2nd General Psychiatric Management (GPM) International Congress

MAY 4 & 5, 2025

Karolinska Institute, Stockholm, Sweden

In Collaboration with:

Psykiatri Sydväst Stockholm

&

McLean Hospital Gunderson Personality Disorders Institute (GPDI)

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Foto: Kathrin Dellblad

Programme

International Conference on Good Psychiatric Management for Personality Disorders 4-5 May 2026

Karolinska Institutet, Campus Flemingsberg

In collaboration with:

Psykiatri Sydväst
REGION STOCKHOLM

McLean Gunderson
Personality Disorders Institute

Karolinska Institutet

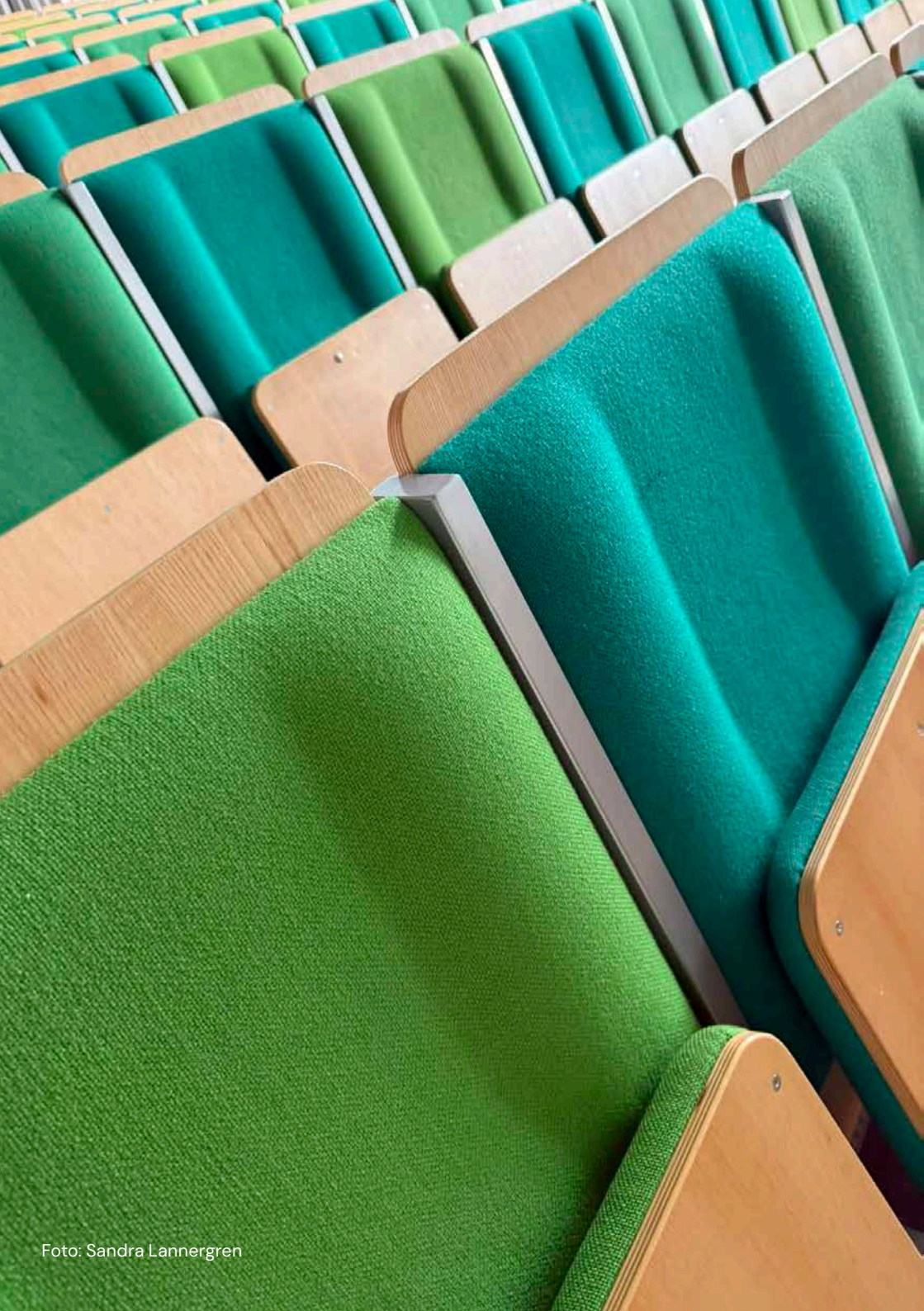

Foto: Sandra Lannergren

International Conference on Good Psychiatric Management for Personality Disorders

STOCKHOLM 4–5 MAY 2026

We welcome you to two days filled with updates on research, method development, and discussions about Good Psychiatric Management in different contexts.

You will meet researchers and clinicians from various areas of mental health care and from different parts of the world, who we hope will inspire you in how you can use GPM in your own practice. We also believe that you will build networks with dedicated and insightful colleagues!

The Swedish Organizing Committee

Good psychiatric management is emerging as a compromise between manualized therapies built for severe personality disorders and the usual treatments that are administered in the real world of clinical services. It provides the structure, knowledge base, and principles that map out pitfalls and roads to progress, like the specialist treatments, but encourages clinicians to remain professional while also being thoughtful about how to adapt their care to each individual case."

Lois Choi-Kain, Director, Gunderson Personality Disorders Institute

Programme day 1 | 4 MAY

Lecture hall H2	
08.30–09.00	REGISTRATION
09.00–09.15	Welcome **Dr. Lois Choi-Kain, director of the Gunderson Personality Disorders Institute** **Christian Rück, professor, senior physician, Department of Clinical Neuroscience, KI** **Lina Martinsson, MD, PhD, Department of Clinical Neuroscience, KI, Senior Psychiatrist, Head of Psykiatri Sydväst, Sweden**
09.15–09.45	State of GPM 2026 **Dr. Lois Choi-Kain, director of the Gunderson Personality Disorders Institute**
09.45–10.30	GPM as frame for an out-patient personality disorders clinic at Psykiatri Sydväst **Georgia Tzavara, psychologist** **Jeanette Lindholm, psychiatric nurse** **Anton Sandell, psychologist** **Ola Starck, social worker** **Niki Sundström, psychologist, director** **Peder Björling, consultant psychiatrist, medical director** **Sarah Gullbjörk, user involvement coordinator**
10.30–11.00	COFFEE BREAK
11.00–11.20	GPM implementation in northern Sweden **Lina Olsson, social worker, psychotherapist, psychiatric clinic, Region Västerbotten** **David Singmo, psychologist, psychiatric clinic, Region Västerbotten**
11.20–11.30	GPM as entry point at a general psychiatric clinic **Hanna Rösman, consultant psychiatrist, medical director, out-patient clinic 8, Norra Stockholms Psykiatri** **Lo Edberg, psychologist, out-patient clinic 8, Norra Stockholms Psykiatri**
11.30–11.50	When MBT and DBT therapists unite: Implementation and clinical experiences from a GPM matched register control study **Sophie I. Liljedahl, National Specialized Medical Care Unit for Severe Self-Harm Behaviours Sahlgrenska University Hospital, Gothenburg, Center for Personality Disorder, Sahlgrenska University Hospital** **Lina Nordström, Center for Personality Disorders, Department of Affective Psychiatry; Center for Personality Disorder, Sahlgrenska University Hospital** **Dr. Lois Choi-Kain, director of the Gunderson Personality Disorders Institute**
11.50–12.10	PANEL
12.10–13.10	LUNCH

Lecture hall H2	
13.10–13.40	GPM as a framework for a dimensional, trigger-based approach to emotion dysregulation in borderline personality disorder **Martin Blay, MD, MSc psychiatrist at ADDIPSY (SBD group), Lyon, France**
13.50–14.10	GPM and alcohol use disorder framework **Dr. Lois Choi-Kain, director of the Gunderson Personality Disorders Institute**
14.10–14.30	Implementing at a SUD clinic **Susanna Krus, specialist nurse, specialist psychologist, Adult Psychiatry Clinic – Addiction, Malmö** **Klara Schultz, psychologist, specialist psychologist, Adult Psychiatry Clinic – Addiction, Malmö** **Isabel Jadbäck, specialist psychologist, Adult Psychiatry Clinic – Addiction, Malmö**
14.30–14.50	PANEL
14.50–15.20	COFFEE BREAK
15.20–15.50	GPM-complex cases **Cathy McLeod Everitt, Service Development Manager, Borderline Personality Disorder Collaborative, Barossa Hills Fleurieu LHN, Mental Health Services, Australia** **Laura Cooke-O'Connor, Borderline Personality Disorder Collaborative, Adelaide**
15.50–16.20	GPM in the psychiatric emergency services Australia **Melissa Casey, professor, principal psychologist and founder of Agile Mental Health**
16.20–16.40	CONCLUDING REMARKS
18.00	CONFERENCE DINNER

Programme day 2 | 5 MAY

Lecture hall H2	
09.00-09.30	Personality Disorder and autism (UK) **Robert Dudas, affiliated assistant professor at University of Cambridge**
09.30-10.00	GPM-eating disorders **Kimberley Siscoe, consultant psychiatrist, Eating Recovery Centre, Denver** **Marcelo J. A. A. Brañas, M.D. co-director, Adolescent BPD Outpatient Program (ADRE)** **Marcos Signoretti Croci, Doctor of Medicine, co-director, Adolescent BPD Outpatient Clinic**
10.00-10.30	GPM for complex eating disorder **Anja Lewin, social worker, director, Stockholm Center for Eating disorders** **Sara Botolfsson, social worker, counsellor, Stockholm Center for Eating disorders** **Sara Petersson, psychologist, Stockholm Center for Eating disorders**
10.30-11.00	COFFEE BREAK
11.00-11.15	GPM for ADHD **Jihed Seli, consultant psychiatrist, Le Jolimont**
11.15-11.30	Adapting GPM-A for conduct disorder **Kiely Foley, psychiatric nurse practitioner, Maine Behavioral Health**
11.30-12.00	PANEL
12.00-13.00	LUNCH

Lecture hall H2	
13.00–13.30	GPM in primary health care (US) **Dr. Lois Choi-Kain, Gunderson Personality Disorder Institute, McLean Hospital, Boston, USA** **Dr. Mithira Nithianandan, acting executive clinical director, Spectrum – statewide service specialising in personality disorder and complex trauma, Victoria, Australia**
13.30–13.50	Teaching GPM to Primary health care **Josefin Rashidi, psychologist, Psychiatric Clinic, team for emotional instability, Malmö**
13.50–14.00	PANEL
14.00–14.20	Implementing GPM-A in Brazil **Marcelo J. A. A. Brañas, M.D. co-director, Adolescent BPD Outpatient Program (ADRE)** **Marcos Signoretti Croci, Doctor of Medicine, co-director, Adolescent BPD Outpatient Clinic**
14.20–14.30	New Zealand - GPM implementation **Sonja Quan, consultant psychiatrist, Kāinga Tiaki Centre, New Zealand**
14.30–15.00	COFFEE BREAK
15.00–15.20	GPM and ICD-11 in Practice: Developing Group Treatment for Personality Disorders Beyond BPD **Erik Ydrefelt, licensed psychologist, Outpatient Clinic for Emotionally Unstable Personality Disorder, Malmö. Clinical Lead, Standardized Care for Personality Disorders, Region Skåne, Sweden** **Manne Frankenstein, psychiatrist, Outpatient Clinic for Emotionally Unstable Personality Disorder, Malmö, Outpatient Clinic for Bipolar Disorder, Malmö, Sweden**
15.20–15.40	First data on GPM-internet treatment **Dan Bengtsson, psychologist, Phd student, Personality Disorders Clinic, Psykiatri Sydväst**
15.40–16.10	Addressing spiritual and transcendent experiences in borderline personality disorder using Good Psychiatric Management and other evidence-based treatments **Brandon Unruh, M.D. Harvard Medical School, Medical Director, Gunderson Residence; Director, Mentalization-Based Treatment Clinic** **Sophie I. Liljedahl, National Specialized Medical Care Unit for Severe Self-Harm Behaviours Sahlgrenska University Hospital, Gothenburg, Center for Personality Disorders, Sahlgrenska University Hospital**
16.15–17.00	Summarizing Panel: GPM Future directions **Moderator: Dr. Lois Choi-Kain, director of the Gunderson Personality Disorders Institute**

Organisers

The conference is a collaboration between Dr. Lois Choi-Kain of the Gunderson Personality Disorders Institute, Karolinska Institutet (Department of Clinical Neuroscience), and Psykiatri Sydväst, Sweden.

Karolinska Institutet

Karolinska Institutet Executive and Professional Education provides professional development for regional authorities, municipalities, and companies — primarily within healthcare, social care, and health — and works to support the development of healthcare services and a healthier society.

Lois Choi-Kain, Director of the Gunderson Personality Disorders Institute, Harvard Medical School, USA

Lois Choi-Kain is the Director of the GPM Trainers and Researchers Network which connects clinicians and researchers invested in GPM training and research. She has a long history of training clinicians in DBT, MBT and GPM and developing training programs.

Her own research focuses on personality disorders, novel adaptations and methods in psychotherapy. Lately her focus has been access to care for patients with personality disorders. She is a frequent key-note speaker and author/co-author of multiple books.

The Personality Disorders Program at Psykiatri Sydväst, Sweden

Our out-patient clinic for personality disorders started in 2016, with the mission of assessing and treating individuals with personality disorders. A staff of 15 clinicians are responsible for about 250 patients. In order to provide care for people with different personality profiles and needs, we have implemented a range of treatments, including MBT for BPD and NPD, GPM for personality disorders, and individually tailored GPM-based approaches for complex cases.

Director Niki Sundström, Medical Director Peder Björling

List of presenters

Mats Adler	Associate Professor, Consultant Psychiatrist, Psykiatriutveckling Sverige AB, Sweden
Dan Bengtsson	Psychologist, PhD student, Personality Disorders Clinic, Psykiatri Sydväst, Sweden
Peder Björling	Consultant Psychiatrist, Medical Director, Personality Disorders Clinic, Psykiatri Sydväst, Sweden
Martin Blay	M.D., MSc Psychiatrist at ADDIPSY (SBD group), Lyon, PhD candidate in Clinical Research (Graduate School Santé Publique Paris-Saclay) Member of the European Society for the Study of Personality Disorders (ESSPD) President-founder of Lyon's Network of Personality Disorders, France
Sara Botolfsson	Social Worker, Counsellor, Stockholm Centre for Eating disorders, Sweden
Marcelo J. A. A. Brañas	M.D., Co-director, Adolescent BPD Outpatient Program (ADRE), Institute of Psychiatry, School of Medicine, University of São Paulo, Brazil
Melissa Casey	Professor, Principal Psychologist and founder of Agile Mental Health
Lois W. Choi-Kain	M.D., M.Ed., Director, Gunderson Personality Disorders Institute, Associate Professor of Psychiatry, Harvard Medical School, Distinguished Fellow, American Psychiatric Association, USA
Laura Cooke-O'Connor	Borderline Personality Disorder Collaborative, Adelaide, Australia
Marcos Signoretti Croci	M.D., Co-director, Adolescent BPD Outpatient Clinic, Department of Psychiatry, University of São Paulo, Brazil
Robert Dudas	M.D., PhD, FRCPsych PGCert Med Ed, Affiliated Assistant Professor at University of Cambridge, UK
Lo Edberg	Psychologist, out-patient clinic 8, Norra Stockholms Psykiatri, Sweden

Cathy McLeod Everitt	Service Development Manager, Borderline Personality Disorder Collaborative, Barossa Hills Fleurieu LHN, Mental Health Services, Australia
Manne Frankenstein	Psychiatrist, Outpatient Clinic for Emotionally Unstable Personality Disorder, Malmö, Outpatient Clinic for Bipolar Disorder, Malmö, Sweden
Kiely Foley	Psychiatric Nurse Practitioner, Maine Behavioral Health, USA
Sarah Gullbjörk	User Involvement Coordinator, Psykiatri Sydväst and Psykiatricentrum Södertälje, Sweden
Isabel Jadbäck	Psychologist, SUD-clinic Malmö, Sweden
Susanna Krus	Psychiatric Nurse, SUD-clinic Malmö, Sweden
Anja Lewin	Social Worker, Director, Stockholm Center for Eating disorders, Sweden
Sophie I. Liljedahl	National Specialized Medical Care Unit for Severe Self-Harm Behaviours, Sahlgrenska University Hospital, Gothenburg, Center for Personality Disorder, Sahlgrenska University Hospital, Institute of Neuroscience and Physiology, Sahlgrenska Academy, University of Gothenburg, Sweden
Jeanette Lindholm	Psychiatric Nurse Practitioner, Personality Disorders Clinic, Psykiatri Sydväst, Sweden
Lina Martinsson	M.D., PhD Department of Clinical Neuroscience, KI, Senior Psychiatrist, Head of Psykiatri Sydväst, Sweden
Hanna Rösman	Consultant Psychiatrist, Medical Director, out-patient clinic 8, Norra Stockholms Psykiatri, Sweden
Georgia Tzavara	Psychologist, Personality Disorders Clinic, Psykiatri Sydväst, Sweden
Mithira Nithianandan	Acting Executive Clinical director, Spectrum - statewide service specialising in personality disorder and complex trauma, Victoria, Australia
Lina Nordström	Psychologist, PhD student, Center for Personality Disorders, Sahlgrenska University Hospital, Institute of Neuroscience and Physiology, Sahlgrenska Academy, University of Gothenburg, Sweden

Lina Olsson	Social Worker, psychiatric clinic, Region Västerbotten, Sweden
Sara Petersson	Psychologist, Stockholm Center for Eating disorders, Sweden
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Erik Ydrefelt	Licensed Psychologist, Outpatient Clinic for Emotionally Unstable Personality Disorder, Malmö. Clinical Lead, Standardized Care for Personality Disorders, Region Skåne, Sweden

Foto: Ulf Sirborn

As one of the world's foremost medical universities, Karolinska Institutet (KI) accounts for the single largest share of all academic medical research conducted in Sweden. KI also offers the country's broadest range of education in medicine and health sciences.

Karolinska Institutet offers professional education for health care professionals in areas such as global & public health, primary care, dentistry and management & organisation.

ki.se/epe

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McLean Gunderson
Personality Disorders Institute

Karolinska Institutet

GPM in 2026 as a General Model of Outpatient Care for Personality Disorders across the Swedish System

Morning May 4th

9:00 A.M. Welcome

9:15 A.M. State of GPM 2026

9:45 A.M. GPM as frame for an out-patient personality disorders clinic at Psykiatri sydväst

11:00 A.M. GPM implementation in northern Sweden

11:20 A.M. GPM as an entry point at a general psychiatric clinic

11:30 A.M. When MBT and DBT therapists unite: Implementation and clinical experiences from a GPM matched register control study

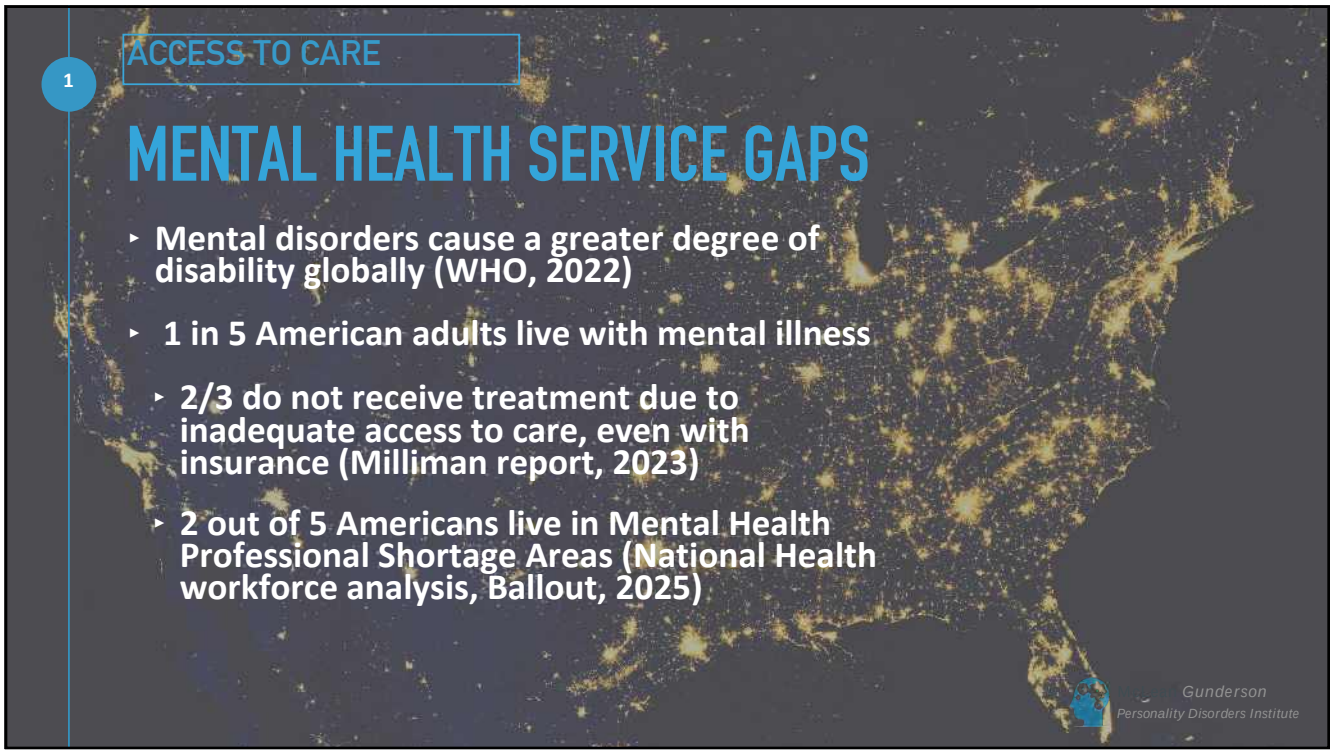
11:50 A.M. Panel


UPDATES IN 2026: STOCKHOLM EDITION
GOOD PSYCHIATRIC MANAGEMENT 2.0
(GPM 2.0)
Lois W. Choi-Kain M.D. M.Ed.
Gunderson Personality Disorders Institute, McLean Hospital
Department of Psychiatry, Harvard Medical School
McLean Gunderson
Personality Disorders Institute

