional dysfunction)
  - ICD-11 & AMPD
- Great models… but with little implementation in clinical practice
- The categorical approach remains the most widely used
- In this context, there is a need for a simple, accessible, trans-diagnostic and dimensional approach of ED for patients fulfilling BPD criteria, to pragmatically solve this important question

Blay et al., 2024, 2026

The place of GPM

- Initially developed for BPD, GPM conceptualizes personality disorders and its comorbidities as characterized by typical emotional and interpersonal triggers/dilemmas
  - Loss of relational dependance and fear of abandonment (for BPD)
  - Loss of ideal self-image and threat to self-esteem (for NPD)
  - Loss of control (for OCPD)
  - Loss of ideal body image and weight (for comorbid ED)
  - Loss of control over trauma cues (for comorbid PTSD)
- Such approach, if adapted to the more specific dimension of ED and extended to other disorders, would provide a clinical framework directly compatible with a transdiagnostic understanding of this complex psychopathological dimension

The last three years in a nutshell

- Development of a dimensional, trans-diagnostic trigger-based approach of ED
- Development of a a GPM adaptation directly integrating this trigger-based approach, to treat patients fulfilling the criteria for BPD.
- Naturalistic evaluation of the usefulness of this adaptation in real-world outpatients

Our model *(further described on Wednesday!)*

Evaluation (1)

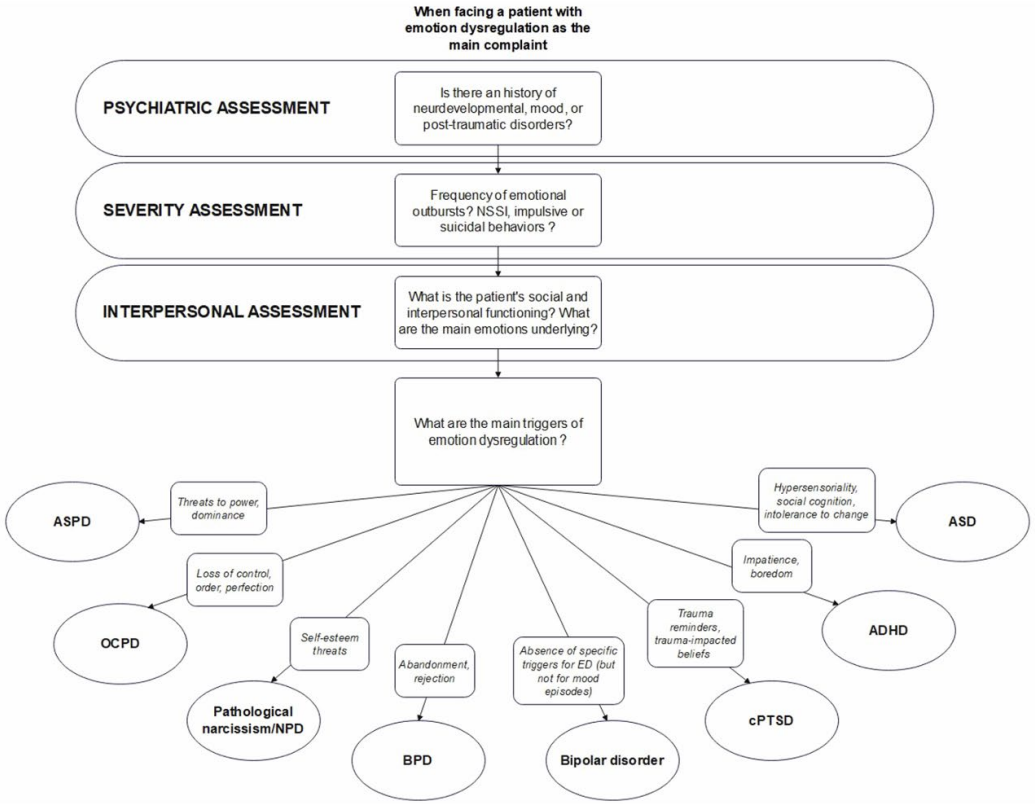


FIGURE 1
Sumary of our processual approach. ADHD, attention deficit hyperactivity disorder; ASD, autism spectrum disorder; BPD, borderline personality disorder; cPTSD, complex post-traumatic stress disorder; NPD, narcissistic personality disorder; OCPD, obsessive-compulsive personality disorder.

