

Transdiagnostic Uses of GPM across Other Psychiatric Disorders and Personality Disorders



Afternoon May 4th

1:10 P.M. GPM as a framework for a dimensional, trigger-based approach to emotion dysregulation in borderline personality disorder

1:50 P.M. GPM and alcohol use disorder framework

2:10 P.M. Implementing at a SUD clinic

2:30 P.M. Panel

3:20 P.M. GPM—complex cases

3:50 P.M. GPM in the psychiatric emergency services Australia

4:20 P.M. Concluding Remarks

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



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2nd International conference on GPM– Karolinska Institute, Stockholm, Sweden – May 4-5th 2026

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Conflict of interest

- None

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It always starts with patients...

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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

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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

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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”

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Let's slow down a bit...

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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

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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 lens
 - 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

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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 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

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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

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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 dependence 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

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The last three years in a nutshell

- Development of a dimensional, trans-diagnostic trigger-based approach of ED
- Development of 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

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Our model *(further described on Wednesday!)*

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Evaluation (1)

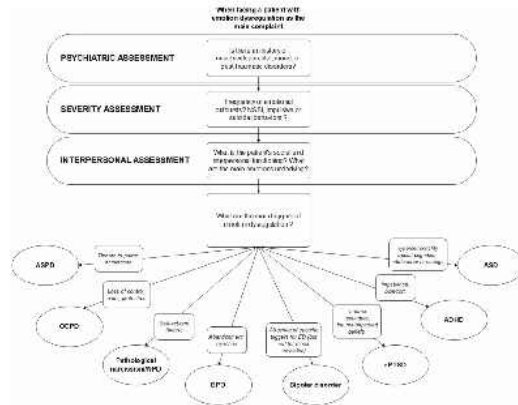


FIGURE 1
Summary of our processual approach. ADHD, attention deficit hyperactivity disorder; ASD, autism spectrum disorder; EPPS, borderline personality disorder; PTSD, complex post-traumatic stress disorder; NPD, narcissistic personality disorder; OCPD, obsessive-compulsive personality disorder.

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Evaluation (2)

TABLE 1. Summary of assessment goals and recommended types.

	Individual	T-Unit	Interpersonal/Unit
Personality Features	General personality disorder	General clinical history and description	Commonly shared patterns of relationships, developmental and family patterns, environmental
	Obsessive-compulsive personality disorder	History of obsessive-compulsive traits	Dependency system, demands, role, role, environment, ego, self, common ego defense, relationship, communication
	Axis I personality disorder	Characteristics of the personality disorder	Functioning in relationships and social adjustment, role, role, environment, ego, self, common ego defense, relationship, communication
Axis I Features	Mood disorder	Onset, duration, course, and severity	Substance use, personality, and social history, personality, and social history
	Complex post-traumatic stress disorder	History of trauma, and current symptoms	History of trauma, and current symptoms, personality, and social history
	Axis I personality disorder	Characteristics of the personality disorder	Functioning in relationships and social adjustment, role, role, environment, ego, self, common ego defense, relationship, communication
	Axis I personality disorder	Characteristics of the personality disorder	Functioning in relationships and social adjustment, role, role, environment, ego, self, common ego defense, relationship, communication

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Treatment

TABLE 2 Summary of personal and social (relational) interventions for (1) clinical psychopathology, particularly mood and anxiety

Disorder	Psychosocial focus	Relational work	Case formulation
Major depressive disorder (MDD) or minor depression	Focus on the concept of clinical high risk (CHR) or ultra-high risk. Focus on social isolation.	Focus on the diagnosis or clinical presentation of disorder, and on the extent of illness (e.g., severity, mood, and level of symptoms), possibly	Focus on a coming-into-being (existential) and learning (social) focus.
Bipolar disorder	Focus on depressive and manic episode diagnoses, on the differences between mood and emotion, and on the importance of medication.	Focus on the early signs of the disorder (e.g., onset of depression or mania in adolescence) and on the link with family history.	Focus on the exploration, tolerance, and adherence to matter of (re)city through the development of a reciprocal therapeutic relationship, but also on the acceptance of overall life changes and self-management of symptomatic episodes.
Complex post-traumatic stress disorder	Focus on the three dimensions of PTSD and their biological underpinnings, on the disturbance of self-organization symptoms, and on the construction of an individualized trauma model (encompassing typical sensorimotor or egoic, subjective, and cognitive-behavioral) relationships.	Focus on the role of self-disturbance of self-organization symptoms (e.g., of, with, or, through, the use of, the human condition) in social.	Focus on the access and construction of specific trauma-focused psychotherapy (e.g., EMDR, TF-CBT, DBT, Prolonged Exposure, etc.), with possibly a special emphasis on mindfulness to manage the associated responses and related acceptance.
Other disorders			
Autism spectrum disorder	Focus on social cognitive, hyper-sensitivity, and intolerance to sensory stimuli, and on how these symptoms may be related with IQ.	Focus on the notion of neurodevelopmental disorder and on the experience of symptoms throughout patient's history (e.g., childhood, adolescence, and adulthood).	Focus on social cognition training, with also an emphasis on the treatment framework (person and context), on unexpected change in general, and on cognitive flexibility.
Attention deficit hyperactive disorder	Focus on hyperactivity and inattentive symptoms, with a clear emphasis on their neuropsychological underpinnings and on the link with IQ. Also provide psychoeducation on medication.	Focus 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 executive dysfunction.	Focus on the importance of psychotropic medication (stimulation, tolerance, and adherence), but also of psychotherapy (mainly through cognitive-behavioral and reinforcement of compensatory strategies).