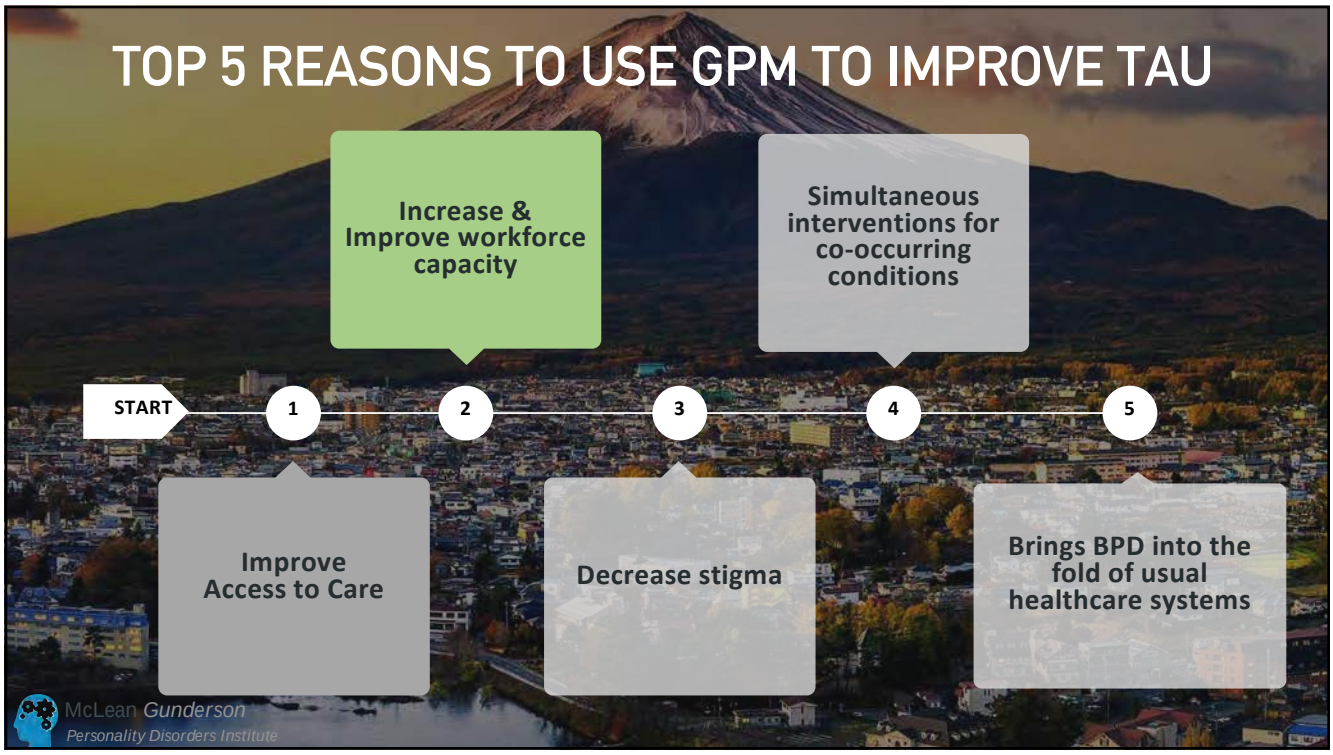
1


TOP 5 REASONS TO USE GPM TO IMPROVE TAU
START
1
Improve Access to Care
2
Increase & Improve workforce capacity
3
Decrease stigma
4
Simultaneous interventions for co-occurring conditions
5
Brings BPD into the fold of usual healthcare systems
McLean Gunderson
Personality Disorders Institute

2


1
ACCESS TO CARE
MENTAL HEALTH SERVICE GAPS
Mental disorders cause a greater degree of disability globally (WHO, 2022)
1 in 5 American adults live with mental illness
2/3 do not receive treatment due to inadequate access to care, even with insurance (Milliman report, 2023)
2 out of 5 Americans live in Mental Health Professional Shortage Areas (National Health workforce analysis, Ballout, 2025)
Gunderson
Personality Disorders Institute

3


TOP 5 REASONS TO USE GPM TO IMPROVE TAU
Increase & Improve workforce capacity
Simultaneous interventions for co-occurring conditions
START
1
2
3
4
5
Improve Access to Care
Decrease stigma
Brings BPD into the fold of usual healthcare systems
McLean Gunderson
Personality Disorders Institute

4

INCREASE WORKFORCE CAPACITY

2

DEMAND FOR BPD CARE

- Not enough specialists in even best resourced countries to meet needs (Iliakis et al., 2019)
- Netherland: 1 specialists per 600 treatment seeking patients
- United States: 1 specialist per 6,000
- Poland: 1 specialist per 20,000
- South Korea: 1 specialist per 120,000
- Mexico: 1 specialist per 140,000

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5

INTRODUCTION

1

CARE IN HIGH INCOME COUNTRIES

- Netherlands (Hermens et al., 2011)
  - 23% BPD patients receive some form of psychotherapy, not EBTs and often suboptimal dosing
- Japan (Igo et al., 2025)
  - 11.8% therapists identify as DBT practitioners, 8.5% MBT practitioners
  - 52.3% supportive, 44.4% ecelectic, 40.5% psychoanalytic, and 37.3% CBT

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Table 1. Current Supply of the Behavioral Health Workforce

Profession	Year	Supply
Addiction counselor [a]	2022	99,771
Marriage and family therapist [a]	2022	28,066
Mental health counselor [a]	2022	135,662
Psychiatric aide [b]	2023	32,310
Psychiatric advanced practice registered nurse [c]	2022	39,354
Psychiatric physician assistant/associate [d]	2023	2,999
Psychiatrist [e]	2022	47,864
Psychologist [a, f]	2022	99,030
Social worker [a]	2022	537,338

[a] 2022 American Community Survey 5-year Public Use Microdata. [b] 2023 BLS Occupational Employment and Wage Statistics, May 2023. [c] 2022 American Psychiatric Nurses Association's Psychiatric Mental Health Nursing Workforce Survey [d] 2023 National Commission on Certification of Physician Assistants Annual Report. [e] 2022 American Medical Association Physician Professional Data. [f] Psychologist totals include psychologists with a PhD degree.

7

INCREASE WORKFORCE CAPACITY

2

TRAINING

- GPM training: 6-8 h one day training
- Live courses (donor funded)
- International trainers in four continents
- Used in training curriculums

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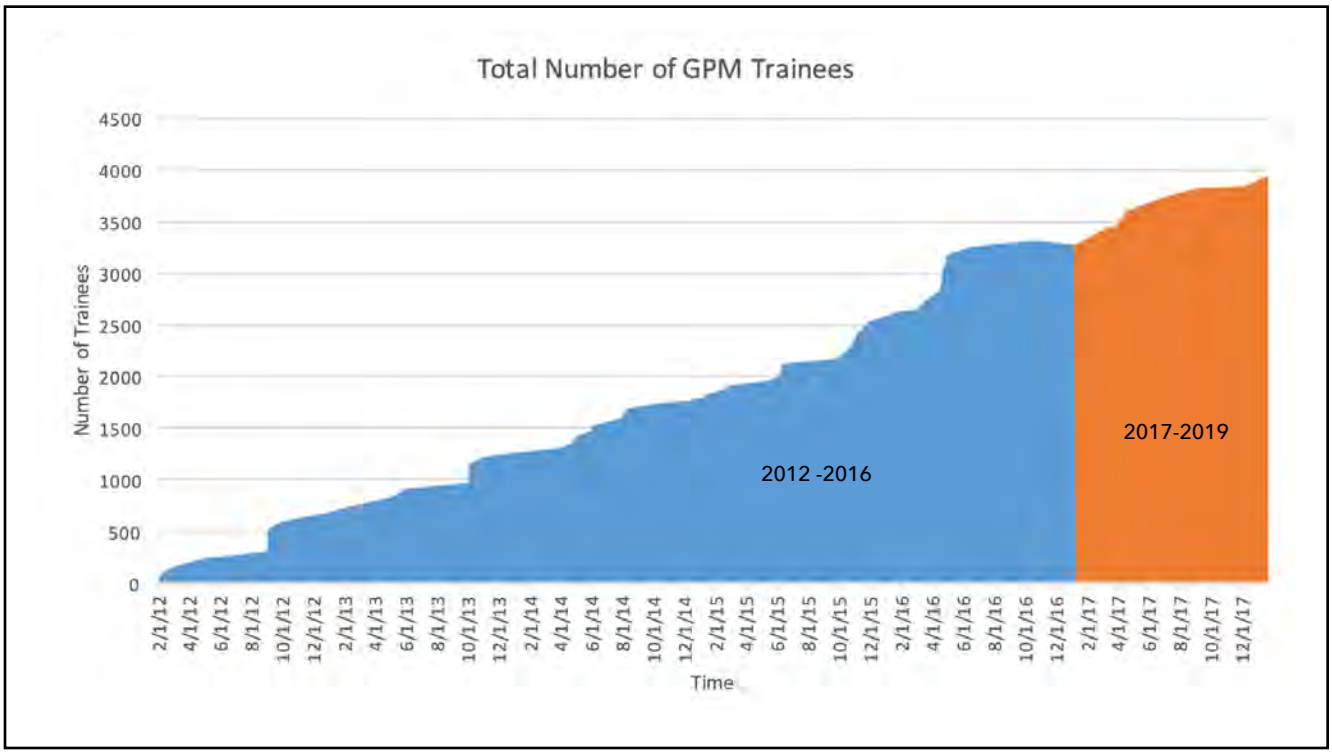
Total Number of GPM Trainees
Number of Trainees
4500
4000
3500
3000
2500
2000
1500
1000
500
0
2012 -2016
2017-2019
Time
2/1/12
4/1/12
6/1/12
8/1/12
10/1/12
12/1/12
2/1/13
4/1/13
6/1/13
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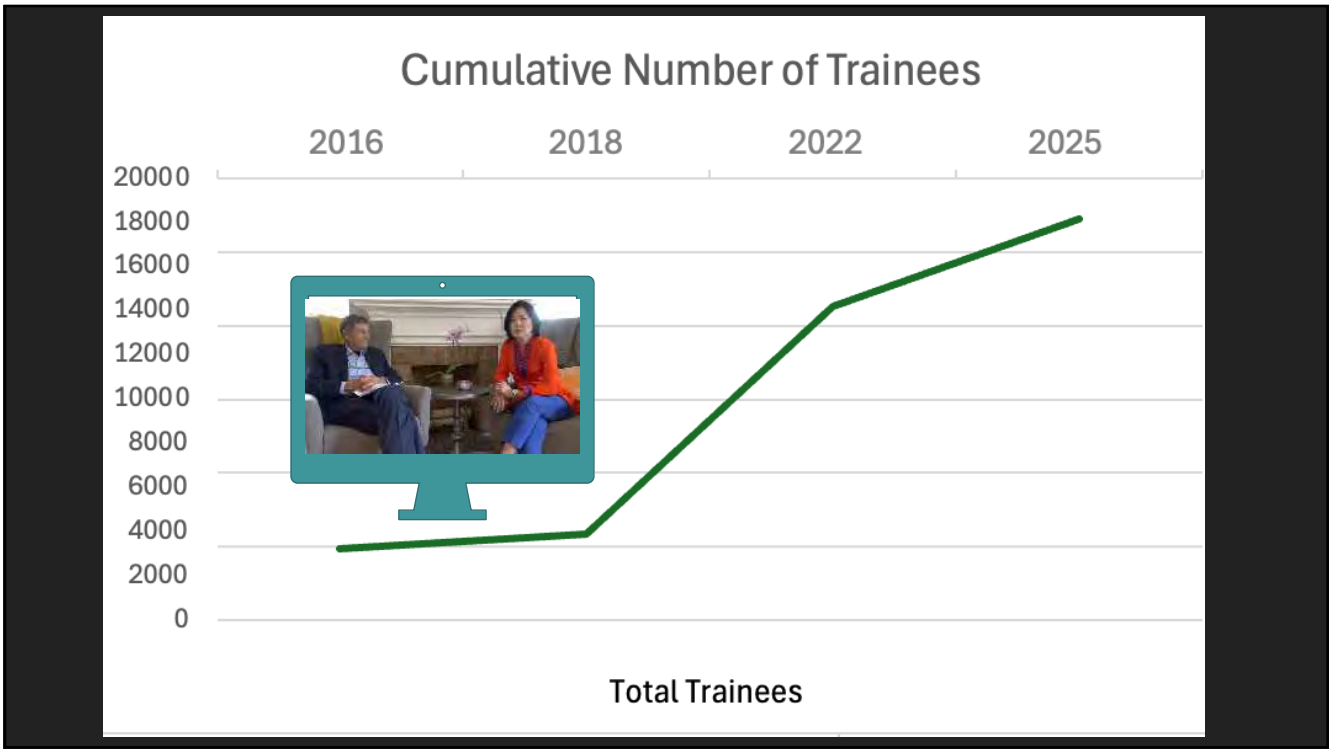
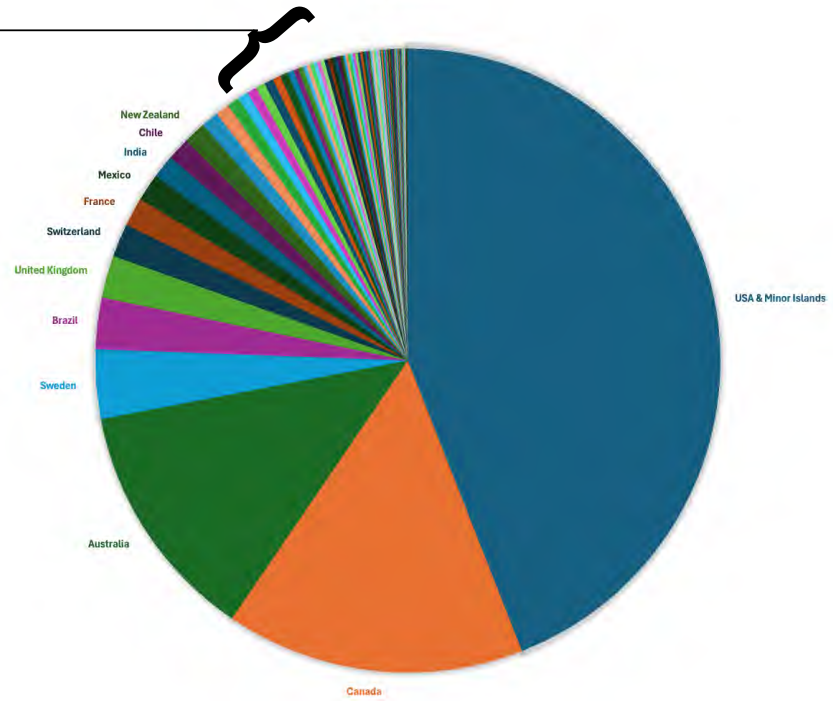

Cumulative Number of Trainees
2016
2018
2022
2025
20000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
Total Trainees

10

Other countries represented

117 COUNTRIES REPRESENTED

South Africa
Portugal
Germany
Greece
Singapore
Saudi Arabia
United Arab Emirates
Spain
Malaysia
Ireland
Hong Kong
Italy
Argentina
Peru
Indonesia
Romania
Pakistan
Colombia
China
Israel
Philippines
Japan
Georgia
Turkey
Poland
Paraguay
Lebanon
Finland
Belgium
Netherlands
Austria
Puerto Rico
Russia
Tanzania
Tunisia
Kuwait
Vietnam
Macao
Taiwan
New Caledonia
Barbados
Armenia
Grenada
Macedonia
Dominica
Korea
Denmark
Costa Rica
Kazakhstan
Morocco
Ecuador
Uruguay
Croatia
Thailand
Antigua and Barbuda
Bahrain
Czech Republic
Lithuania
Nigeria
Qatar
Luxembourg
Oman
Uganda
Montenegro
Sudan
Guatemala
Malta
Egypt
El Salvador
Bermuda
Cyprus
Azerbaijan
Serbia
Ukraine
Norway
Bangladesh
Iraq
Dominican Republic
Sri Lanka
Jordan
Venezuela
Nepal
Uzbekistan
Bosnia/Herzegovina
Ethiopia
Kenya
Myanmar
Ghana
Cambodia
Brunei
Iran
Guyana
Cayman Islands
Bulgaria
Afghanistan
Slovenia
Trinidad and Robago
Fiji
Albania
Algeria
Nicaragua
Bhutan
Bolivia
Saint Lucia



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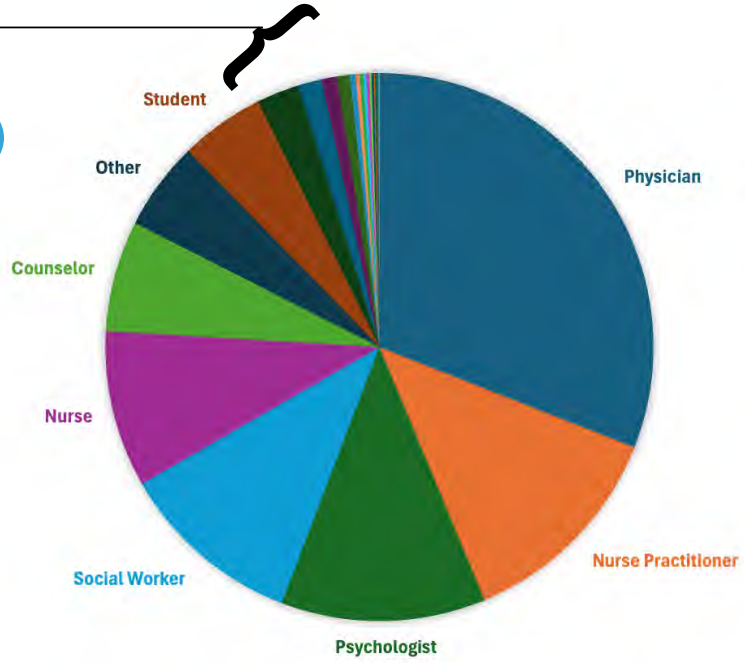
Other professions represented

Physician Assistant
Occupational Therapist
Coach/Consultant
Professor/Educator
Administrator
Researcher/Scientist
Dietitian
Employee of Industry
Pharmacist
Technician
Physical Therapist
Dentist
Chiropractor
Lawyer
Clergy
Athletic Trainer
Speech Pathologist
Optometrist

>26 PROFESSIONS REPRESENTED



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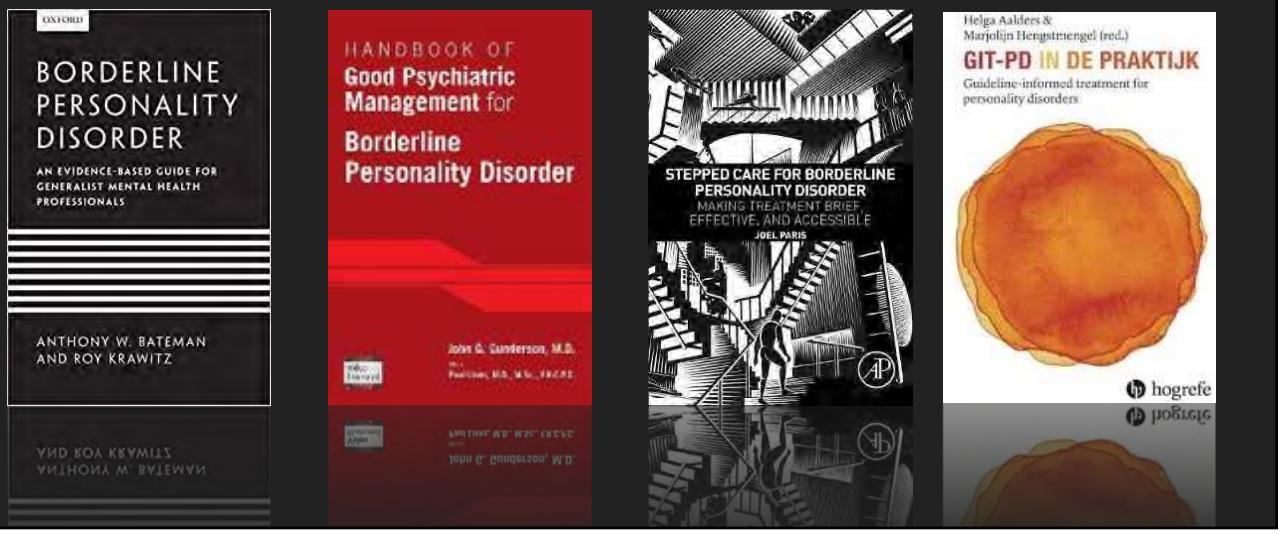
GENERALIST BPD TREATMENT