Evaluation (2)

TABLE 1 Summary of specific triggers and interpersonal styles.

Disorder		Trigger	Interpersonal style
Personality disorders	**Borderline personality disorder**	Real or imagined rejection and abandonment	Intense and unstable patterns of idealization and devaluation, emotional and identity dependency toward others
	Narcissistic personality disorder/ Pathological narcissism	Real or imagined self-esteem threats	Dependency on external admiration, validation or reassurance to regulate self-esteem, arrogancy and devaluation towards others, victimization
	Obsessive-compulsive personality disorder	Internal or external threat to perfection, order, or control	Tendency to overcontrol others' behaviors, or to avoid relationships because of fear of not meeting other's expectations. Relegation of relationships after one's productivity and effort.
	Antisocial personality disorder	Threats to power and dominance over others	Tendency to manipulate, lie, and exhibit aggressiveness toward others. Relations are marked by dominance and intimidation, with a lack of concern and remorse. Others are seen as ways to reach personal gains.
Other disorders	**Bipolar disorder**	No specific triggers for ED (autonomous variations), but not for mood episodes.	Euthymic bipolar patients have more stable relationships than BPD patients, but may present alterations linked with impulsivity, persistent depressive symptoms and neurocognitive impairments.
	Complex post-traumatic stress disorder	Reminders of traumatic events and trauma-impacted beliefs about self and relationships	Severe emotional detachment, tendency to avoid relationships, mistrust, feeling of worthlessness
	Autism spectrum disorder	Difficulties in filtering environmental stimuli (including sensory), cognitive rigidity (notably intolerance to change)	Lack of understanding of social norms, lack of willingness to enter in relations, lack of understanding non-verbal communication and social reciprocity
	Attention deficit hyperactive disorder	Impatience, boredom	Too talkative and excitable, impulsivity and novelty seeking leading to logistical and organizational issues

Treatment

TABLE 2 Summary of general and specific therapeutic interventions in terms of psychoeducation, narrative work, and goal setting.

Disorder		Psychoeducation	Narrative work	Goal setting
Every disorder (General interventions)		Focusing on the concept of ED, using DBT, MBT, or other evidence-based conceptualizations.	Focusing on the early signs of emotion dysregulation in childhood, and on the mismatch between the patients' needs and what the environment provided.	Focusing on providing emotion regulation guidelines and learning chain analysis.
Other disorders	**Bipolar disorder**	Focusing on depressive and manic episodes characteristics, on the differences between mood and emotion, and on the importance of medication.	Focusing on the early signs of the disorder (e.g., severe depressive episodes in adolescence) and on the link with family history.	Focusing on the equilibration, tolerance, and adherence to medication (notably through the development of a transparent therapeutic relationship), but also on the importance of overall life hygiene and self-monitoring of symptomatic relapses.
	Complex post-traumatic stress disorder	Focusing on the three dimensions of PSTD and their biological underpinnings, on the disturbance of self-organization symptoms, and on the construction of an individualized trauma-model (encompassing typical reviviscences triggers, maladaptive avoidance, and escape behaviors)	Focusing on *how and why* disturbance of self-organization symptoms appeared, with for example the use of the traumatic invalidation model.	Focusing on the access and conduction of specific trauma-focused psychotherapy (e.g., EMDR, TF-CBT, DBT-PTSD, MBT-PTSD), with possibly a special emphasis on motivation to change, skills-assisted exposure, and radical acceptance.
	Autism spectrum disorder	Focusing on social cognition, hyper-sensoriality, and intolerance to change issues, and on how these symptoms may be linked with ED.	Focusing on the notion of neurodevelopmental disorder and on the exploration of symptoms throughout patient's history (e.g., childhood, adolescence, and adulthood).	Focusing on social cognition learning, with also an emphasis on the treatment framework (low-noise location, no unexpected changes in agenda) and on cognitive flexibility.
	Attention deficit hyperactive disorder	Focusing on hyperactivity and inattention symptoms, with a clear emphasis on their neurobiological underpinnings and on their link with ED. Also provide psychoeducation on medication.	Focusing on the notion of neurodevelopmental disorder and on the exploration of symptoms throughout patient's history (e.g., childhood, adolescence, and adulthood), with also a clear emphasis on the link between ADHD symptoms and socio-educative issues.	Focusing on the importance of psychostimulant medication equilibration, tolerance, and adherence, but also of psychotherapy (notably through cognitive rehabilitation and development of compensating strategies).