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GPM-extended

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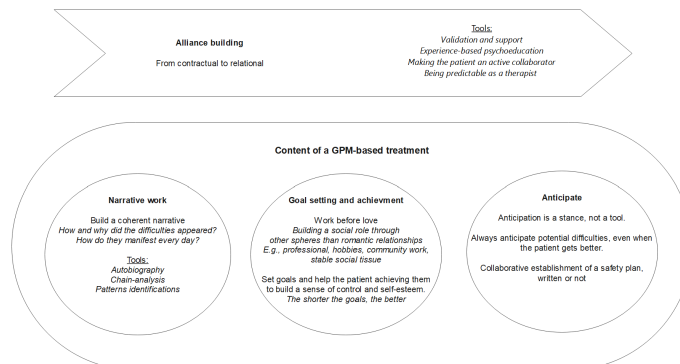
General presentation

- 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.

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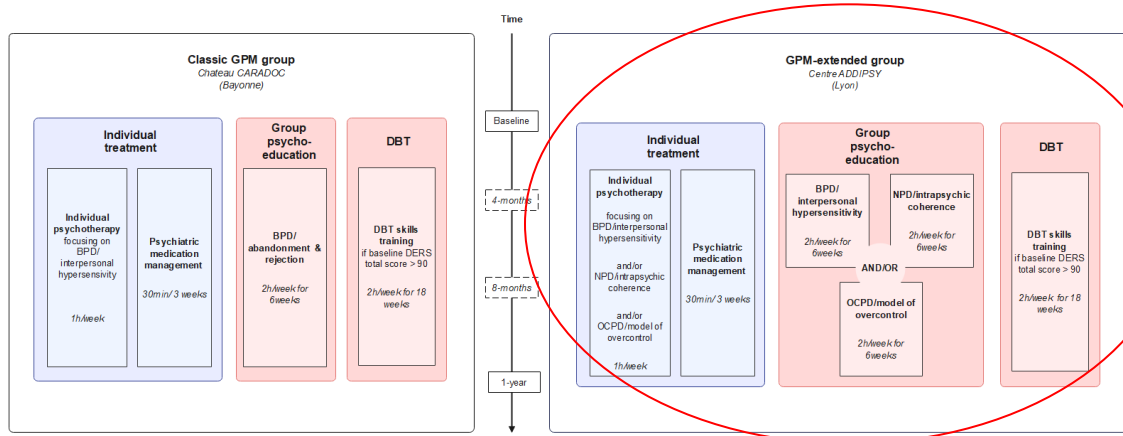
Treatment content

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



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The EPSYLIA study



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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.

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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.

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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

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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%)

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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

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What can we say?

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Summary of results

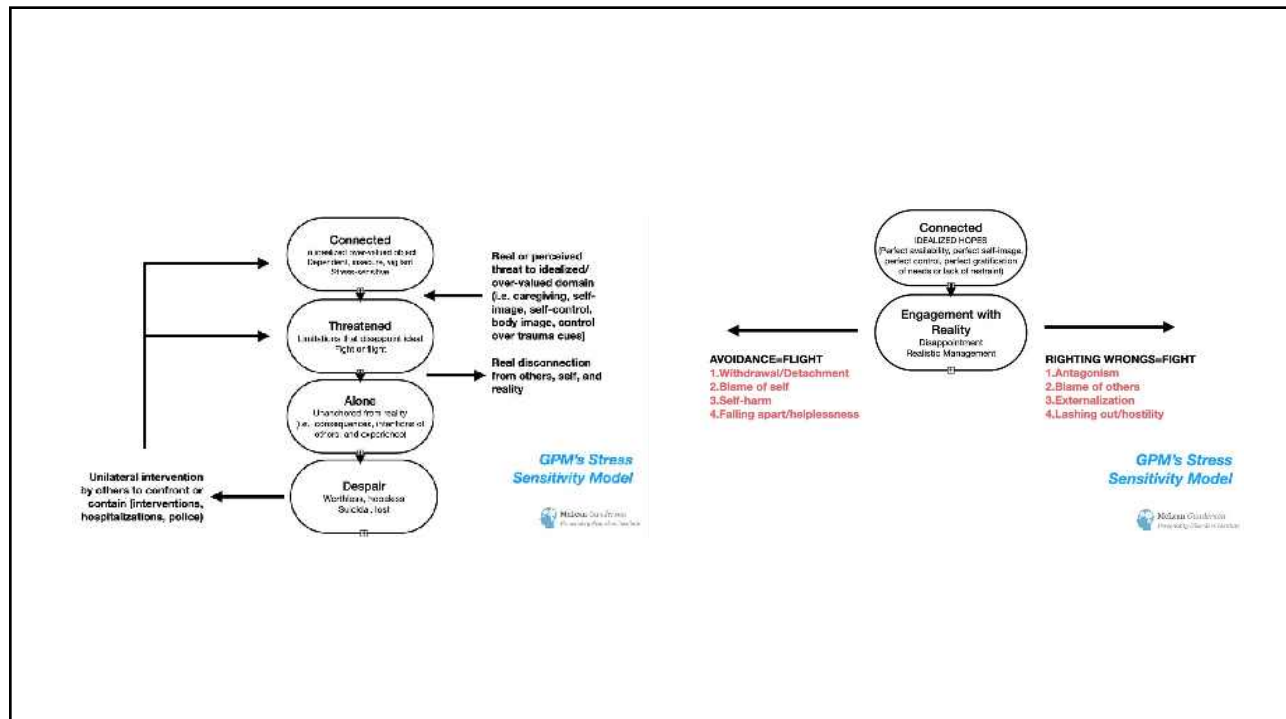
- These preliminary results suggested that, despite important methodological limitations, a dimensional *trigger-based* GPM (GPM-extended) was feasible in routine outpatient care and can lead to clinically meaningful improvements of ED and BPD symptoms
- Furthermore, they offer preliminary support for 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...