13

GENERALIST BPD TREATMENT

14


GPM Papers Published Per Year since 2009
20
18
16
14
12
10
8
6
4
2
0
2
1
0
3
4
4
4
7
6
8
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4
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19
4
2009
2010
2011
2012
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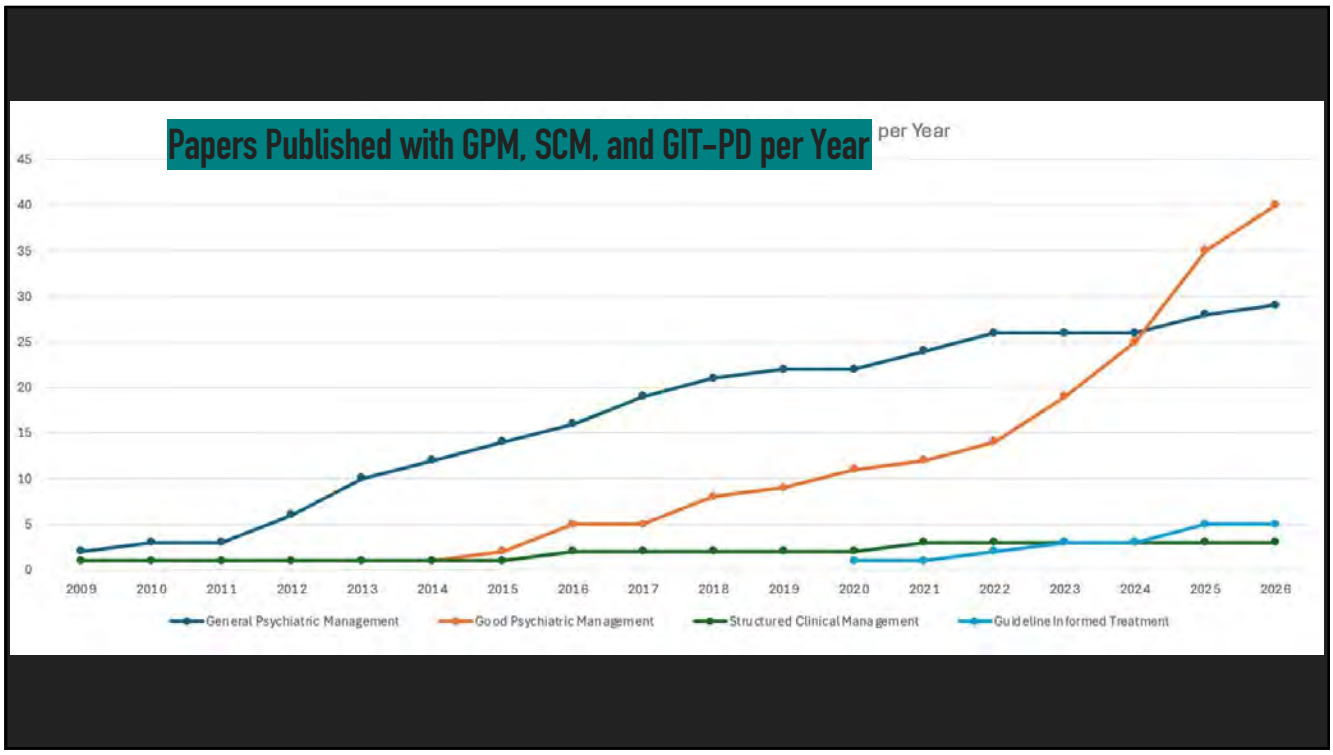
2018
2019
2020
2021
2022
2023
2024
2025
2026
GPM Papers Published Per Year

15


Papers Published with GPM, SCM, and GIT-PD per Year
per Year
45
40
35
30
25
20
15
10
5
0
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
General Psychiatric Management
Good Psychiatric Management
Structured Clinical Management
Guideline Informed Treatment

16

TOP 5 REASONS TO USE GPM TO IMPROVE TAU

START

1. Improve Access to Care
2. Increase & Improve workforce capacity
3. Decrease stigma
4. Simultaneous interventions for co-occurring conditions
5. Brings BPD into the fold of usual healthcare systems

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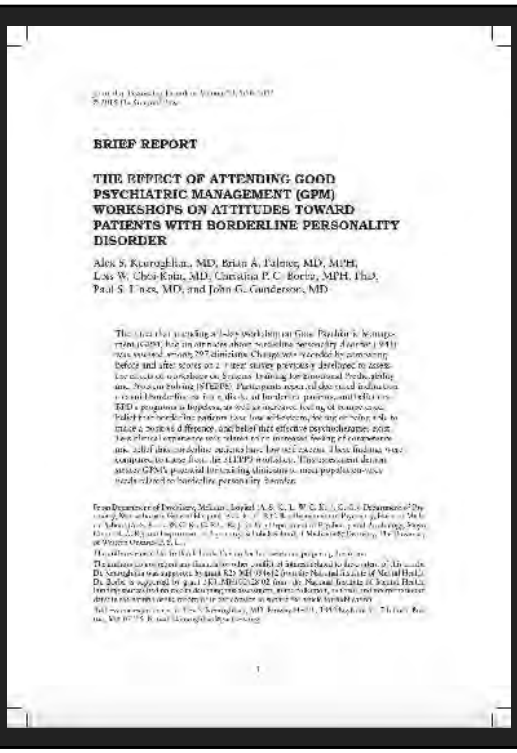
17

DECREASE STIGMA

TRAINING

GPM courses improves attitudes towards treating people with BPD to enhance compassion, empathy, willingness to take on patients, and provide the diagnosis…

3



BRIEF REPORT

THE EFFECT OF ATTENDING GOOD PSYCHIATRIC MANAGEMENT (GPM) WORKSHOPS ON ATTITUDES TOWARD PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Alex S. Kleinglass, MD, Brian A. Palmer, MD, MPH, Lois W. Choi-Kain, MD, Christina P. C. Boettig, MPH, PhD, Paul S. Links, MD, and John G. Gunderson, MD

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ORIGINAL ARTICLE

Enduring Effects of One-Day Training in Good Psychiatric Management on Clinician Attitudes About Borderline Personality Disorder

Sara Rose Masland, PhD, Daniel Price, MD,† Jacob MacDonald, BA,‡ Ellen Finch, BA,‡ John Gunderson, MD,‡§ and Lois Choi-Kain, MD‡§*

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Attitude Questionnaire

1. If I had a choice, I would prefer to avoid caring for a BPD patient.
2. I feel professionally competent to care for BPD patients.
3. I dislike BPD patients.
4. BPD is an illness that causes symptoms that are distressing to the BPD individual.
5. I feel I can make a positive difference in the lives of BPD patients.
6. The prognosis for BPD treatment is hopeless.
7. Some psychotherapies are very effective in helping patients with BPD.
8. I would like more training the management and treatment of BPD patients.
9. I have more difficulty feeling empathy/compassion for BPD patients than other patients.
10. I am less comfortable during sessions with BPD patients than with other patients.
11. I am confident in my ability to identify and diagnose BPD accurately.
12. I am willing to disclose the BPD diagnosis to patients.
13. I am willing to take on new patients with BPD.

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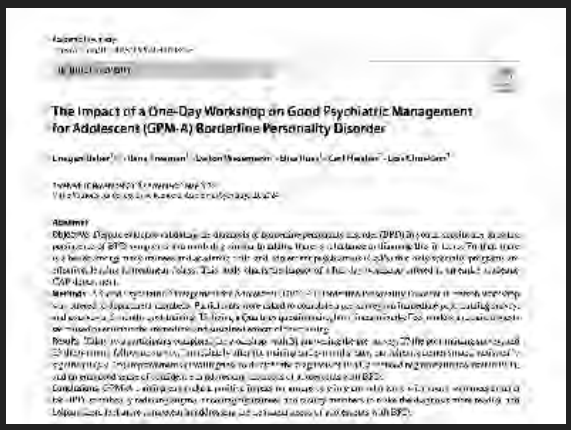
GPM–A TRAINING IN 8 HOURS

- 8 hour GPM-A training in child fellowship program at OHSU (n=32)
- Pre and post test assessment of attitudes
- Immediately after training, participants were more willing to disclose the diagnosis, had reduced negative attitudes, and enhanced sense of confidence in treating young people with BPD
- Gains were maintained at 6 month follow up



The Impact of a One-Day Workshop on Good Psychiatric Management for Adolescent (GPM-A) Borderline Personality Disorder

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RESEARCH ARTICLE

Associations Between Generalist Knowledge of Borderline Personality Disorder and Clinician Factors and Attitudes

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Keywords: borderline personality disorder | clinician attitudes | good psychiatric management | stigma

ABSTRACT

Borderline personality disorder (BPD) is highly stigmatized. It is associated with negative clinician attitudes, which have been shown to improve with training. This study presents data collected at formal trainings in good psychiatric management (GPM) of BPD at several sites in the United States, Canada, Brazil, and Sweden. Three hundred twenty seven clinical professionals completed a 48-question true/false quiz testing knowledge of GPM, with a small subset ($N = 33$) that also completed a 13-item assessment of attitudes about BPD. Knowledge of GPM did not differ between course participants of different disciplines (e.g., psychiatry, psychology, and social work) but did differ according to level of GPM training and experience practicing GPM. Clinicians

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TABLE 4 | Results of linear regression predicting attitudes by GPM knowledge test score.

Item	Slope estimate	Standard error	*p*
1. If I had a choice, I would prefer to avoid caring for a BPD patient.	**−0.12**	0.05	**0.07***
2. I feel professionally competent to care for BPD patients.	0.01	0.04	0.72
3. I dislike BPD patients.	**−0.12**	0.04	**0.07***
4. BPD is an illness that causes symptoms that are distressing to the BPD individual.	0.00	0.03	0.89
5. I feel I can make a positive difference in the lives of BPD patients.	**0.05**	0.02	**0.09***
6. The prognosis for BPD treatment is hopeless.	**−0.06**	0.03	**0.07***
7. Some psychotherapies are very effective in helping patients with BPD.	0.03	0.03	0.23
8. I would like more training in the management and treatment of BPD patients.	0.04	0.03	0.17
9. I have more difficulty feeling empathy/compassion for BPD patients than other patients.	−0.09	.05	0.14
10. I am less comfortable during sessions with BPD patients than with other patients.	−0.06	0.05	0.21
11. I am confident in my ability to identify and diagnose BPD accurately.	0.06	0.04	0.21
12. I am willing to disclose the BPD diagnosis to patients.	0.07	0.04	0.17
13. I am willing to take on new patients with BPD.	**0.10**	**0.05**	**0.10***

Note: Bolded items represent attitudes with statistically significant association to level of GPM knowledge.
*$p < 0.1$.

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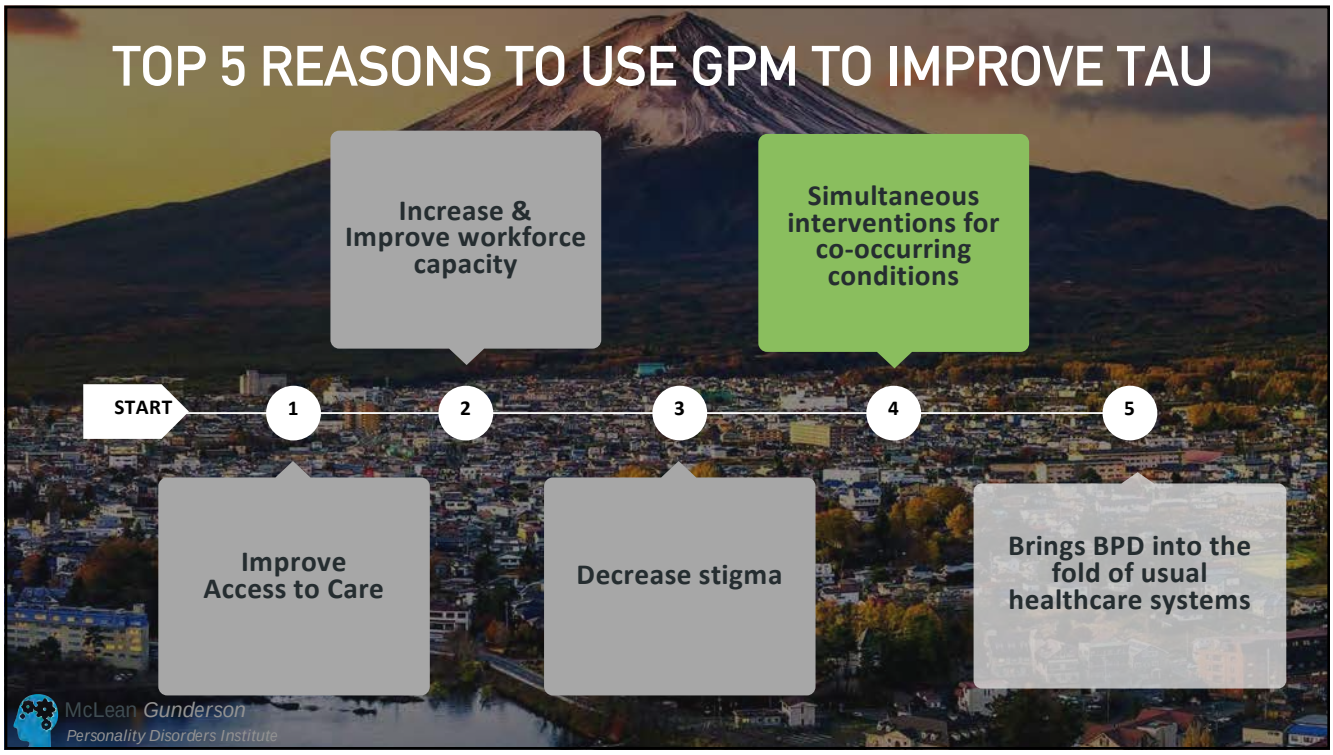

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TREAT CO-OCCURRING DISORDERS

GPM SUPERIOR TO DBT

- **Significantly lower dropout rates with high Axis I co-morbidity when assigned to GPM (Wnuk e tal., 2013)**
- **Greater psychiatric severity and impulsivity predicted better outcomes when randomized to GPM> DBT (Keefe et al., 2023)**

TABLE 2. Multivariate Logistic Regression Analysis Modeling Dropout Status

Parameter	Estimate (SE)	Odds Ratio	95% Confidence Interval	p
Intercept	1.56 (1.18)	.21	(0.05, 0.78)	.02
STAXI Anger Out	0.10 (0.04)	1.10	(1.02, 1.19)	.01
WAI-S	0.04 (0.01)	0.96	(0.94, 0.99)	.002
Lifetime Suicide Attempts	0.47 (0.19)	1.17	(1.03, 1.37)	.05
Current Axis I Disorders	0.37 (0.17)	0.69	(0.50, 0.97)	.03
Axis II Disorders	−0.12 (0.22)	0.73	(.49, 1.09)	.13
Condition × Current Axis I Disorders	0.83 (0.24)			<.0001
Axis I Disorders: GPM		0.69	(0.50, 0.97)	
Axis I Disorders: DBT		1.60	(0.99, 2.58)	

Note: STAXI = State-Trait Anger Inventory; WAI-S = Working Alliance Inventory.

Table 2. Descriptions of attained moderator variables (combined $n = 156$)

Moderator variable	Direction of moderation	DBT β	GPM β	Omnibus model p value	Interaction semi-partial r
GSI symptom severity	More general symptoms: GPM > DBT	0.79	0.13	0.002**	0.20
Childhood emotional abuse	More emotional abuse: DBT > GPM	−0.15	0.23	0.008**	0.17
Dependent personality traits	More dependent personality: DBT > GPM	−0.11	0.22	0.015*	0.16
Zanarini-impulsivity score	More impulsive BPD symptoms: GPM > DBT	0.24	−0.07	0.028*	0.14
Social adjustment scale	More maladjusted: DBT > GPM	−0.16	0.20	0.041*	0.13
Beck depression inventory	More depressed: DBT > GPM	−0.13	0.25	0.074	0.11

Note: β represents a standardized beta for comparison. Lower AUC values indicate better long-term outcomes on the GSI.

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THIS FORMULATION [IHS] RESTS CLOSER TO THE SURFACE PHENOMENOLOGY AND IS MORE INTERPERSONAL THAN KERNBERG'S . . . IT DOES NOT RELY AS HEAVILY ON DEFENSES OF SPLITTING AND PROJECTIVE IDENTIFICATION. MOREOVER, IT GIVES LESS EMPHASIS TO THE INNATENESS AND THE PERVASIVENESS OF AGGRESSION THAN DOES KERNBERG, AND IT GIVES MORE CREDENCE TO THE POSITIVE OBJECT-DIRECTED MOTIVES OF BORDERLINE PATIENTS.
GUNDERSON, 1984, P. 39

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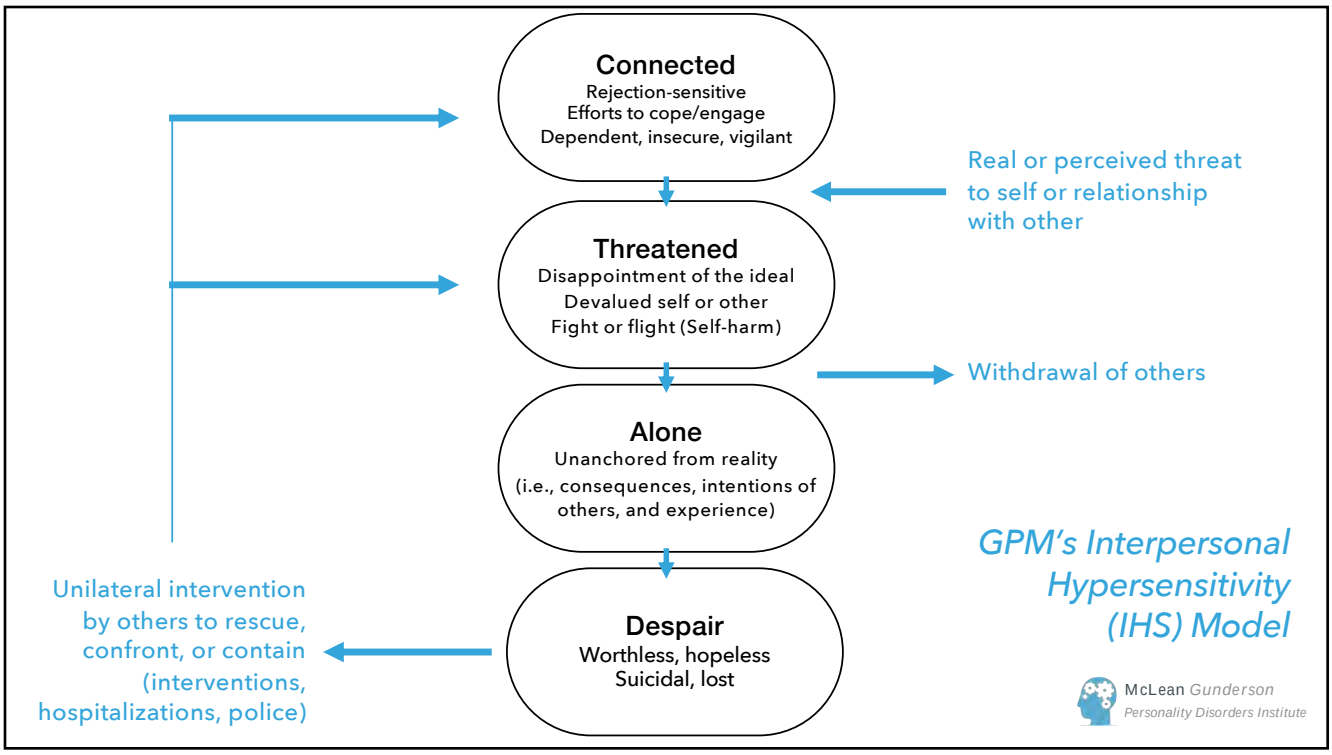

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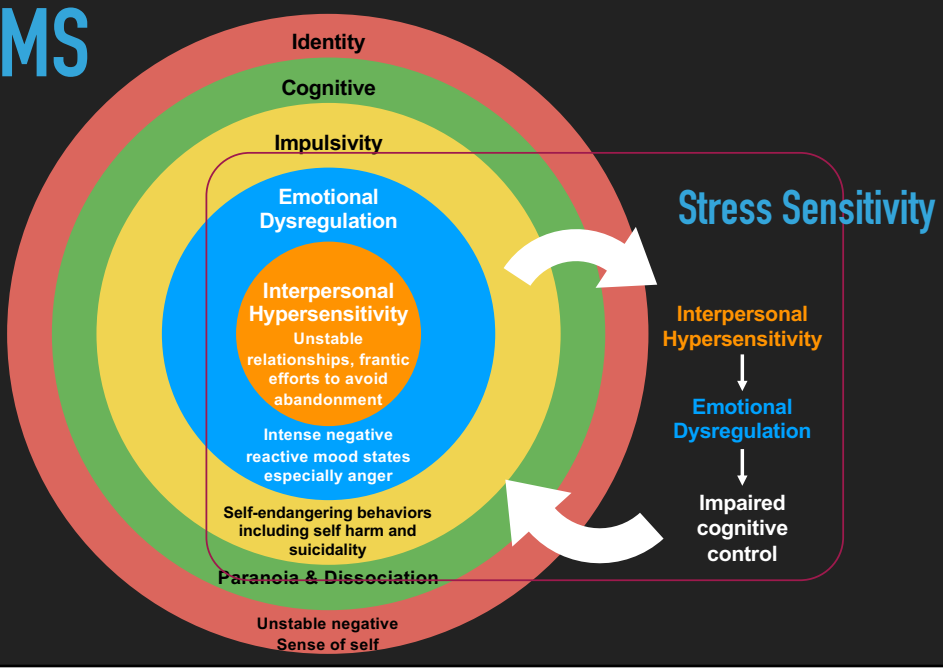
- GPM congress Stockholm Choi-kain