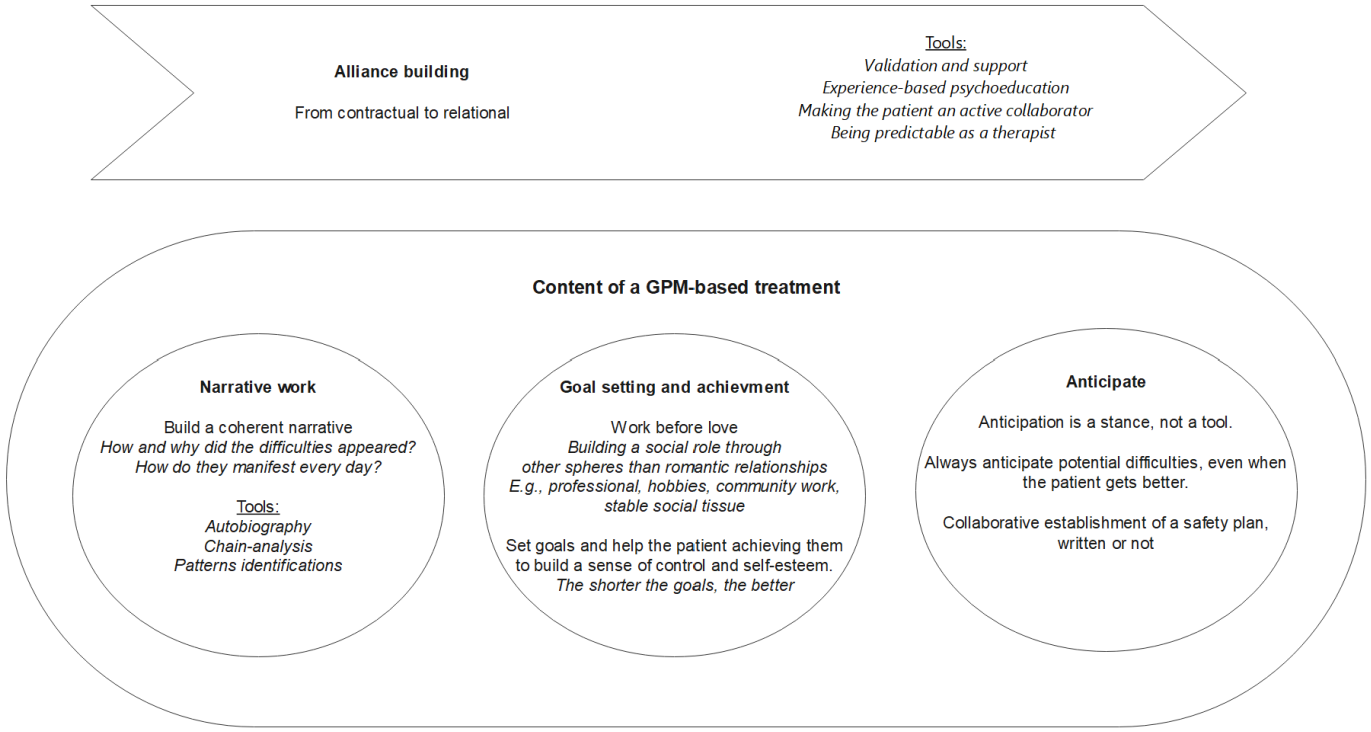
GPM-extended

General presentation

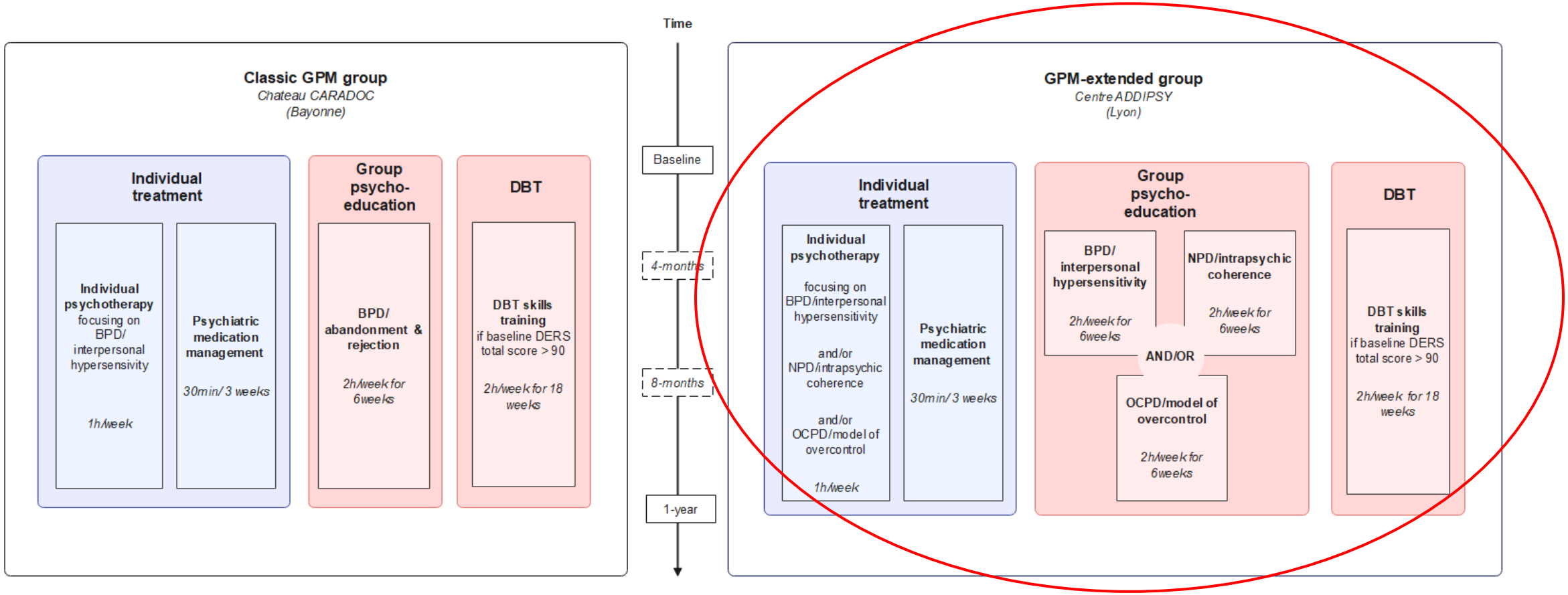
- GPM-extended builds on the foundational principles of GPM for BPD
- Diagnostic process focuses on BPD criteria and integrates dimensional AMPD tools (for personality functioning)
- This process is enhanced using the three main GPM dilemmas developed at that time to assess *how* one's personality may dysfunction.
- The assessment of the presence/absence and relevance of each dilemma for each patient relies on both clinical and psychometric investigation
- Once the main dilemmas are identified, both the clinician and the patient work on a clear prioritization of the treatment targets, with the most impacting dilemmas being the first one to focus on.

Treatment content

- The content remains the same… but GPM-extended tailors psychoeducation and case management to each patient's specificities.



The EPSYLIA study



Outcomes

- Primary : change in overall intensity of ED, as assessed by the DERS total score, between before and after 1 year of treatment.
- Secondary : change between before and after 1 year of treatment on
  - Emotion dysregulation subdimensions severity, using DERS sub-scores
  - Interviewer-rated BPD symptoms, using the ZAN-BPD total score
  - Self-rated BPD symptoms, using the BSL-23 mean score
  - Emotion dysregulation related behaviors, including anger outbursts, affective dysregulation, self-harming/suicidal behaviors, and self-damaging impulsive behaviors, using ZAN-BPD’s items 1, 2, 7 and 8 scores.

Methods

- Data from the larger EPSYLIA study (NCT06913738) were used for the present analyses.
- Inclusion criteria :
  - 1°) being >18 years old
  - 2°) having a diagnosis of BPD made using the SCID-II
  - 3°) having signed an informed consent
  - 4°) being affiliated with or beneficiary of the French social security system.
- Scale used in the present analyses
  - SCID-II, ZAN-BPD, BSL-23, DERS
- Analyses:
  - On complete cases only.
  - Paired Student t tests (or Wilcoxon tests), effect sizes.

Results (1)

- 33 patients diagnosed with BPD were included in the study (mean age = 27.85 (SD = 7.33) years, 69.7% female).
  - 2 drop out, 5 finishers that did not undergo the final evaluation
  - 26 patients underwent final psychometric evaluation, with only 25 fulfilling DERS and BSL
- With 25 pairs, we had 80% statistical power to detect a medium-sized effect (d = 0.58) on the total DERS score in a two-tailed paired t-test at a significance level of 5%,

Table 12. Baseline characteristics of the 33 patients treated with GPM-extended

Quantitative variables – Mean (SD) [range]	
Age	27.85 (7.33) [19-49]
Number of previous	
Day hospitalization	0.64 (1.11) [0-5]
Inpatient hospitalization	2.82 (3.4) [0-15]
Suicide attempts	1.97 (2.54) [0-10]
ZAN-BPD total score	15.69 (5.57) [3-28]
BSL-23 mean score	2.17 (0.85) [0.3-3.69]
DERS total score	127.12 (19.6) [78-159]
Qualitative variable – n (%)	
Sex (female)	23 (69.7%)
Comorbid personality disorder	
Narcissistic	11 (33.3%)
Obsessive-compulsive	18 (54.55%)

Abbreviations: BSL-23 = Borderline Symptom List – 23 items, DERS = Difficulties in Emotion Regulation Scale – 36 items, ZAN-BPD = Zanarini Rating Scale for Borderline Personality Disorder

Results (2)

- Regarding treatment delivered, 3 therapists were involved
  - Therapist 1 = 21, 63.84%
  - Therapist 2 = 9 (27.27%)
  - Therapist 3 = 3 (9.09%)).
- Alongside individual therapy
  - 31 patients underwent the BPD-focused psychoeducation group (93.94%)
  - 14 underwent the narcissism-focused psychoeducation group (42.42%)
  - Only one 1 underwent the OCPD-focused psychoeducation group (3.03%), the lack of participation was mostly due to organizational reasons
  - 26 patients underwent the DBT-skills training group (78.79%).

Results (3)

- Significant decrease in overall ED severity with a strong effect size, and with an intensity going from severe to mild
  - At the subscale level, only lack of emotional awareness did not decrease significantly
- Regarding borderline symptom severity, we observed a significant decrease in the BSL mean score and ZAN-BPD total score, with strong effect sizes, going from high to moderate intensity (BSL) and from moderate to mild intensity (ZAN-BPD).
  - At the item level, significant decreases were observed for anger, affective dysregulation, suicidal behaviors and/or non-suicidal self-injury and self-damaging impulsive behaviors, with small-to-medium effect sizes.
- Finally, at the diagnostic level, 10/26 patients did not fulfill the BPD diagnosis anymore after treatment (38.46%).