SYMPTOMS



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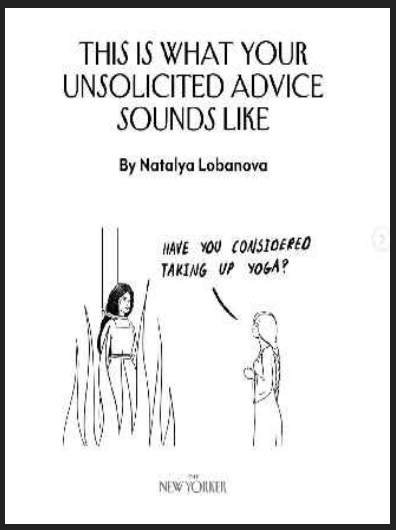
MANAGING STRESS SENSITIVITY



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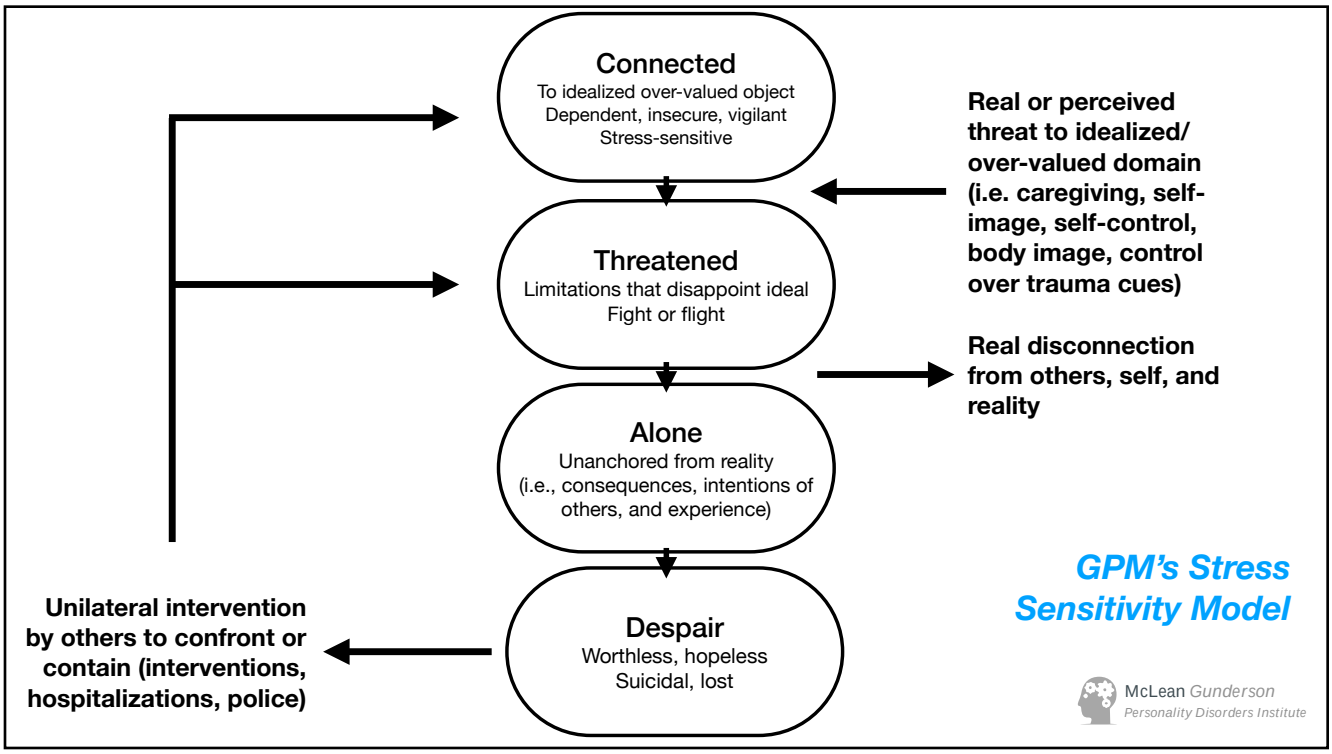
Connected
To idealized over-valued object
Dependent, insecure, vigilant
Stress-sensitive
Threatened
Limitations that disappoint ideal
Fight or flight
Alone
Unanchored from reality
(i.e., consequences, intentions of others, and experience)
Despair
Worthless, hopeless
Suicidal, lost
Real or perceived threat to idealized/ over-valued domain (i.e. caregiving, self-image, self-control, body image, control over trauma cues)
Real disconnection from others, self, and reality
Unilateral intervention by others to confront or contain (interventions, hospitalizations, police)
GPM's Stress Sensitivity Model
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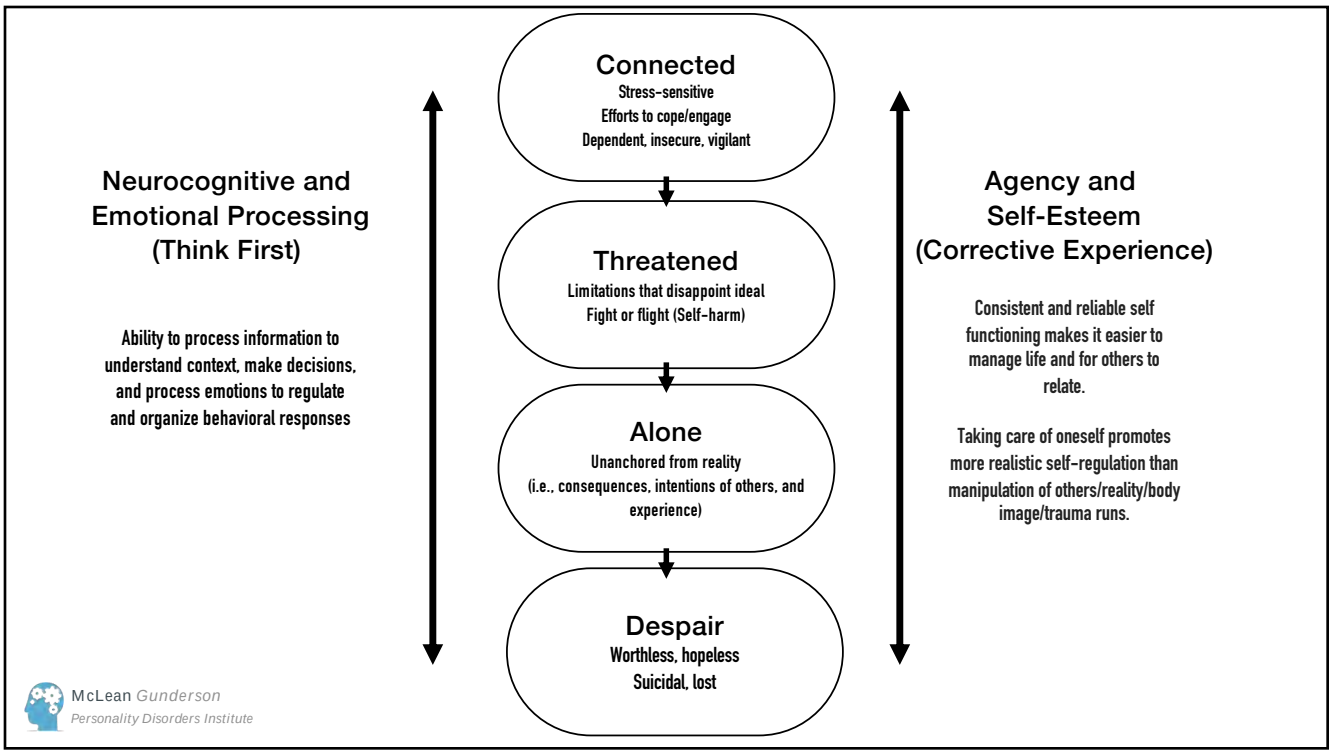
Connected
Stress-sensitive
Efforts to cope/engage
Dependent, insecure, vigilant
Threatened
Limitations that disappoint ideal
Fight or flight (Self-harm)
Alone
Unanchored from reality
(i.e., consequences, intentions of others, and experience)
Despair
Worthless, hopeless
Suicidal, lost
Neurocognitive and Emotional Processing (Think First)
Ability to process information to understand context, make decisions, and process emotions to regulate and organize behavioral responses
Agency and Self-Esteem (Corrective Experience)
Consistent and reliable self functioning makes it easier to manage life and for others to relate.
Taking care of oneself promotes more realistic self-regulation than manipulation of others/reality/body image/trauma runs.
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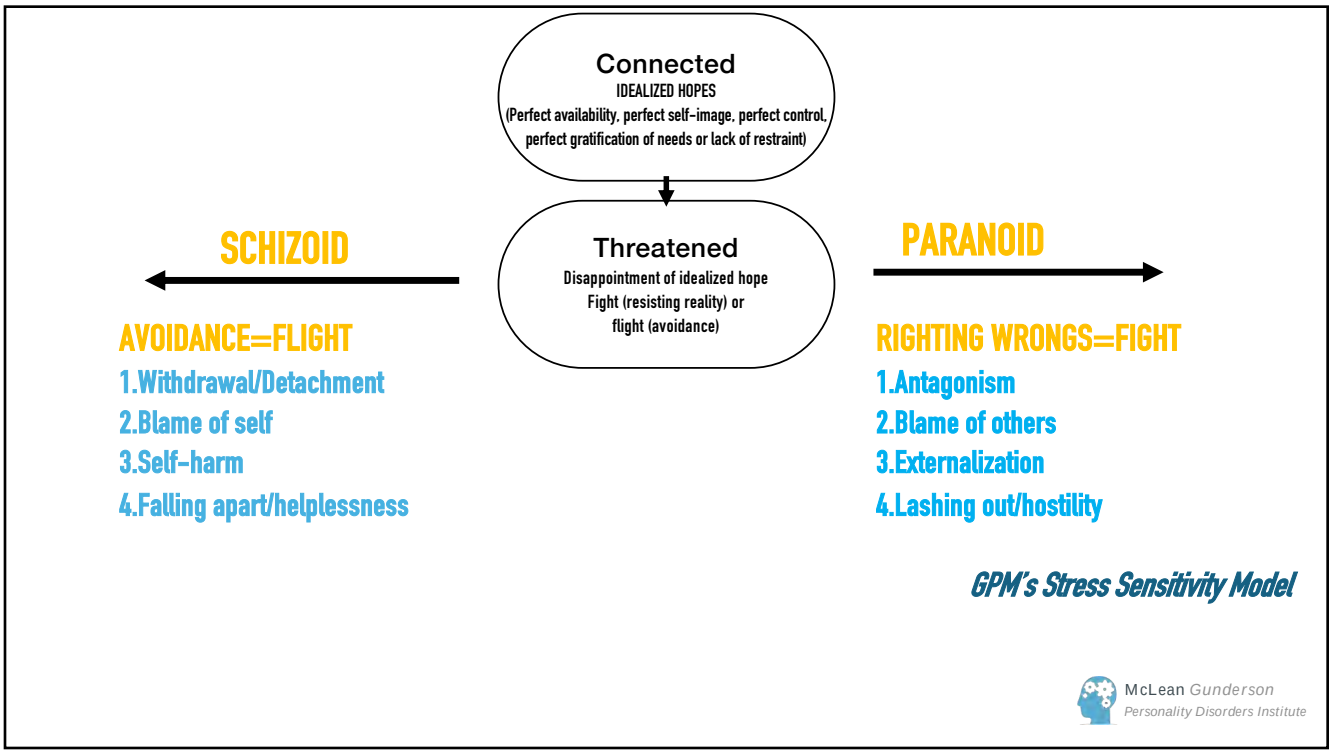
Connected
IDEALIZED HOPES
(Perfect availability, perfect self-image, perfect control, perfect gratification of needs or lack of restraint)
Threatened
Disappointment of idealized hope
Fight (resisting reality) or
flight (avoidance)
SCHIZOID
AVOIDANCE=FLIGHT
1.Withdrawal/Detachment
2.Blame of self
3.Self-harm
4.Falling apart/helplessness
PARANOID
RIGHTING WRONGS=FIGHT
1.Antagonism
2.Blame of others
3.Externalization
4.Lashing out/hostility
GPM's Stress Sensitivity Model
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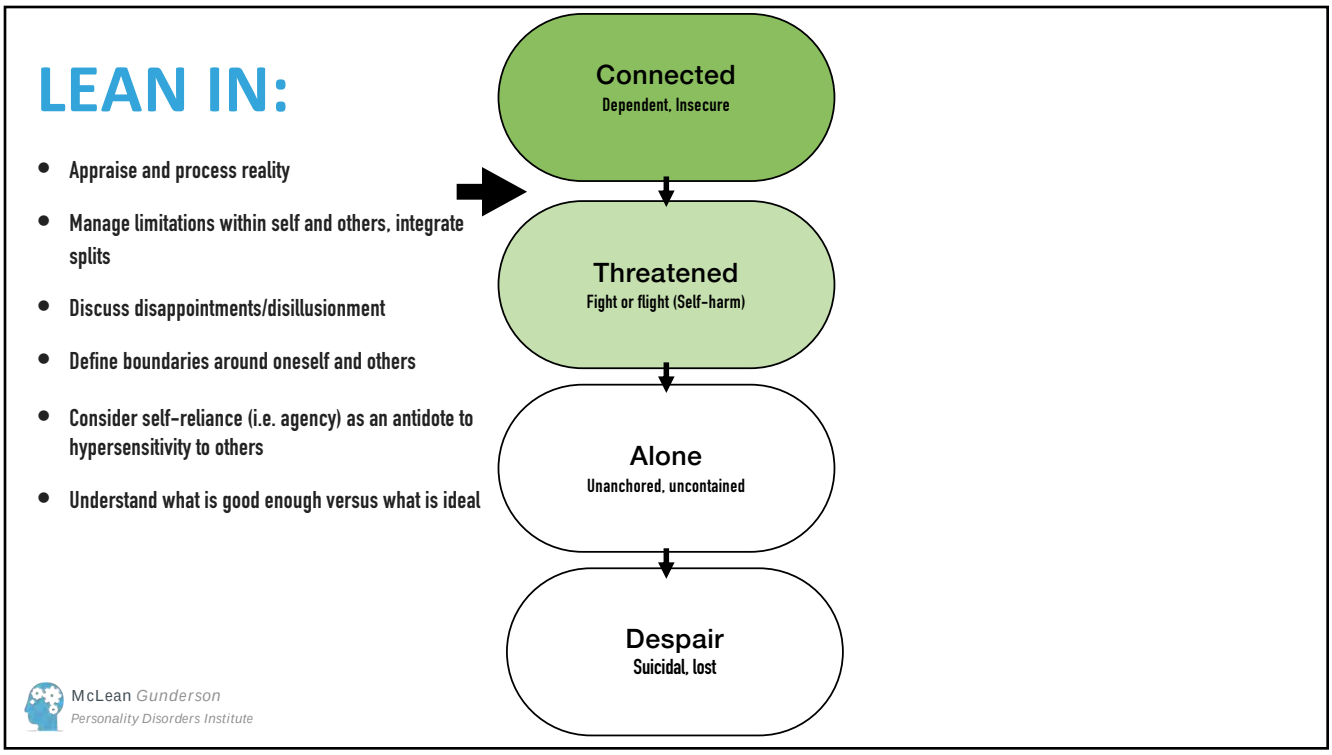
LEAN IN:
Appraise and process reality
Manage limitations within self and others, integrate splits
Discuss disappointments/disillusionment
Define boundaries around oneself and others
Consider self-reliance (i.e. agency) as an antidote to hypersensitivity to others
Understand what is good enough versus what is ideal
Connected
Dependent, Insecure
Threatened
Fight or flight (Self-harm)
Alone
Unanchored, uncontained
Despair
Suicidal, lost
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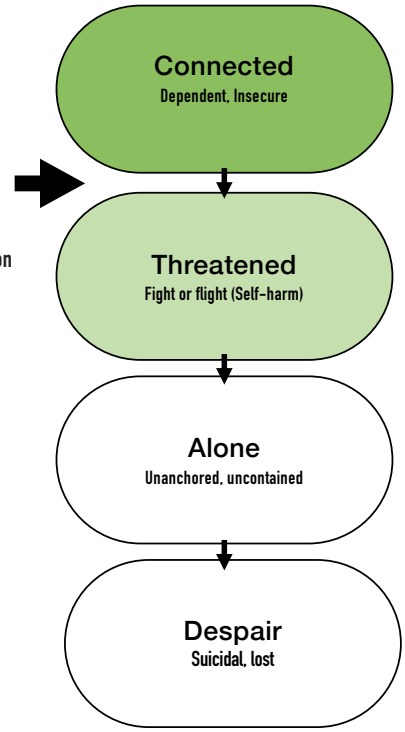
LEAN IN:

- Mentalization
- Mindfulness, Interpersonal Effectiveness, Emotion Regulation
- Healthy Adult Mode to integrate other modes
- Think First



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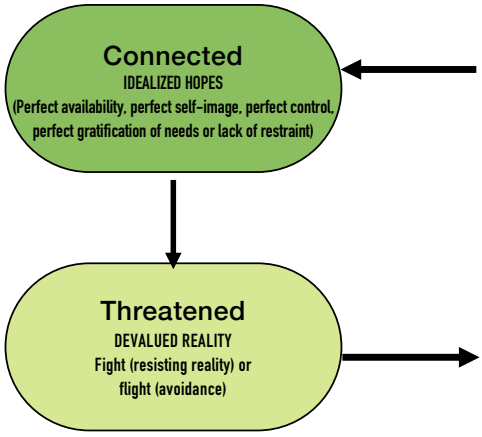

What do you want? What will it take to get what you want? At what cost? Is what you are doing in the service of that? What would work better?

What is difficult about this reality to accept? What does it make you feel about yourself? What are the implications to your relationship?