Table 13. Pre-post comparison of patients.

Variables	Pre – m (SD)	Post - m (SD)	Test value (p)	d
DERS				
Total	127.12 (19.60)	99.20 (24.95)	**t=6.03 (<0.001)**	1.21
Awareness	16.78 (5.00)	15.40 (6.07)	t=1.10 (0.280)	0.22
Clarity	16.09 (4.51)	12.08 (4.12)	**t=5.24 (<0.001)**	1.05
Non-acceptance	20.81 (6.42)	16.36 (6.60)	**t=3.15 (0.004)**	0.63
Impulsive behaviors	21.12 (6.00)	13.72 (4.99)	**t=7.70 (<0.001)**	1.54
Engagement	21.84 (2.87)	19.80 (4.50)	**V= 200.5 (0.017)**	0.44
Strategies	30.47 (5.85)	21.84 (6.23)	**V = 265 (<0.001)**	1.24
BSL mean score	2.17 (0.85)	1.35 (0.93)	**t=5.44 (<0.001)**	1.09
ZAN-BPD				
Total score	15.69 (5.57)	9.77 (7.13)	**t=4.19 (<0.001)**	0.82
Anger	1.38 (1.04)	0.92 (0.98)	**V=108.5 (0.033)**	0.44
Affective dysregulation	2.22 (1.26)	1.50 (1.48)	**t=2.77 (0.01)**	0.54
Suicidal behaviors and/or non-suicidal self-injury	0.53 (0.92)	0.08 (0.27)	**V=33 (0.037)**	0.45
Self-damaging impulsive behaviors	1.88 (1.39)	1.23 (1.11)	**t=2.41 (0.024)**	0.47

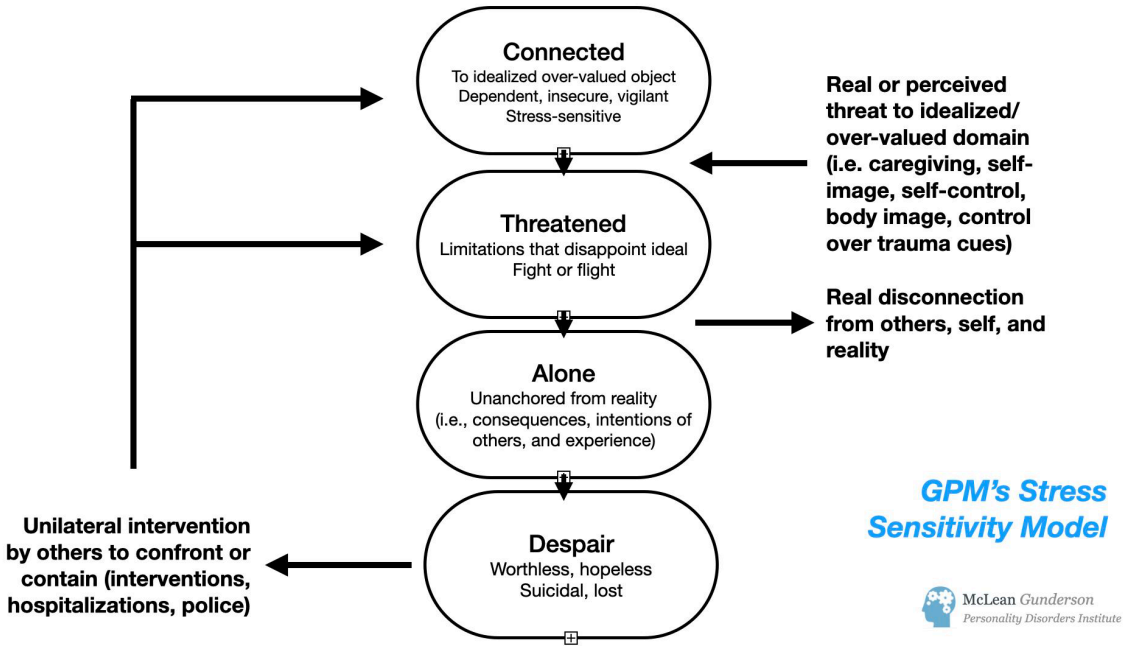
What can we say?