GPM's Stress Sensitivity Model

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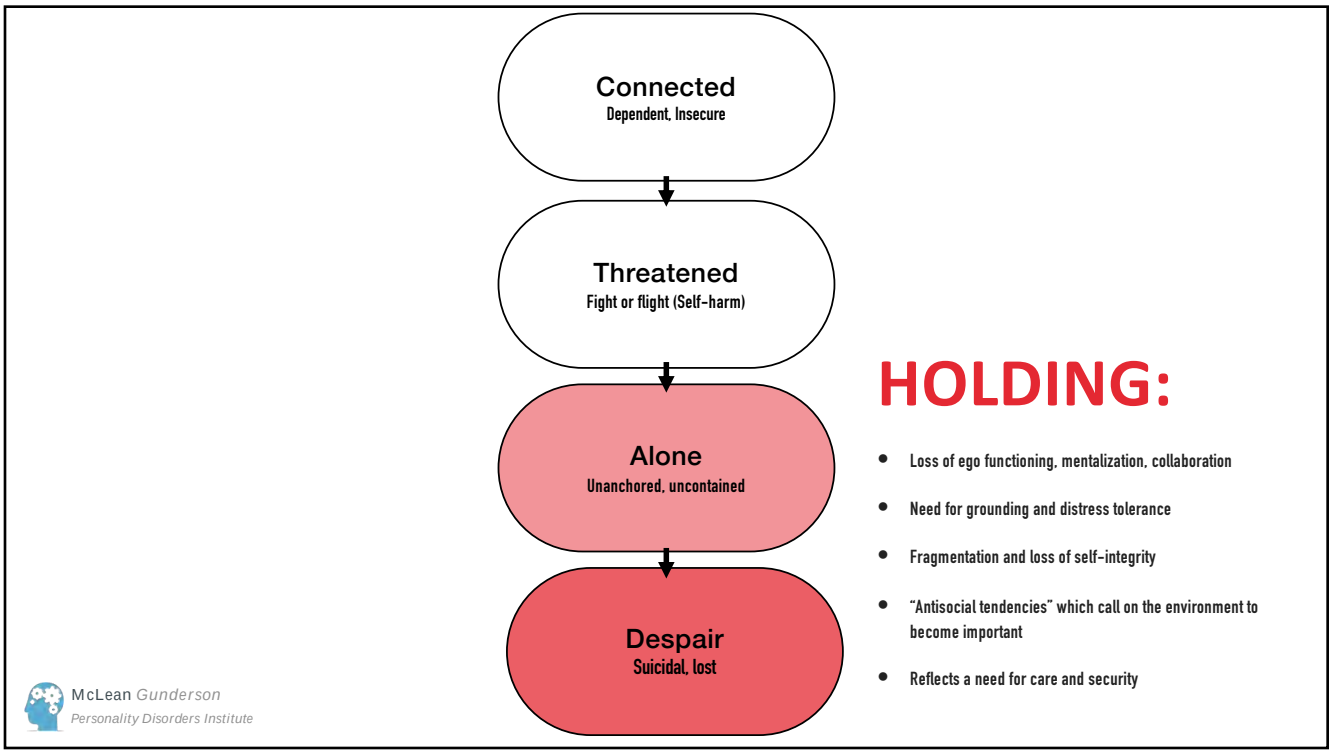
Connected
Dependent, Insecure
Threatened
Fight or flight (Self-harm)
Alone
Unanchored, uncontained
Despair
Suicidal, lost
HOLDING:
Loss of ego functioning, mentalization, collaboration
Need for grounding and distress tolerance
Fragmentation and loss of self-integrity
"Antisocial tendencies" which call on the environment to become important
Reflects a need for care and security
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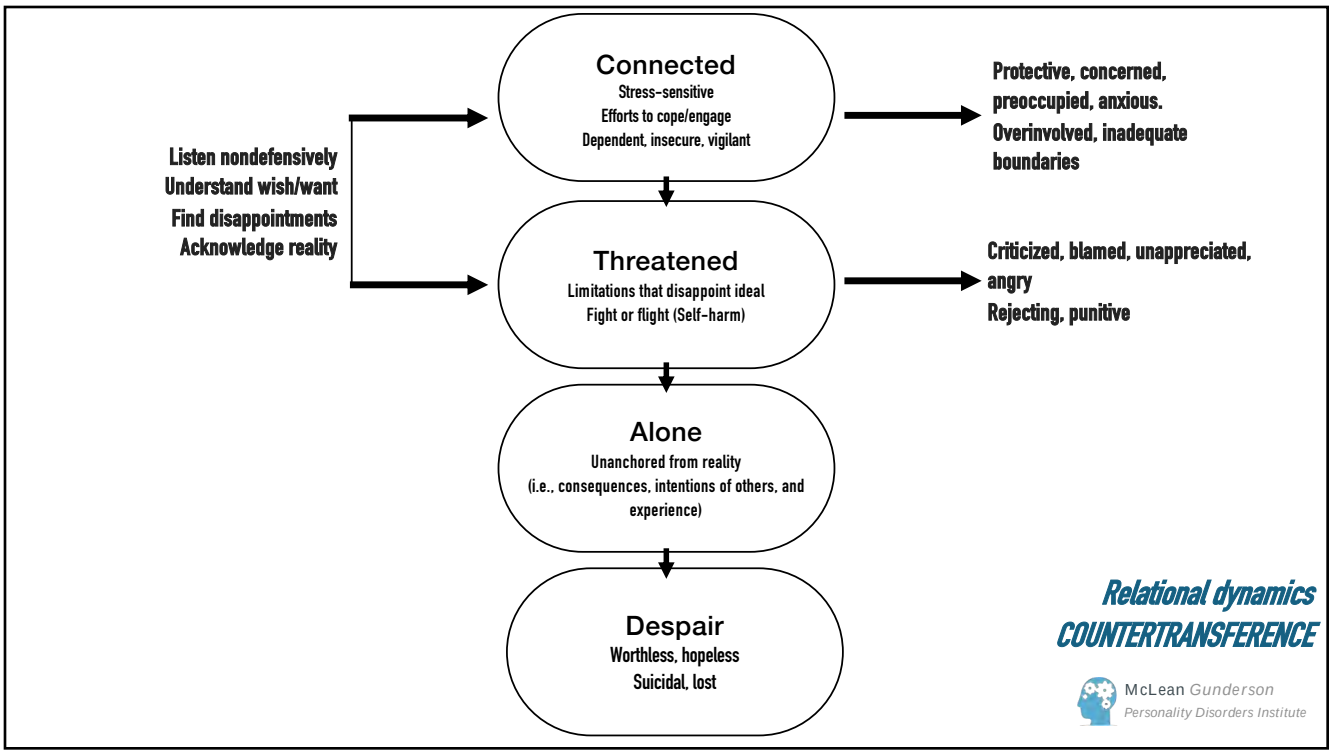
Listen nondefensively
Understand wish/want
Find disappointments
Acknowledge reality
Connected
Stress-sensitive
Efforts to cope/engage
Dependent, insecure, vigilant
Protective, concerned, preoccupied, anxious.
Overinvolved, inadequate boundaries
Threatened
Limitations that disappoint ideal
Fight or flight (Self-harm)
Criticized, blamed, unappreciated, angry
Rejecting, punitive
Alone
Unanchored from reality
(i.e., consequences, intentions of others, and experience)
Despair
Worthless, hopeless
Suicidal, lost
Relational dynamics
COUNTERTRANSFERENCE
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ADDRESS COMORBIDITY

	CONSIDERATION	EXAMPLES
PRIORITIZE COMORBIDITY WHEN	COMORBIDITY PRECLUDES ACTIVE LEARNING	MANIA, NEURODIVERSITY ASPD, SEVERE SUD ANOREXIA, PSYCHOSIS
PRIORITIZE BPD WHEN (TREAT SIMULTANEOUSLY)	COMORBIDITY IS UNLIKELY TO REMIT OR LIKELIER TO RECUR	DEPRESSION, ANXIETY, SOCIAL PHOBIA, REMITTED BIPOLAR DISORDER (I OR II), BULIMIA PTSD, AUD
STABILIZE BPD BEFORE ADDRESSING COMORBIDITY	INCREASE PATIENT'S ABILITY TO TOLERATE EXPOSURE THERAPY	PTSD OCD PANIC DISORDER

ADAPTED FROM MERCER & LINKS, 2019

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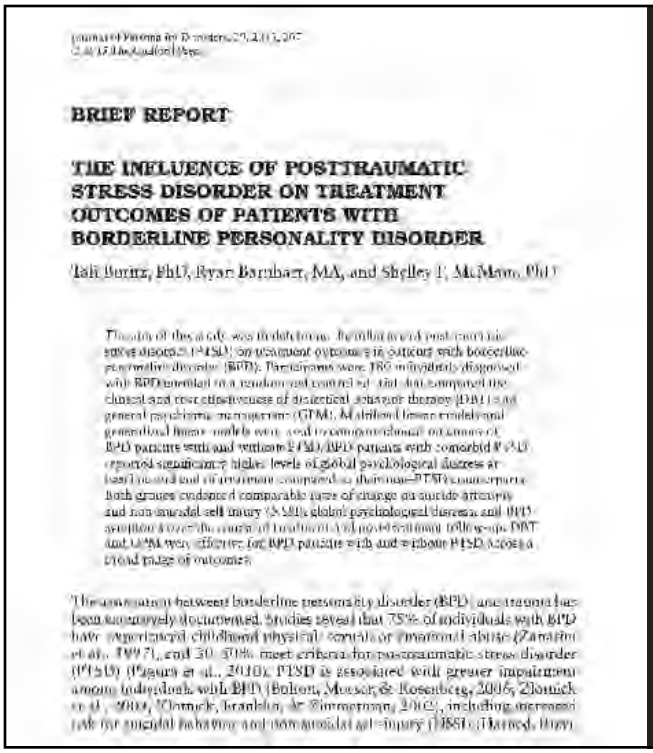

BRIEF REPORT

THE INFLUENCE OF POSTTRAUMATIC STRESS DISORDER ON TREATMENT OUTCOMES OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Jaki Boritz, PhD, Ryan Barnhart, MA, and Shelley J. McMain, PhD

Boritz, Barnhart & McMain, 2015

- Comparing clinical outcomes of patients with BPD with and without PTSD
- N=180 patients enrolled in RCT of one year of DBT vs GPM
- Patients with BPD + PTSD reported higher global psychological distress at baseline and end of treatment compared to group with BPD but otherwise equivalent outcomes
- Both DBT & GPM were effective for patients with BPD and BPD + PTSD

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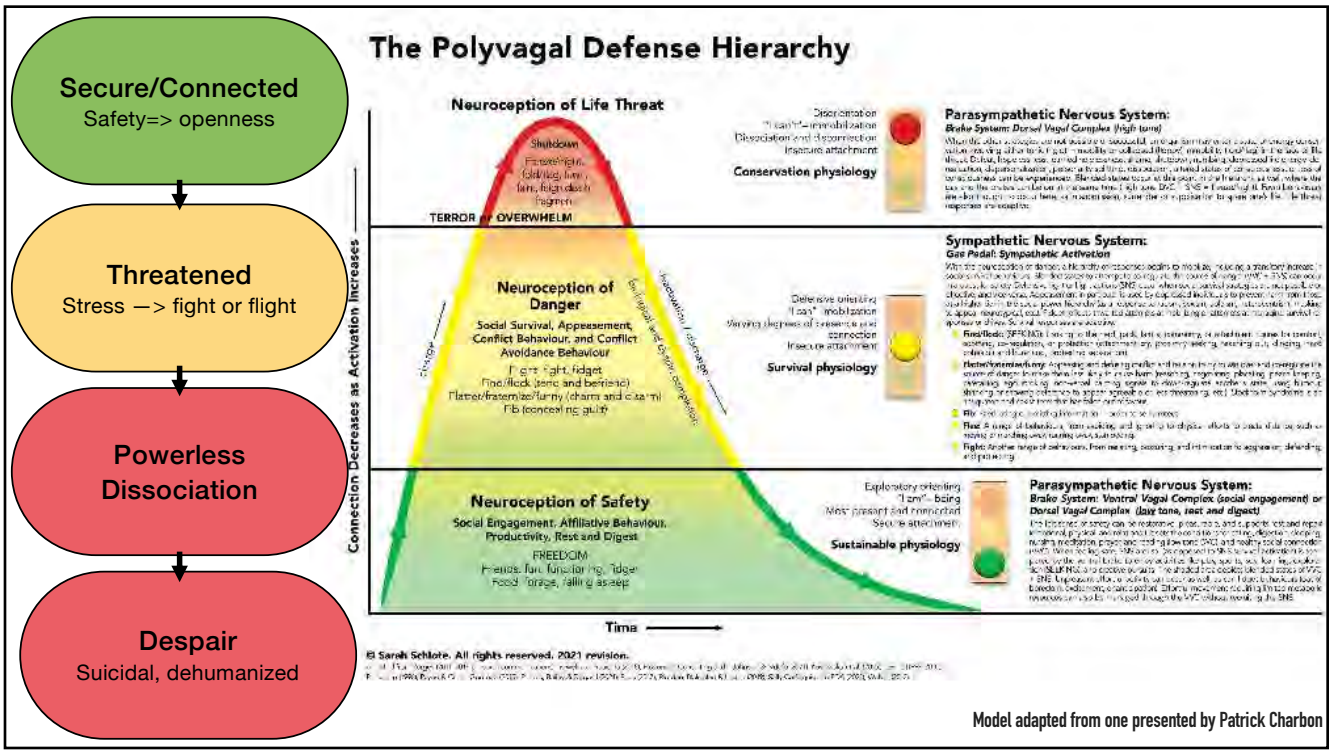

Model adapted from one presented by Patrick Charbon

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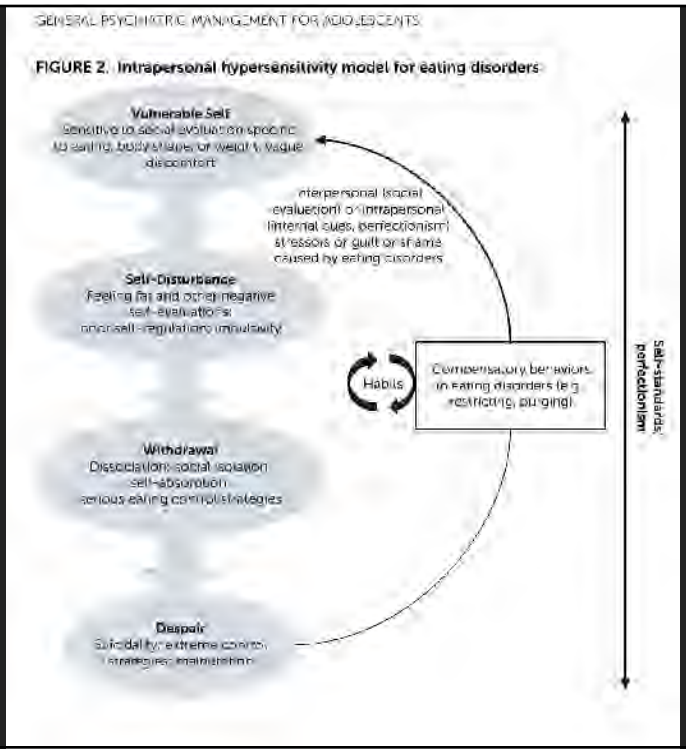
GPM-A for Eating Disorders

Croci et al., 2025



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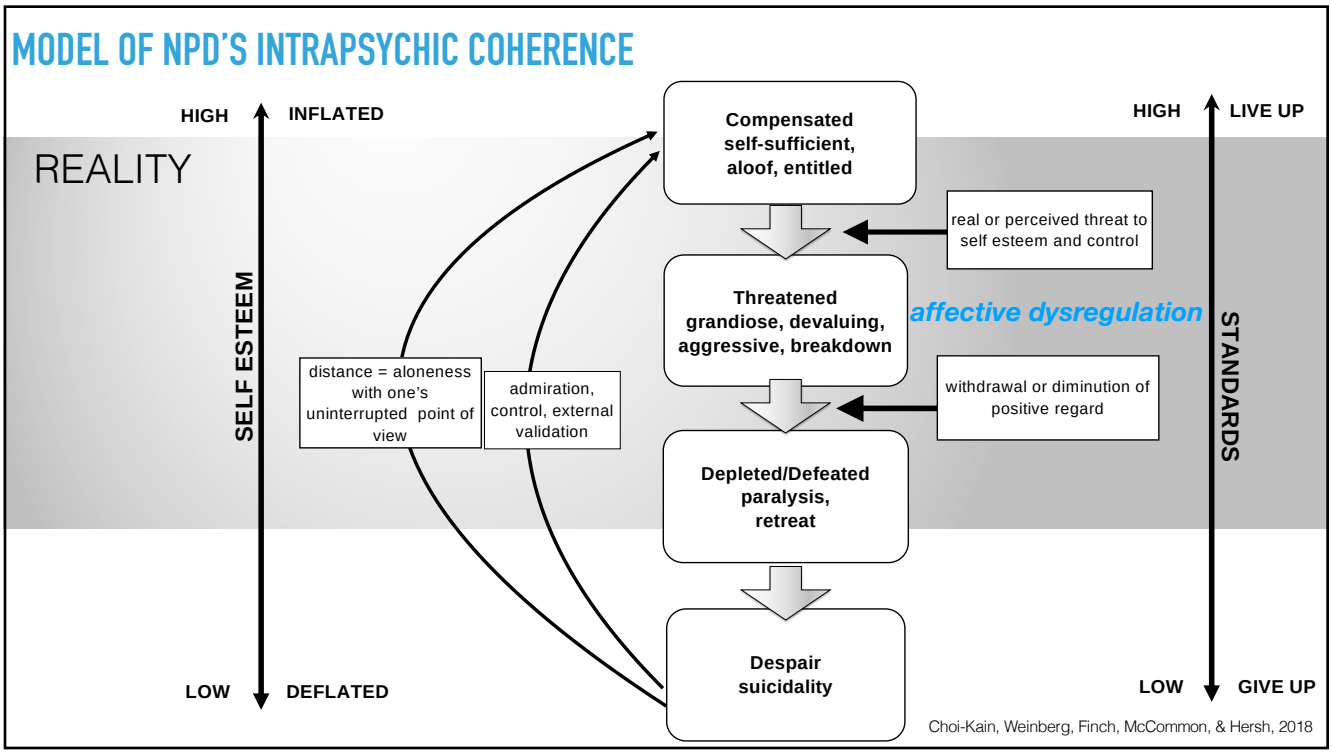
MODEL OF NPD'S INTRAPSYCHIC COHERENCE
HIGH
INFLATED
REALITY
SELF ESTEEM
LOW
DEFLATED
Compensated self-sufficient, aloof, entitled
real or perceived threat to self esteem and control
Threatened grandiose, devaluing, aggressive, breakdown
affective dysregulation
withdrawal or diminution of positive regard
Depleted/Defeated paralysis, retreat
Despair suicidality
distance = aloneness with one's uninterrupted point of view
admiration, control, external validation
HIGH
LIVE UP
STANDARDS
LOW
GIVE UP
Choi-Kain, Weinberg, Finch, McCommon, & Hersh, 2018

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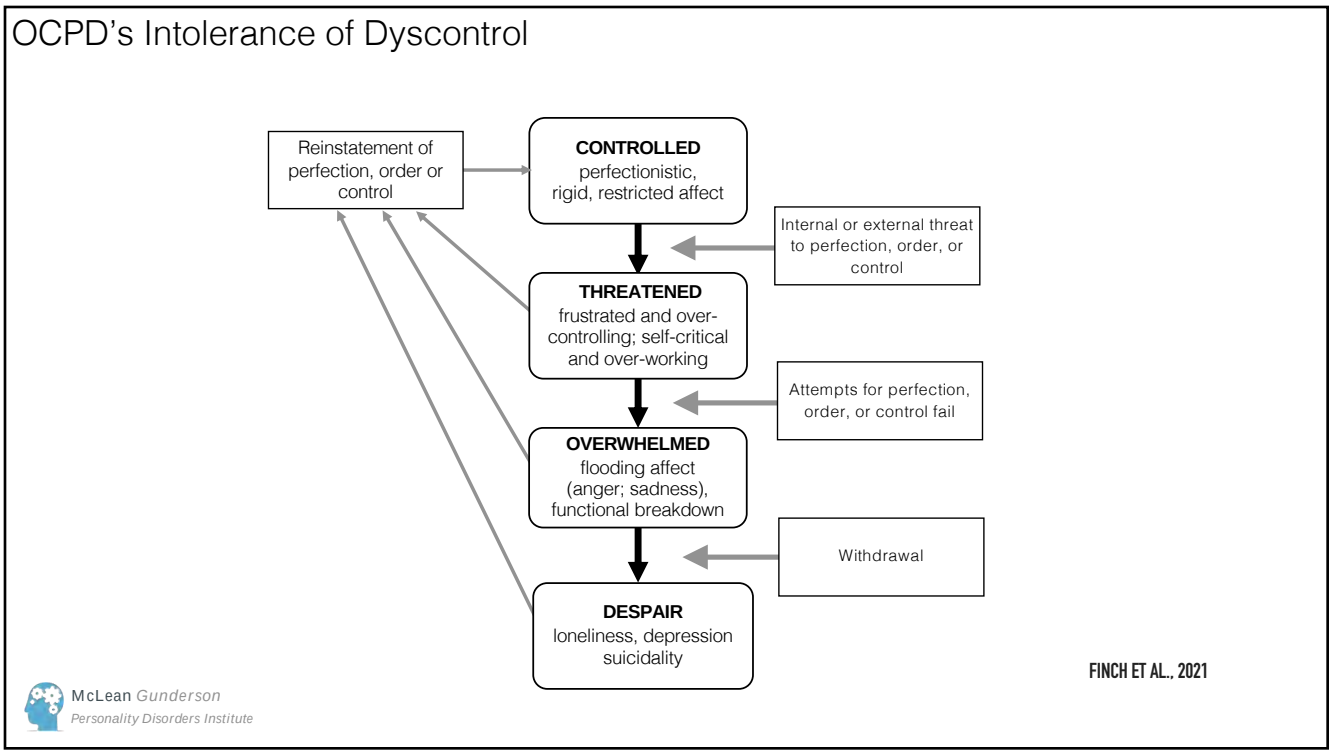
OCPD's Intolerance of Dyscontrol
Reinstatement of perfection, order or control
CONTROLLED
perfectionistic, rigid, restricted affect
Internal or external threat to perfection, order, or control
THREATENED
frustrated and over-controlling; self-critical and over-working
Attempts for perfection, order, or control fail
OVERWHELMED
flooding affect (anger; sadness), functional breakdown
Withdrawal
DESPAIR
loneliness, depression suicidality
FINCH ET AL., 2021
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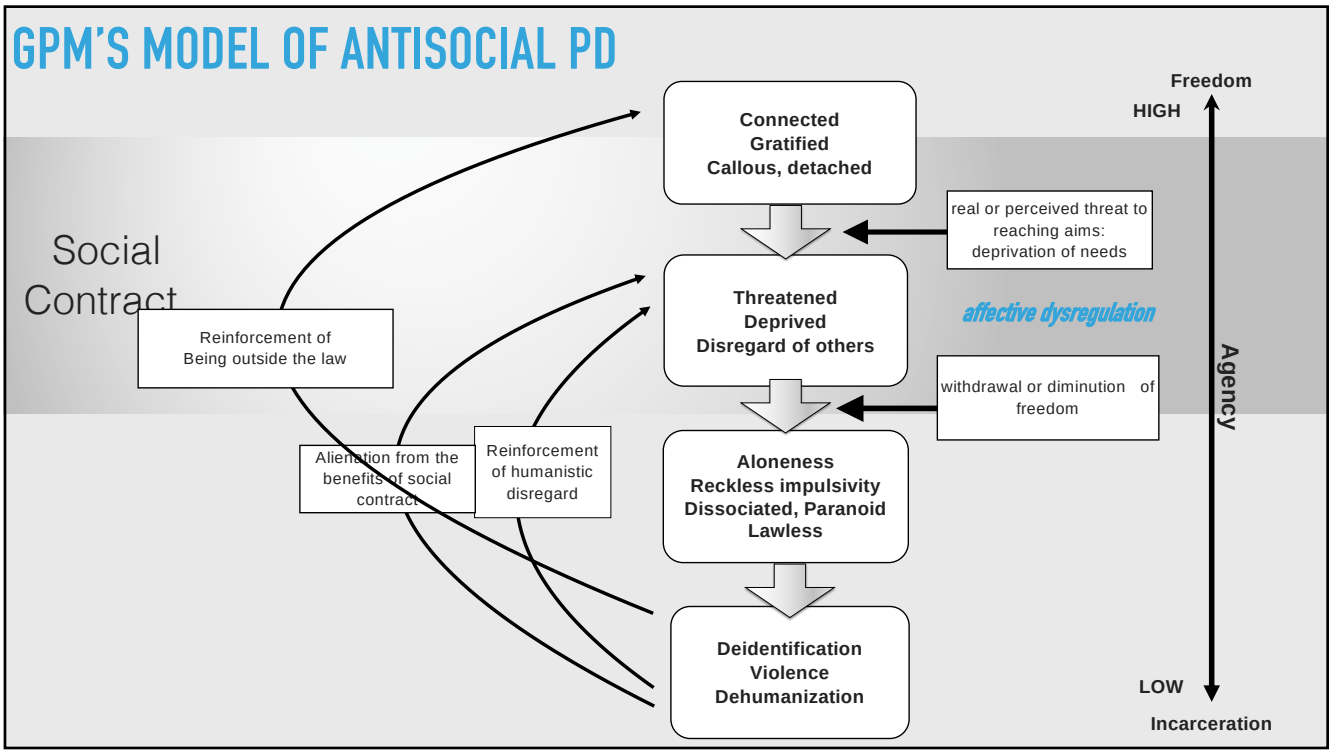
GPM'S MODEL OF ANTISOCIAL PD
Freedom
HIGH
Connected
Gratified
Callous, detached
real or perceived threat to reaching aims: deprivation of needs
Social Contract
Threatened
Deprived
Disregard of others
affective dysregulation
withdrawal or diminution of freedom
Agency
Reinforcement of Being outside the law
Alienation from the benefits of social contract
Reinforcement of humanistic disregard
Aloneness
Reckless impulsivity
Dissociated, Paranoid
Lawless
Deidentification
Violence
Dehumanization
LOW
Incarceration

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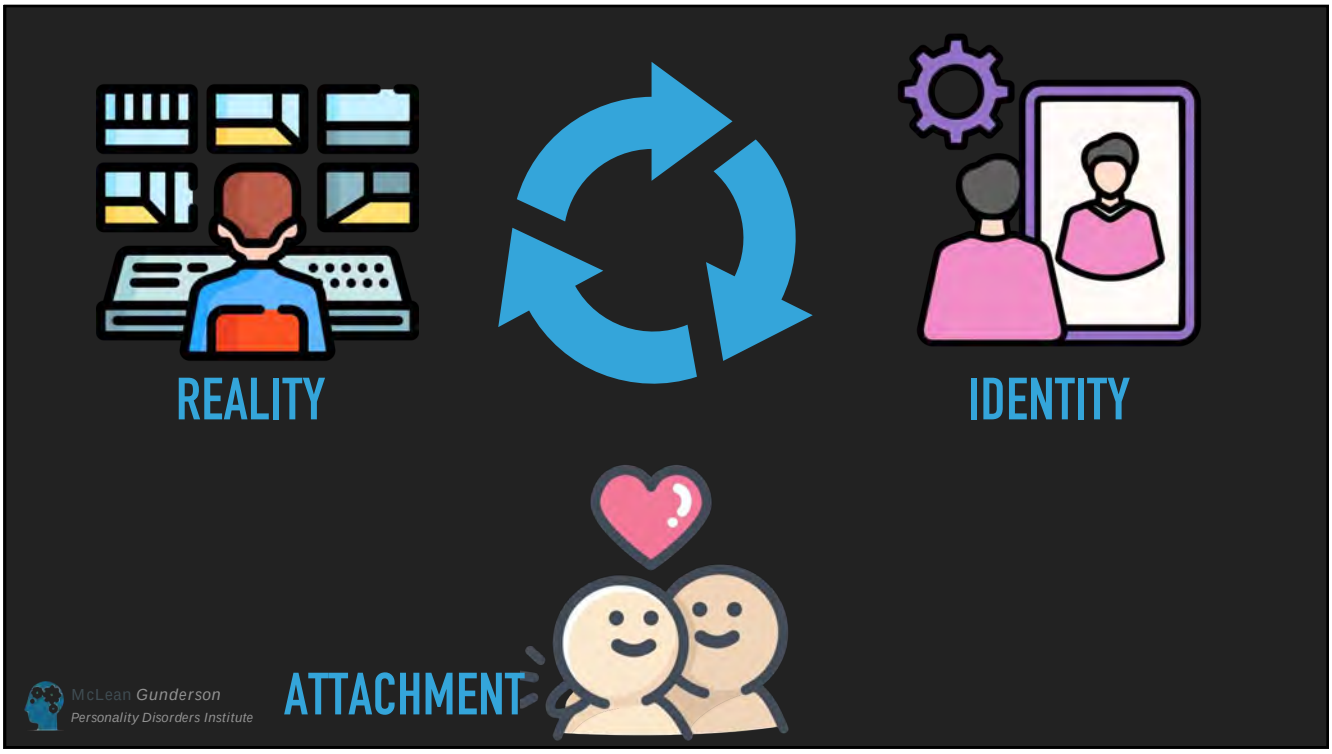
REALITY
IDENTITY
ATTACHMENT
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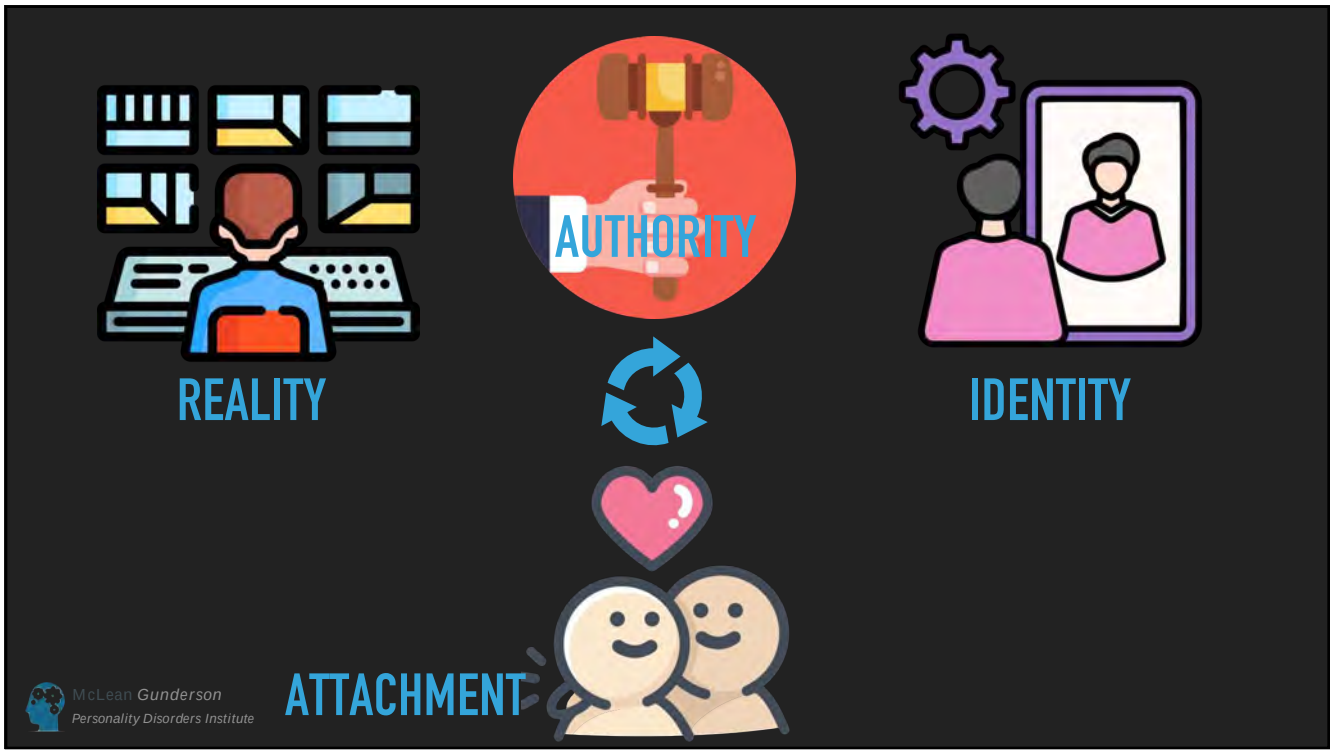
AUTHORITY
REALITY
IDENTITY
ATTACHMENT
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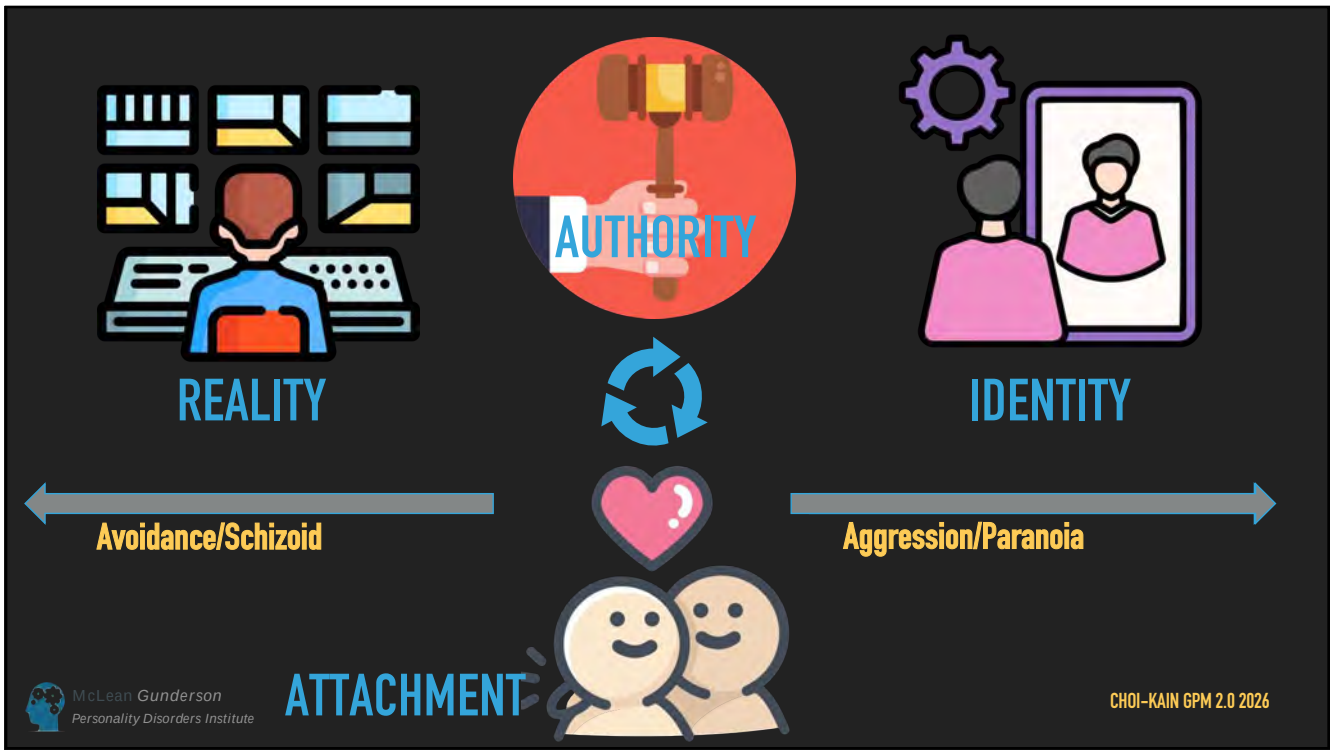
AUTHORITY
REALITY
IDENTITY
Avoidance/Schizoid
Aggression/Paranoia
ATTACHMENT
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CHOI-KAIN GPM 2.0 2026

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TOP 5 REASONS TO USE GPM TO IMPROVE TAU
Increase & Improve workforce capacity
Simultaneous interventions for co-occurring conditions
START
1
2
3
4
5
Improve Access to Care
Decrease stigma
Brings BPD into the fold of usual healthcare systems
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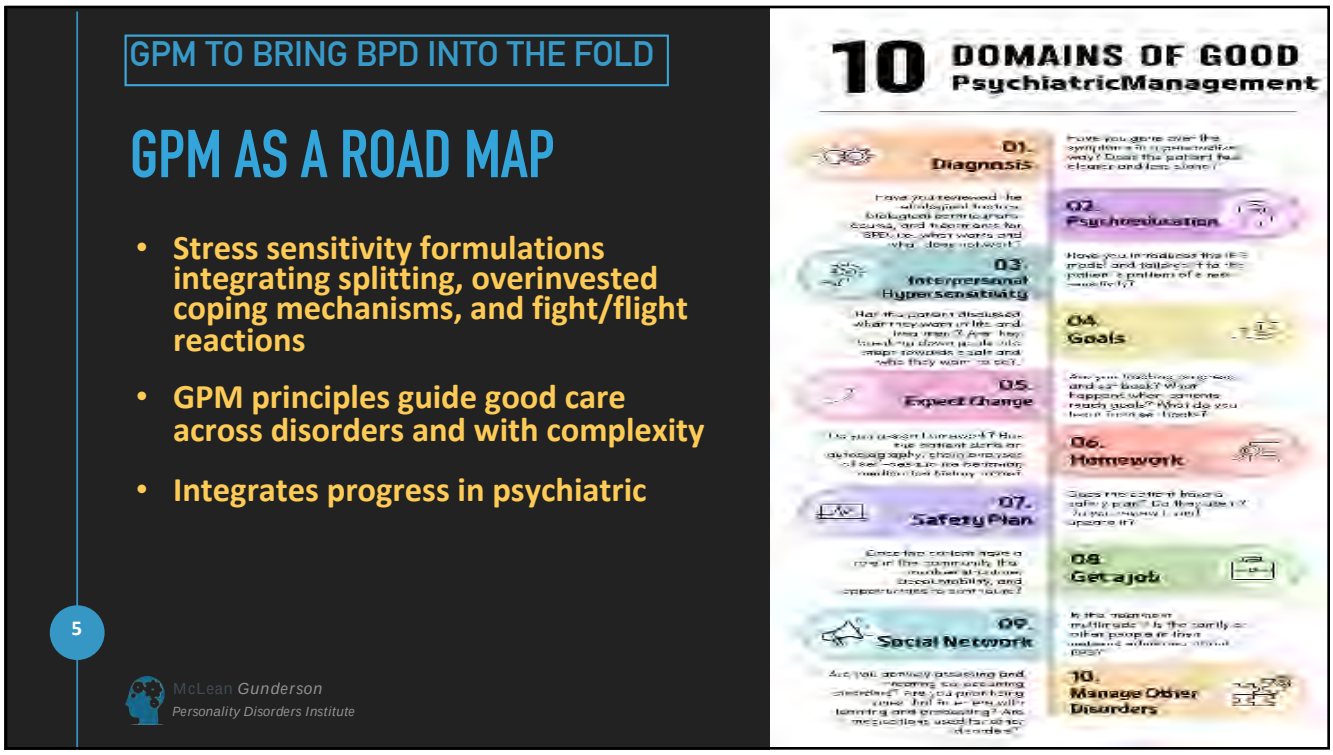
GPM TO BRING BPD INTO THE FOLD
GPM AS A ROAD MAP
• Stress sensitivity formulations integrating splitting, overinvested coping mechanisms, and fight/flight reactions
• GPM principles guide good care across disorders and with complexity
• Integrates progress in psychiatric
5
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10 DOMAINS OF GOOD PsychiatricManagement
01. Diagnosis
02. Psychoeducation
03. Interpersonal Hypersensitivity
04. Goals
05. Expect Change
06. Homework
07. Safety Plan
08. Get a job
09. Social Network
10. Manage Other Disorders

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“ Less is more. Less what not to do, simple essentials of BPD treatment ”
“ Most clinicans are good enough to care for those with BPD with key adjustments ”

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FOR THE SPIRIT OF JOHN GUNDERSON
ENJOY THE CONGRESS

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Psykiatri
Sydväst

We are all about
groups!

1

The Personality Program at Psykiatri Sydväst

- Started September 2016
- Mission:
  Assess and treat personality disorder
- We work from two models, GPM and MBT

2

The personality program

- Staff of 16-20: psychologists, doctors, secretaries, social worker, psychiatric nurse, work-rehab coordinator
- ~250 ongoing patients
- Steady in- and out-flow of patients

3

Why groups in public health psychiatry?

- Group is part of some of the most helpful PD treatments (DBT, MBT)
- Treat more people!
- In Sweden, group treatments are hard to find outside of psychiatry

4

GPM in group therapy - A therapeutic stance and framework, not a manual

- We utilize every clinician's expertise and experience, within the GPM framework
- Working together this way builds mutual competence and knowledge

Group therapists:

- Basic GPM training
- Experience with the patient group and GPM
- Two group leaders: 1 experienced, 1 learning

5

Principles of GPM used in group

1. Offer psychoeducation
2. Be active, not reactive
3. Be thoughtful
4. Therapeutic relationship is real
5. Change is expected
6. Accountability and responsibility
7. Focus on life outside treatment
8. Be flexible, pragmatic and eclectic

6

Psychoeducation

All patients refered to us are invited to an introductory course (up to 25 patients) of 90 x 6 sessions. Lecture on relevant themes and "light" group discussions on the course themes.

Patients in structured treatment:

- All group therapy sessions starts with psychoeducative intervention
- Discussion follows, using patients' examples and experiences

7

User involvement in the introduction course

- A new part of the introduction course where the user involvement coordinator participates.
- "*Going into psychological treatment – a patient perspective.*" Talking about my own experience of living with emotional instability and going through treatment.
- Sharing my own path with mental illness, encounters with psychiatry, difficulties in getting treatment, challenges in treatment and what helped me get better.
- Emphasizes the importance of realistic expectations and that you yourself must do the work.
- Opportunity for participants to ask questions.
- I emphasize that my experience is mine and that it may look very different for others.

8

Be active, not reactive

- Two group therapists
- Encourages patients to be active and help regulate individual affect and group tension
- Therapists model a stance of warm curiosity and being thoughtful. Individually and by our interactions with each other and patients.

9

Change is expected

- Goals for change are mandatory before starting therapy
- New patients tell the group about problems areas and goals for change
- Goals must be specific and related to change in patients life outside of psychiatry
- Goals are evaluated at follow-up meetings with patient and therapists
- If change is not happening, meet with patient. *Stop treatment or change strategy?*

10

Flexible, pragmatic and eclectic

- Utilizing competences and experience in clinicians
- Care-plan meetings benefit from multiple competences of the different clinicians.
  Bring in work-rehab coordinator, case worker, psychiatrist when needed.

11

Creating group therapy content

- Serves as support and structure for the therapists
- Gives patients structure and ensures them of our professionality
- Based on GPM principles combined with PD theory
- NOT A MANUAL!
- The material also needs to be flexible so that every session can be adapted according to the group situation and needs
- Continous revisions from our experiences, input from patients and new knowledge

12

ICD-11 Personality Disorder

- Problems of self and interpersonal functioning
  - Self-functioning
    - Identity
    - Self-worth
    - Self-image
    - Goal direction
  - Interpersonal functioning
    - To develop close and mutual relationships
    - Taking other's perspectives
    - Handling conflict and misunderstandings
  - >2 years
  - Manifests in maladaptive affect, cognition, and behavior
  - Manifests in multiple personal and interpersonal situations
  - Not better explained by social or cultural factors
  - Significant impairment in function and subjective suffering in many areas of life

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Personality problems/disorder

- Self image
- Relationships
- Affects
- Cognitions (thoughts about oneself and others)
- Behaviour

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GPM block structure
The Personality Program

48 weeks = One year

Block 1	**Problem solving**	**Intake**	**2 weeks**
	Affects		5
	Impulses		5
	Total		12
Block 2	**Problem solving**	**Intake**	**2 weeks**
	Relationships		5
	Affects		5
	Total		12
Block 3	**Problem solving**	**Intake**	**2 weeks**
	Impulses		5
	Relationships		5
	Total		12
Block 4	**Problem solving**	**Intake**	**2 weeks**
	Affects		5
	Relationships		5
	Total		12

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Group therapy structure

- 3-12 months
- 8-10 patients + 2 therapists.
- Care-plan meeting every 3 months
- Weekly, 90 minutes
- Semi-open groups, new patients start at every block start
- 10 minutes of theory about the current theme
- The session material supports the psychoeducation and group discussion but therapist decides how
- Often combined with weekly individual therapy

16

17

Good Psychiatric Management for patients with avoidant traits

18

PS – Avoidant traits

- Social inhibition: Avoids activities that require interaction with others.
- Sensitivity to criticism: Extremely sensitive to the opinions of others and afraid of rejection.
- Low self-esteem: Feeling inferior, uninteresting, or inadequate.
- Isolation: Limits close relationships for fear of being rejected or ridiculed.
- High anxiety: Living with a fundamental sense of fear and anxiety in social situations.