Summary of results

- These preliminary results suggested that, despite important methodological limitations, a dimensional *trigger-based* of GPM (GPM-extended) was feasible in routine outpatient care and can lead to clinically meaningful improvements of ED and BPD symptoms
- Furthermore, they offer preliminary support for the use of GPM as a foundational framework for a modular approach to the treatment of personality disorders.
  - GPM was not only used as a generalist treatment but also as an overarching clinical framework that structures the integration of additional therapeutic components according to patients' predominant personality profile.
- But many, many limitations to take into account…

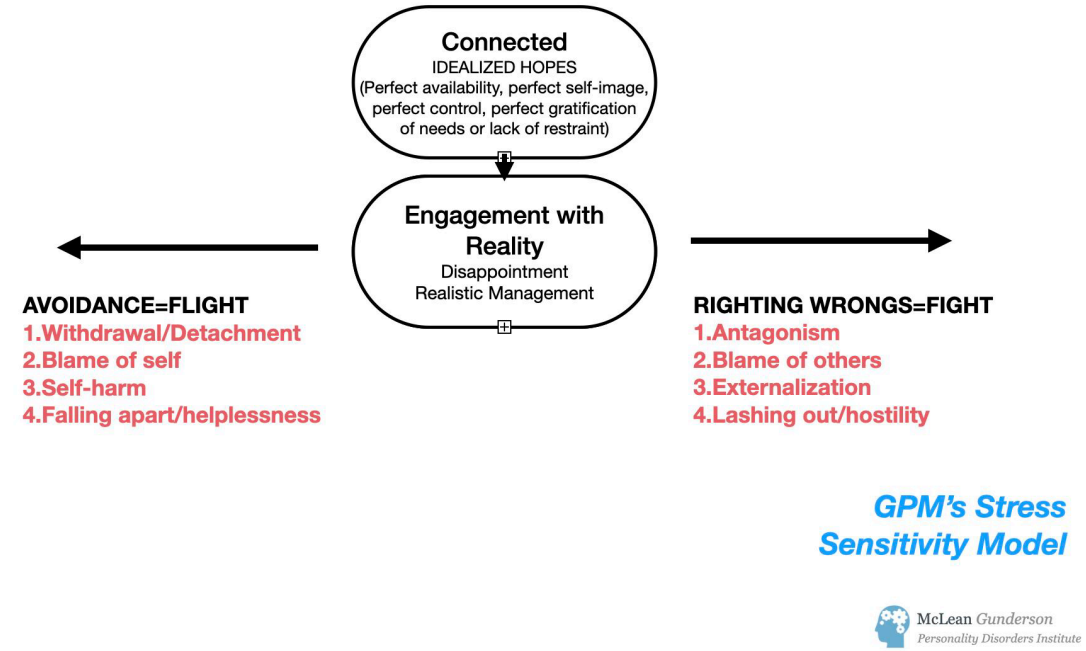
Towards a stress-sensitive GPM general conceptualization?

- While the notion of triggers provides a descriptive and clinically useful framework for ED conceptualization and treatment, we believe that it can also be used more broadly in the specific context of PDs.
- In these disorders, triggers can be understood as situations in which the mechanisms that ordinarily support self-regulation are compromised or temporarily lost.
  - This interpretation introduces a *stress-sensitive* dimension to the trigger-based model, not as an initial assumption, but as a second-order explanatory framework.
- Put in other words, in PD patients, triggers do not *actually* provoke emotional reactions. Rather, they signal a loss or threat to the structures that ordinarily support self-regulation.
  - ED may thus emerge when these individuals are no longer able to rely on their usual strategies to regulate their identity, emotions, and sense of agency.



GPM's Stress Sensitivity Model

McLean Gunderson
Personality Disorders Institute



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Thank you for your attention.

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