19

Background GPM-avoidance

Why a specific treatment for these patients?

- Difficulty in recognizing oneself in other patients.
- Avoidant patients became very quiet and passive in the mixed groups.
- Dropout of avoidant patients in the mixed GPM groups.

How did we start?

- Inspiration from MBT treatment in Norway and Denmark.
- Group start February 2024.
- Teamwork and adaptation to GPM framework.
- Why GPM?
  - Treatment principles important for this particular patient group
  - We who were interested in working with the group were GPM therapists.

20

Principles of GPM used in group

1. **Offer psychoeducation**
2. Be active, not reactive
3. Be thoughtful
4. **Therapeutic relationship is real**
5. **Change is expected**
6. **Accountability and responsibility**
7. **Focus on life outside treatment**
8. Be flexible, pragmatic and eclectic

21

GPM-Avoidance : Structure and content differences from regular GPM

- Individual therapist = Group therapist
- Individual therapy: guidance on how to work in group therapy.
- Focus on telephone consultation before group meetings.
- Group therapy 12-24 months.
- Individual therapy is gradually phased out, only group therapy.

22

GPM-Avoidance – Structure and content differences

- Focus: Weave psychoeducation into mindfulness, body awareness, exposure and communication exercises.
- Problem formulation & goals are addressed together during group intake.
- Focus on feelings (not thoughts), "too much" fear/shame. "too little" positive affect
- Impulses: avoidant ones.
- Change module: special focus on change and emotions that are aroused. Fear of failure --> difficulty of setting goals. Perfectionism --> difficulty setting reasonable goals.
- Self-compassion: essential element for dealing with recurring feelings of shame.

23

Examples of exposure exercises

- Ball exercise
- Interview
- Two and two
- Share your music/feel the music

24

Patients' experience

- Greater insight and understanding of problem areas, vulnerabilities and one's own personality.
- Group therapy: stabilizing routine, context, recognizing each other's difficulties, less alone, caring.
- Difficult to focus on others when you end up in your own head.
  Difficult to genuinely receive others' answers, reactions, reflections.
  Needs support and training.

25

Patients' experience

"I've been able to be happy with what I've done, be proud of it. Reduced self-criticism when things didn't go well. Accepted that it's okay not to be able to do everything. It became easier to let things go, not dwell on them. Learned to ask for help. It's still hard but I can do it."

"The most important thing is that now I have proof that I can communicate with others. For a long time I didn't dare or didn't know how, but now I know that's not really true. I can put my feelings into words if I give myself the opportunity, I can express them to others and be taken seriously. "

"Remind myself that even if it doesn't go well or as I have planned every time, to keep trying. Remember what is my responsibility and what is the responsibility of others. Try to be kind to myself when things don' t go well and be able to give myself praise when they do. "

26

Our experience - Group therapy

- High attendance.
- Individual differences, some need more time BUT: Active participation.
- Work on homework
- Relate and communicate with each other
- Show emotions, vulnerability, courage, humor
- Difficult for group therapists to have time to go through material, keep to planning and time frame.
- Fun, stimulating, educational and exciting = not boring.

27

GPM for patients with Autism

Exploring psychoeducation in a structured group format

28

Clinical context

- Patients with personality disorders and Autism
- Not possible to refer to autism clinic

We should offer them something!

- Introducing psychoeducation within GPM

29

Adapting the model

- More concrete and structured material
- Autism-specific psychoeducation
- Iterative revisions based on feedback on structure and content

30

Creating predictability

- Clear structure and expectations
- Explicit group rules
- Fixed seating

31

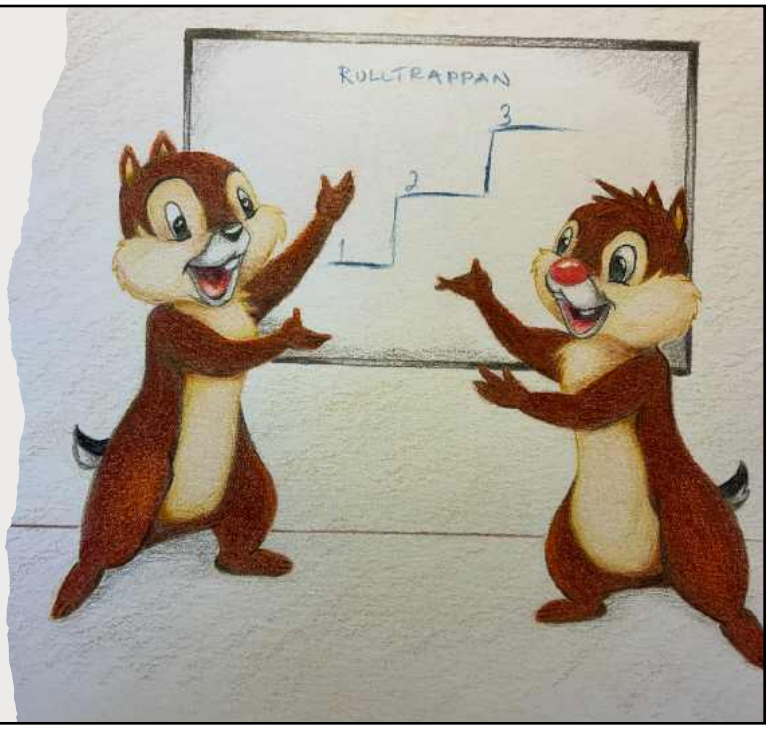
Group Characteristics

- Autism spectrum condition, level 1
- Recently diagnosed
- All women
- Two therapists (male)

32

Session structure

- Theme presentation/education
- Patient examples
- Discussion



33

Group development

- Initally quiet
- Increasingly engaged over time
- Patients suggested they should be able to socialize, with rules

34

What surprised us

- Strong identification between participants
- Sharing of personal and difficult experiences
- More than other groups, patients often address possible misunderstandings between each other in a considerate way.
- Continued interaction after sessons

35

Participant perspective

- ”The only place where I don’t feel like an outsider”
- ”The first group that doesn’t feel like torture”
- ”I learned a lot by hearing others’ examples, things I could not just read about.”

36

Assessment and treatment: 10 sessions

Inspired by “A 10-Session Brief GPM Intervention: From Diagnosis to Psychotherapy ” (Kramer, Charbon, Droz, Kolly)

37

Why combined treatment and assessment?

- To be able to quickly offer patients treatment
- See if this can contribute to more effective and better assessments

Program Structure

- Patients who have not yet been diagnosed
- 10 group therapy sessions
- Combined with individual assessment or therapy
- Up to 10 patients

38

Content

- The structure is the same as that of the other GPM groups
- A slightly greater focus on psychoeducation
- We consistently work with the crisis plan, often as homework

39

Experiences so far

- Well-received by patients
- High attendance rate
- Also suitable for patients without personality disorders
- Facilitates assessment, particularly treatment assessment
- 1–2 patients per group did not need further treatment
- The rest have continued on to longer-term treatment

40

Benefits of the group treatment

- Seeing the patients' interactions in group informs diagnostic assessment and problems/goals/challenges for treatment.
- Gives the patient an idea about what GPM treatment actually is, what it demands from them
- If 10 sessions result in improvement, both patient and clinicians are motivated to consider further treatment

41

Thank you!

- **Peder Björling**, consultant psychiatrist, medical director
- **Niki Sundström**, psychologist, director
- **Sarah Gullbjörk,** user involvement coordinator
- **Jeanette Lindholm**, psychiatric nurse
- **Georgia Tzavara**, psychologist
- **Anton Sandell**, psychologist
- **Ola Starck**, social worker

42

Implementation of GPM in a psychiatric clinic in northern Sweden

David Singmo

Licensed psychologist

Lina Olsson

Licensed clinical social worker, licensed psychotherapist

Stockholm 260504

region västerbotten

1

Psychiatric clinic, Umeå

- Umeå, 134,000 inhabitants
- Largest city in northern Sweden
- University-based city, quickly growing

- Psychiatric clinic
- 8 outpatient care units, 4 inpatient wards, forensic ward

- 400 employees, 8500 patients at the clinic

- Anxiety and trauma unit

- 35 employees, 900 patients with relatively varied kinds of difficulties

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2

GPM - Background

- Need of effective treatment for patients with personality difficulties

- For the patients
- For the organization
- For the work environment

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3

GPM - Background

Project plan 2022 → Internal training 2022 – 2023 → Training days by Psychiatry Southwest, Stockholm → "Study circle" → Treatment start 2024

GPM Congress

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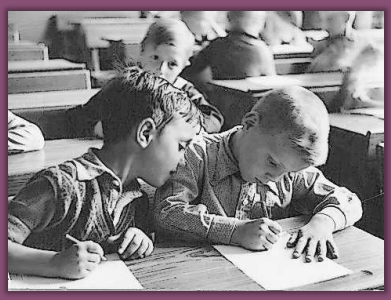
4

Adapting GPM to our unit

- Psychiatry southwest as model
- Dimensionality (APA, 2013) - Assessment and diagnostic instruments
- Dimensionality - Content of psychoeducation material, group treatment, GPM10
- Distribution of responsibility in the team
- Ward round structure
- Annual planning cycle



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5

GPM – Some challenges

- Just one of the patient groups the unit is responsible for.
- Complete specialization of work method not possible
- No standing psychiatrist as part of team
- Group leaders also have individual treatments
- Time management and distribution

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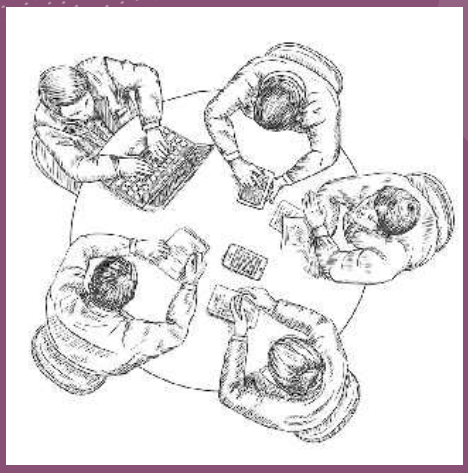
6

Team

- Current team composition;
- Four psychologists, of which two are psychotherapists
- One clinical social worker/licensed psychotherapist
- Access to additional social worker, nurse and psychiatrist



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7

Personality functioning and dimensionality

- **Categorical -> Dimensional**
  - Focus on individual, measurable problem areas that can explain the problem
  - Helps lift individual's unique circumstances to the foreground, rather than seeing them as another member of a group
- Personality **is** something and **does** something (Allport, 1961)

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8

Assessments and diagnostics

- Especially important because…
  - … of complexity
  - … used extensively in following treatment

- Screening phase –
  - PDS-ICD-11 + follow up answers
- Diagnostic phase-
  - PID-5 + follow up answers
  - STiP 5.1

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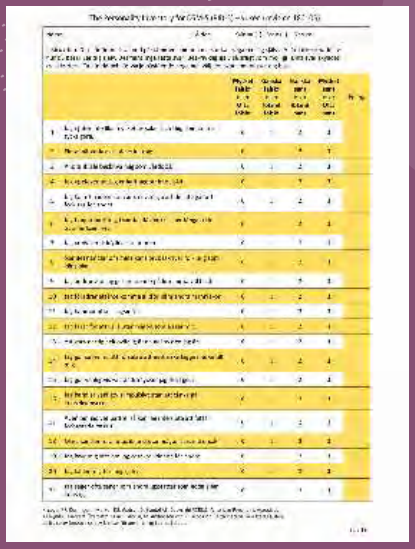
9

PID-5 (2012)

- 220 item personality difficulty questionnaire
- Measures 25 personality traits related to PDs:
- Great for treatment planning and psychoeducation

- **… but takes a while to calculate**



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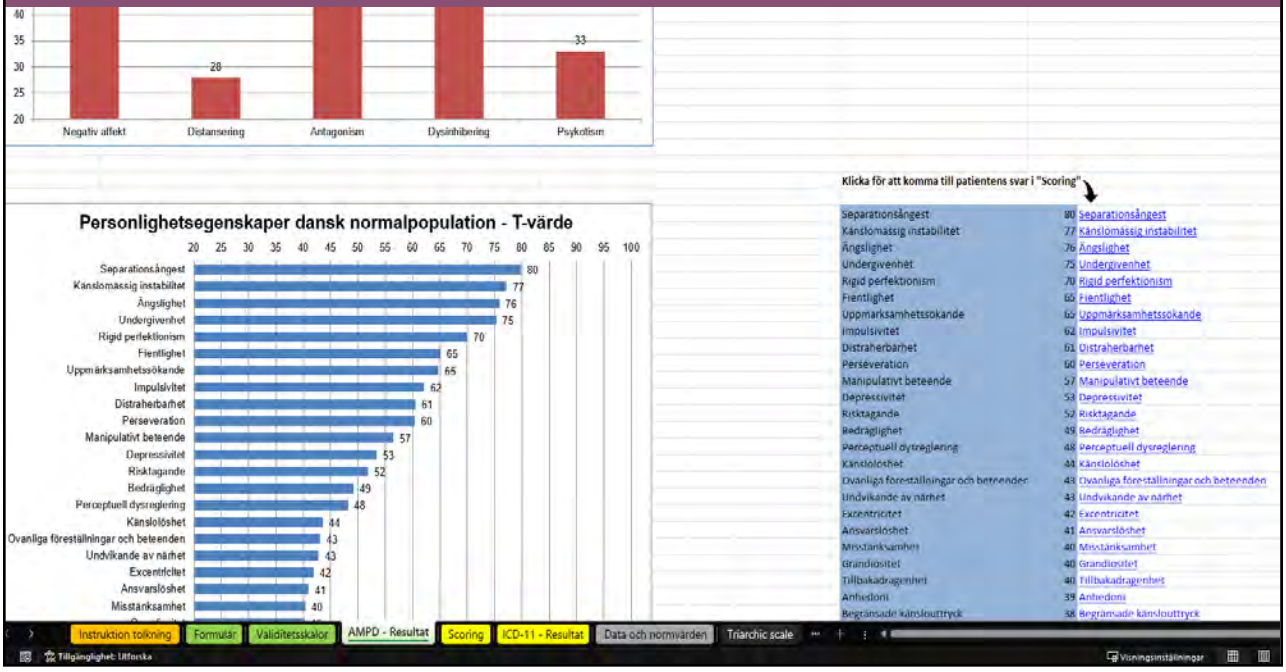
Automated PID-5 calculator



11

GPM treatment content

- Psychoeducation (4 or 6 sessions)
- GPM group + GPM individually, both weekly, 3 - 12 months. Take-home assignments
- GPM-10, weekly, 10 sessions with take-home assignments
- Goals and crisis plans tailored for each individual
- ”Get a life” – one-on-one contact with social worker, when needed
- Two therapists lead GPM group
  Four therapists responsible for individual GPM treatment (sometimes a mixed role is needed)

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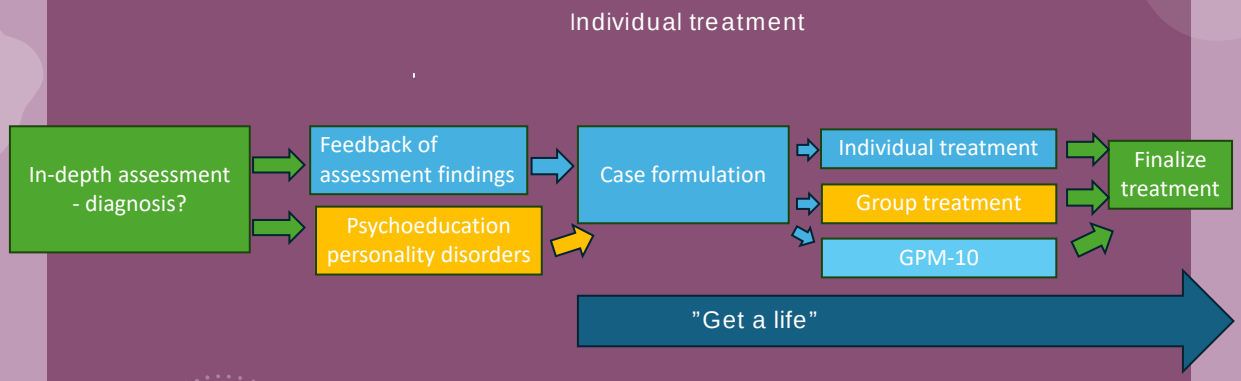
12

The care process



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13

GPM First year

- New diagnostic procedure
- GPM (PPI, group, individual) – 7 patients. 1 was cancelled
- Static group
- GPM-10 – 3 patients
- Coaching from Niki Sundström by video call

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14

GPM Second year

- Project completed, now permanent part of unit treatment repertoire
- Quite stable after first year
- GPM psychoeducation – 8 patients
- GPM group + individual – 8 patients
- GPM10 - 3 patients

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15

Effect of GPM after first year (*n* = 4)

- **Small effect:** $d = 0.2$
- **Moderate effect:** $d = 0.5$
- **Large effect:** $d > 0.8$

No significant change for:
LSAS-SR (p = .604),
SHAI-14 (p = .943),
BBQ (p = .489),
DERS-16 (p = .125)
BSL-23 (p = .138).

No structured treatment evaluation for GPM-10 yet

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16

Experiences

- Teamwork - more engaging and less stressful (“the team’s patients”)
- Ethical relief - offer treatment to difficult patient group
- Flexibility – easy to cover for each other when needed
- The patients have a setting to practice in
- Emotionally unstable and Avoidant personality disorders common
- ”Get a life” - for improving functional ability and promotes patient agency

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17

Experiences

- Concretization for caregivers in treating PDs
- Concretization of what the clinic can offer
- Structured treatment, easier to measure results
- Adapted content with manual, only 2 of the 7 original members remaining, implementation and development have continued.
- Trust and confidence from manager and leadership

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18

The future

- Psychoeducation for relatives, spring 2026
- New patients beginning May and September 2026
- Ongoing research project, PhD Brattmyr. Effect of GPM, qualitatively, quantitatively, self-assessment and interview
- More outpatient care units starting up GPM?

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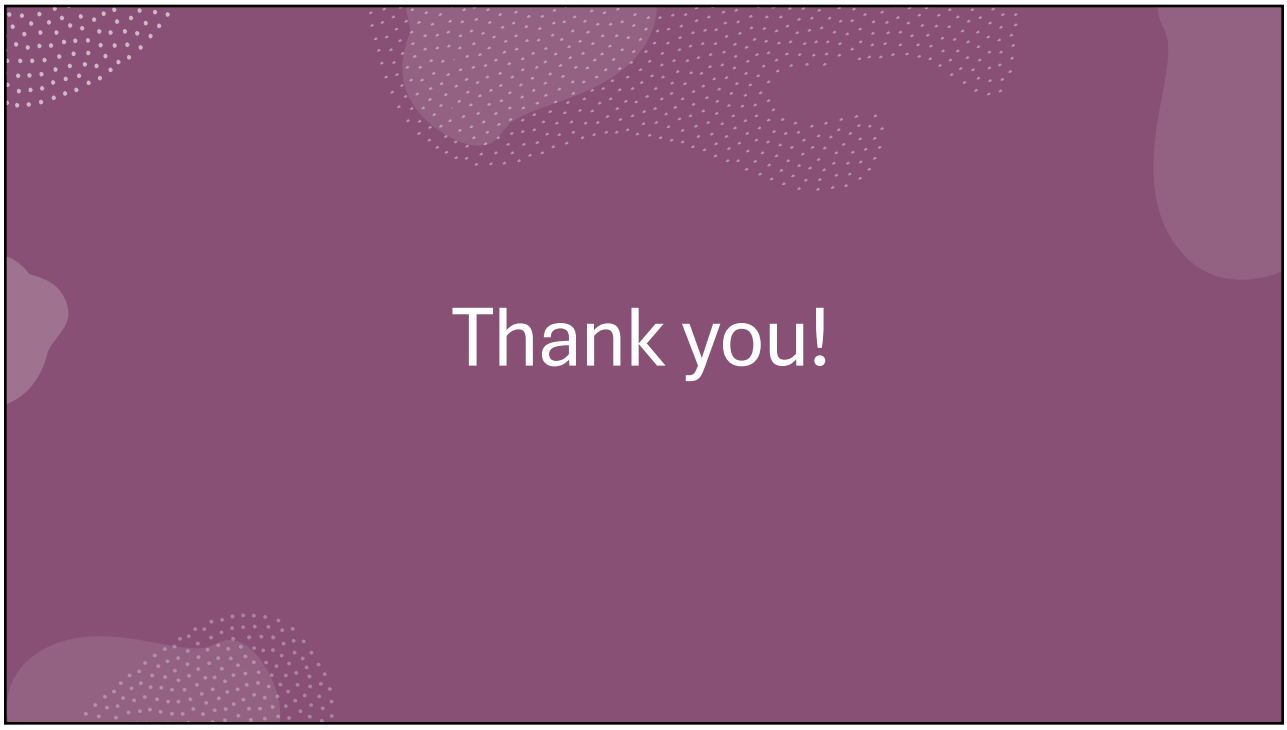
19

Questions?

20



21

GETTING STARTED

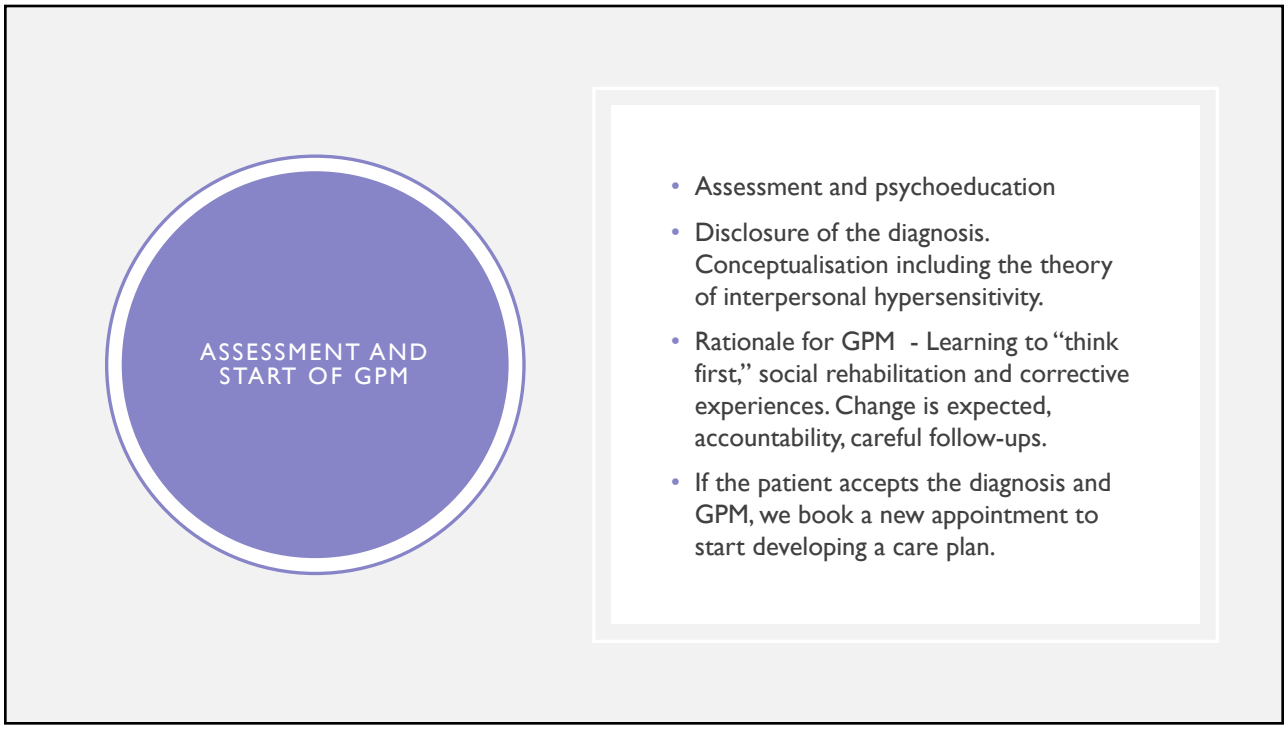
GPM IN GENERAL PSYCHIATRY

Hanna Rösman, Consultant Psychiatrist, clinical lead, out-patient clinic 8, Norra Stockholms Psykiatri
Lo Edberg, Psychologist, out-patient clinic 8, Norra Stockholms Psykiatri.

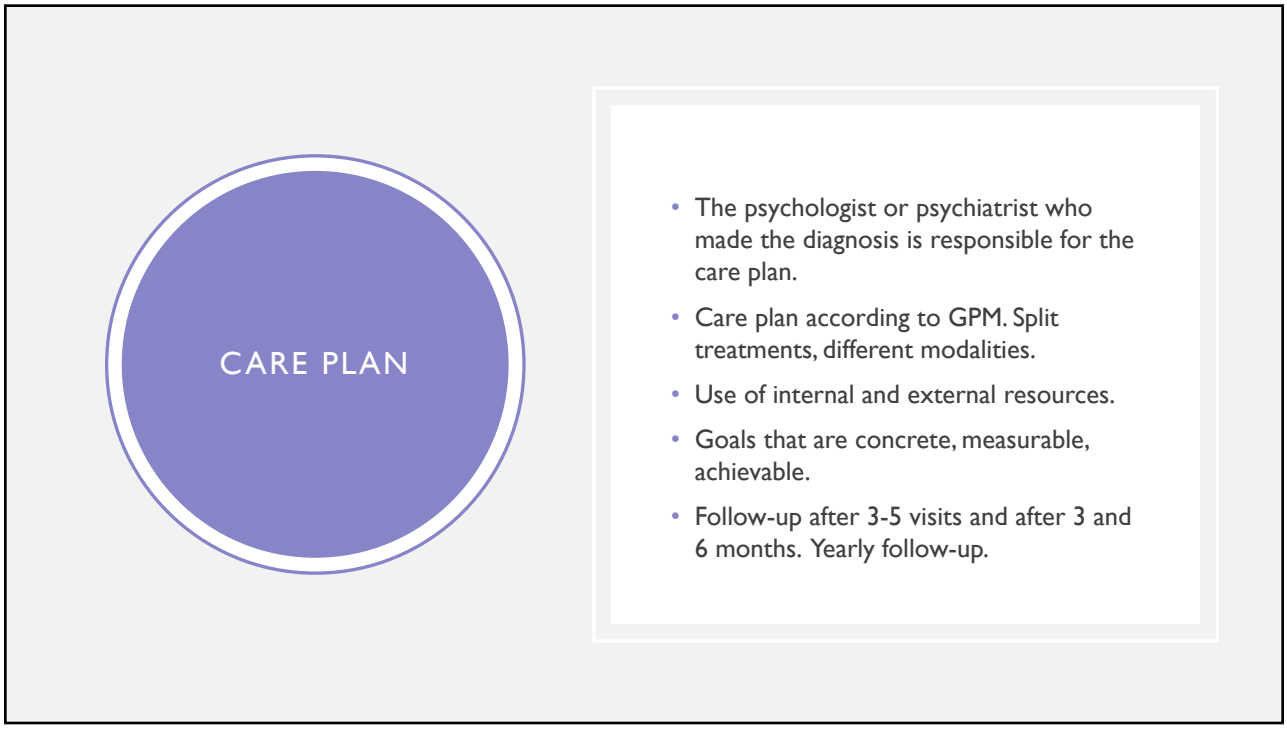
1

- Team that meets regularly.
- Consultation with more experienced colleagues.
- Follow-ups, clinically and by collecting data.

2


ASSESSMENT AND START OF GPM
Assessment and psychoeducation
Disclosure of the diagnosis. Conceptualisation including the theory of interpersonal hypersensitivity.
Rationale for GPM - Learning to "think first," social rehabilitation and corrective experiences. Change is expected, accountability, careful follow-ups.
If the patient accepts the diagnosis and GPM, we book a new appointment to start developing a care plan.

3


CARE PLAN
The psychologist or psychiatrist who made the diagnosis is responsible for the care plan.
Care plan according to GPM. Split treatments, different modalities.
Use of internal and external resources.
Goals that are concrete, measurable, achievable.
Follow-up after 3-5 visits and after 3 and 6 months. Yearly follow-up.

4

EXAMPLES OF INTERNAL AND EXTERNAL RESOURCES

Internal Resources

- Psychologists; patient- and family education and therapeutic treatment. Group treatment-skill training and ERGT. Individual therapy.
- Psychiatrists; medical optimization. Diagnostics and treatment of comorbidities. Collaborate with colleagues to support function and work ability with the goal to end sick leave. Prescribe preventive sick leave. Referral to neighboring care units.
- Nurses: collaborate with psychiatrists regarding medication management. Work with the safety plan. Structured conversation about e.g., lifestyle, physical activity, harmful use of alcohol.
- Rehab coordinator, social worker, occupational therapist; assessments, interventions and collaborations to support life outside of psychiatry, with focus on daily occupation and work. Facilitate contact with the municipality for e.g., debt relief, family counseling.

External Resources

- Social Insurance Agency, Public Employment Service, Social Services. Addiction and primary care.

5

EX OF A CARE PLAN ACCORDING TO GPM

The patient wishes to feel better, have a boyfriend and a place of her own.

Problems BPD with active self-harm, unemployed. Lives with her mother, has a lot of conflicts with her.

Goals Come to the appointments. Do homework. Use the safety plan. Learn to regulate strong emotions in a way that's not self destructive. Find work.

Specific planning

- Patient- and Family Education.
- Individual therapeutic treatment with active work with the safety plan until the start of ERGT.
- If the patient continues to frequently seek emergency- and inpatient care, consider self-elective admission as part of the safety plan.
- Meet with a social worker to support steps towards a more independent life, finding daily occupation/ work.
- Psychiatrist: for a plan for discontinuation of addictive sleeping pills, assessment of co-morbidity.
- Planned follow-up; booked appointments after 3 and 6 months. Adjustment of the care plan if needed.
- Yearly visit (as for all our patients) evaluation of the whole care plan, and level of care needed.

6

REFLECTIONS AND CHALLENGES

- GPM is a freer format than what we are used to.
- What is the actual difference between GPM and regular outpatient care?
- Stigma surrounding personality disorder persists.

7

When MBT and DBT therapists unite: Implementation and clinical experiences from a GPM matched register control study

GRANT: **ALF-medel Västra Götalandsregionen (1005922)**

Liljedahl, S. I., Nordström, L. & Choi-Kain, L. W.

[1]National Specialized Medical Care Unit for Severe Self-Harm Behaviours Sahlgrenska University Hospital, Gothenburg, Sweden, Department of Affective Psychiatry; Sahlgrenska University Hospital
[2]Center for Personality Disorders, Department of Affective Psychiatry; Sahlgrenska University Hospital
[3]Department of Psychiatry and Neurochemistry, Institute of Neuroscience and Physiology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden.
[4]Gunderson Personality Disorder Institute, McLean Hospital, Boston, USA
[5]Harvard Medical School, Boston, USA

1

How this GPM matched register control study fits into the international scientific literature

- Overview by Lois W. Choi-Kain

2

Treating EIPS / BPD in Europe

- In Europe, specialized evidence-based treatments (EBTs) are recommended for the treatment of personality disorder with the gold standard for treating BPD being specialized EBTs (1).
- Experts have proposed that the next generation of researchers and practitioners should focus on non-specialized, relatively simple treatments that may be comparably effective to specialized EBTs (2, 3), with a focus on Good Psychiatric Management (GPM) (4, 5).
- This cost-effective generalist treatment is proposed as a first-line intervention for BPD, with specialized EBTs reserved only for those who do not experience sustained therapeutic gains. Case management and psychotherapy based on six principals encompass GPM which is focused upon having a "productive and satisfactory life" (p. 128) (5).
- Formerly called General Psychiatric Management in its year-long format with greater emphasis on self-harm and suicidal behaviour (2, 3), GPM was rebranded to Good Psychiatric Management GPM) by Gunderson in 2014 (5).

3

Rationale for GPM matched control study: The Swedish context

- There are currently no indicated treatments available in public healthcare for individuals diagnosed with mild-to-moderate forms of BPD in large regions of Sweden such as the Västra Götaland Region (VGR) and Skåne (6; 7).
  - It is therefore unknown how many individuals spontaneously remit, how many remain ill, and how many progress onto severe enough forms of the disorder that they are eligible for specialist indicated treatments reserved for those with severe BPD.
    - People diagnosed with BPD here ask for lifelong sick leave since they are not eligible for evidence-based treatments but are suffering from BPD and express experiencing their lives as "not worth living".

4

Rationale (2)

- The extent to which individuals diagnosed with mild-to-moderate BPD can fully engage in their lives and the workforce is also unknown.
- The Swedish Social Insurance Agency (FK: 8) has reported that 46.3% of all ongoing sickness benefit cases are due to a psychiatric diagnosis, with mental illness being the most common reason for being on sick leave since 2014.
- The current situation for individuals with mild-to-moderate BPD in the VGR and in most communities with limited access to specialized EBTs is treatment in primary care.

  This may involve pharmacotherapy that is not indicated for BPD (9) and/or to be put on sick leave (8) with reliance on loved ones and emergency services for mental health crises (10; 11).

  Healthcare and lost productivity costs are 16 times higher for individuals diagnosed with BPD compared to matched controls (10).

5

Why a matched register control study?

- There may be necessary program adaptations required when exporting a program abroad, to do with language, cultural and pragmatic concerns (12).
- Generalist treatments designed to be flexible and adaptable are much less constrained by these parameters. Evaluating outcomes in relation to national registers as we propose in this project is by definition generalizable to society.

6

OVERARCHING PURPOSE

To develop, implement and evaluate a 10-week GPM group for individuals with mild-to-moderate BPD in the psychiatric system in Gothenburg, Sweden and compare outcomes with matched register controls

7

Aims

- 1. Compare pre-and-post clinical outcomes of GPM to demographically and diagnostically matched BPD-patient controls via Swedish national registers
- 2. Understand acceptability, safety and experience of GPM from the point of view of care providers (including adherence) and those receiving treatment
- 3. Understand the process of symptom remission, recovery, wellness and flourishing from the perspective of people before and after participating in GPM
- 4. Understand functional recovery in relation to employment, training, sick leave benefits, health care utilization and living situation.

8

Design & Methodology

A mixed-method approach using both quantitative methods and qualitative methods will be utilized. The design is a matched control study whereby individuals enrolled in GPM are matched to demographic and diagnostic patient controls

- Pre-post GPM and 1-year follow-up comparisons

Individuals selected as matched controls will further have their data linked to evaluate:

- Treatment; health care utilization; employment; training; sick leave benefits; working and living situation linked at the individual level to other national registers tracking these outcomes and measures

9

Statistical power and planned analyses

Power calculations are estimated on a final sample size of 40-45 GPM participants and 40-45 matched patient controls from the national patient register, following anticipated drop-out of 30% (13).

This sample size should be adequate to detect an effect in pre-post-testing based on descriptive and inferential statistics, and for analyzing matched patient control data from national registers using multilevel modelling.

A similar study evaluating a specialized EBT for BPD in a matched control study design reported adequate power to detect effects using a smaller sample (n=29 treatment cases with matched controls: 14).

Analyses will be based on the "intention to treat" procedure whereby those who drop out are still followed and included in analyses.

10

Matched comparison / control branch

Inclusion criteria: Adult age and documented referral rejection for not having moderate-to-severe EIPS/BPD (too mild or too high functioning)

Identifying controls: Eligibility determined by evaluating lists of individuals rejected for specialist treatment by a referral team and from primary care

Timeframe: Those who had referrals rejected between 2021-09 and 2023-12

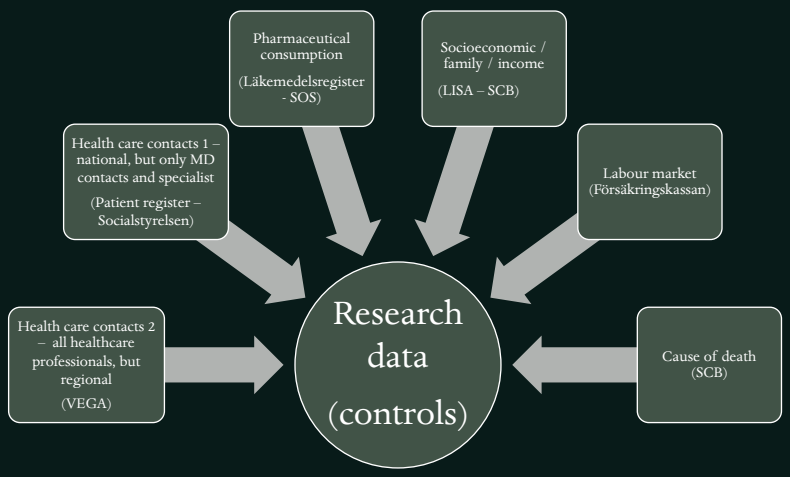
After identifying controls from those rejected for specialist treatment, we sent opt-out letters through the electronic journal system, the notification about which is sent in a text message via smartphone.

The text message notifies eligible candidates that they have a letter to read, which describes the study and gives the option to decline having their de-identified records included in the study.

They have 30 days to consider their study participation.

11

Outcomes



GPM Matched Register Study, 2026

12

Qualitative component

Every 4th participant is eligible to complete interviews regarding their experience of becoming well

On a spectrum from symptom remission to flourishing

Constructs queried by qualitative interview have to do with functional recovery such as engagement with the workforce, relationships and sense of self.

Interviews are conducted pre-and-post GPM and at 1-year follow-up

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Update from clinical branch of the study

IMPLEMENTATION EXPERIENCES

CLINICAL IMPRESSIONS

GROUP PROCESSES

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Implementation experiences

Recruitment process

We wanted to offer GPM to individuals with mild BPD/EIPS. How?

Recruiting from the referral team, from assessment and directly from primary care and other clinics

The challenge of reaching out to people who had been rejected for specialist treatment.

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Implementation experiences: Identifying GPM therapists in a specialist setting

- Genuinely liking the population, being a kind and decent person and having mental health experience from which to generalize should be more than sufficient.
- In the words of John Gunderson (5):

"You don't need to be a specialist, to be selflessly devoted, or have a larger-than life personality to be 'good enough'; you do need to be warm, reliable, interested and unintimidated"…"if you know enough to avoid being harmful, you can be, surprisingly, very helpful" p. 3-4, /5)

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Original GPM Therapist & Consultation Team

- **Therapists**: Lina (MBT therapist) and Sophie (DBT therapist)
- **Expert Consultation**: Ongoing contact with Lois Choi-Kain and the Self-Harm and Eating Disorder Organization (SHEDO) in the context of this study and other ongoing research.
- **Expectations**: We expected GPM groups to go well
- To like the participants and watch them improve
- To learn from each other
- To have fun

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Recruited participants (first 2 cohorts)

- As of March 2026, $N = 27$ individuals were recruited, of whom $n = 22$ met inclusion criteria and completed baseline assessment
  - 12 have completed T2 assessment
  - ($M_{age} = 29.23$, SD = 6.98, 90.0% female).
- A third GPM group cohort is currently ongoing (n=8)

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Clinical Impressions

- Baseline BSL-23 scores were of moderate severity
- (M = 1.51, SD = 0.70, range = 0.48 - 3.13).
- Most participants worked and cared for children.
  - This functionality would exclude them from specialist services / evidence-based treatment
  - A number had completed previous interventions about which they had critical feedback
- Many who worked had leadership positions
- Functional, but tortured:
- *"They don't have major problems with other people. They have major problems with themselves"* – Ahmad Madhawi

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Clinical Impressions: Liking and trusting the person in therapy

- An intially terrifying 180 cm (6 ft 2 in) angry tattooed gorgeous boss who we feared would derail the group due to an angry outburst and group confrontation in the first session was actually the favourite for us both
- Impressed that she dared to return and that the group accepted her
- Demonstrated herself to be charming, vulnerable and very capable:

  Could take the ball and run with it in a way that might take a less gifted person >2 years of individual therapy

  Ex. Spontaneous reflection after we taught the GPM content on Emotions

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Unified therpeutic view, plural clinical resources

- Shared MBT / DBT perspective in GPM clinical context:
  - Both similarities and differences between group members (and therapists) exist, and that is ok
    - without going into deep group processes
  - Participants expressed that they felt validated and understood by each other and supported by GPM content
  - **For example:**
    Feeling challanged by each other also supported forward movement
    - The diagnosis – EIPS is Borderline, the same dx as mother. Angry and wanted to reject this
    - Other members said gently and firmly that they have BPD and use the diagnosis to help them understand themselves. Openly and sincerely asked why she would not want this experience too.

    As therapists we knew enough to see the magic here and leave it alone

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Group process: 1. To stand out or belong

Tension between individual and collective experiences

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Group process 2: To have agency or focus on more care seeking

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Group process 3: Can we trust you / What you say?

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Group Process 4:
Wellness versus perfection (Good Enough creates space for a full life)

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10-week session overview unique to our GPM study

- Session 1. Introduction to GPM and discussion of mild-moderate BPD (symptom patterns and meaning)
- Session 2. Interpersonal hypersensitivity model + pharmacotherapy
- Session 3. Recognizing and understanding emotions
- Session 4. Managing emotions and creating safety (mentalization & simplified chain analysis).
- Session 5. Personal goals and social roles
- Session 6. Management of co-occurring clinical syndromes including pharmacotherapy.
- Session 7. The social network's role + interpersonal hypersensitivity revisited with a focus on perfectionism
- Session 8. The process of becoming well, including flourishing
- Session 9. Guidance for relatives.
- Session 10. Summary and reviewing content by week, maintenance and follow-up (booster session)

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Feedback from participants

All of our participants have had previous therapy that was not necessarily helpful

Some therapeutic terms and activities were associated with perceived failure, like goal-setting. Threatening to this crowd (OCPD traits).

Session 7: "That describes me exactly. How do I get unstuck?"

Session 8: Moving into content that is more individualized and experiential supported reconnecting to values and getting unhooked from "succeeding or failing" in a way that was formerly binary and high-stakes

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Conclusion and Next Steps

In our experience, when DBT and MBT therapists unite in the context of GPM you get complementary clinical perspectives and resources

- **We will complete the 3rd GPM cohort in June 2026 and begin the 4th in September 2026. We are financed by ALF-medel Västra Götalandsregionen (1005922) until December 2027.**

Our register data application has been approved by the Swedish Board of Health and Welfare (Socialstyrelsen).

- **Once the 30-day opt-out period ends next week, we can send the personal identity numbers of eligible controls for linkage to other registers.**

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Questions?
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