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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.

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Thank you for your attention.

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McLean Gunderson
Personality Disorders Institute

Lois W. Choi-Kain MD Med, McLean Hospital & Harvard Medical School
Treating alcohol use and personality disorder simultaneously

GPM-AUD

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GPM CONGRESS STOCKHOLM 2026

CONFLICTS OF INTEREST

- ▶ Royalties from sale of GPM books co-edited by myself and Hilary Smith Connery MD PhD

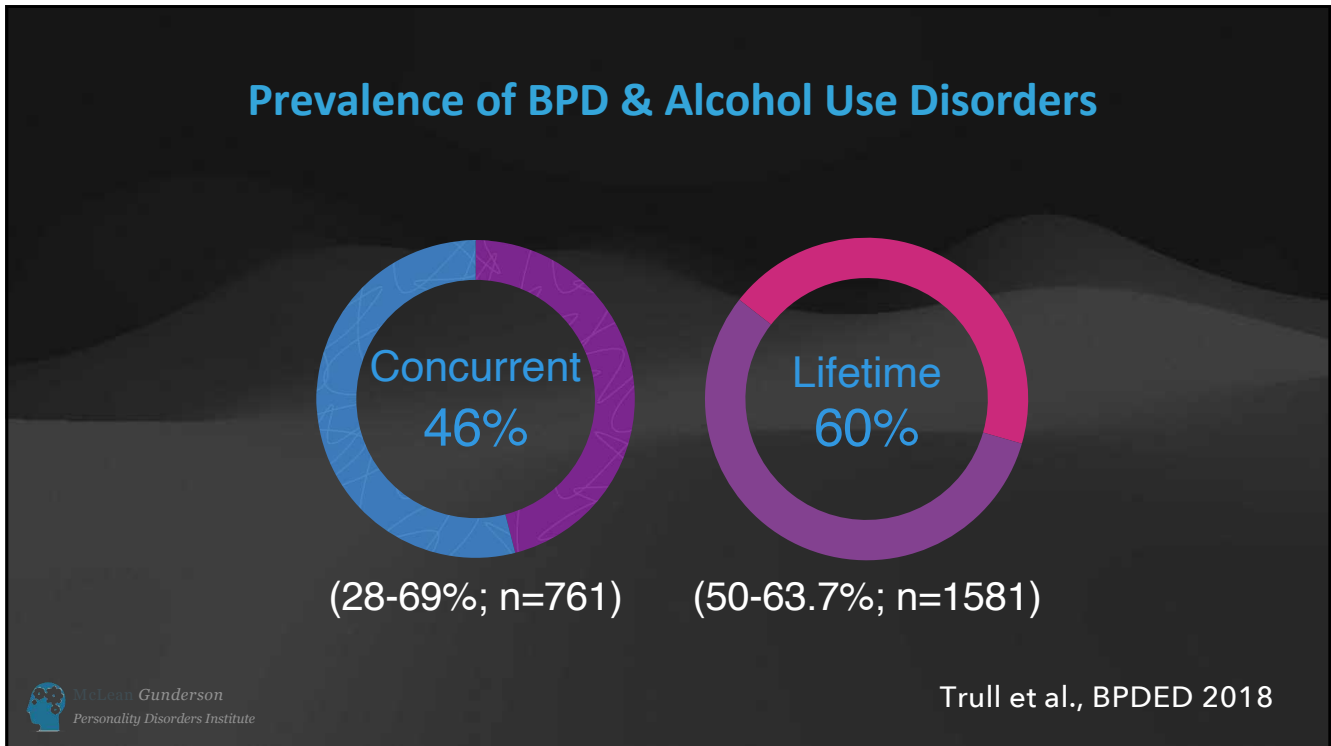
HANDBOOK OF
Good Psychiatric Management FOR
Borderline Personality Disorder

AND
Alcohol Use Disorder

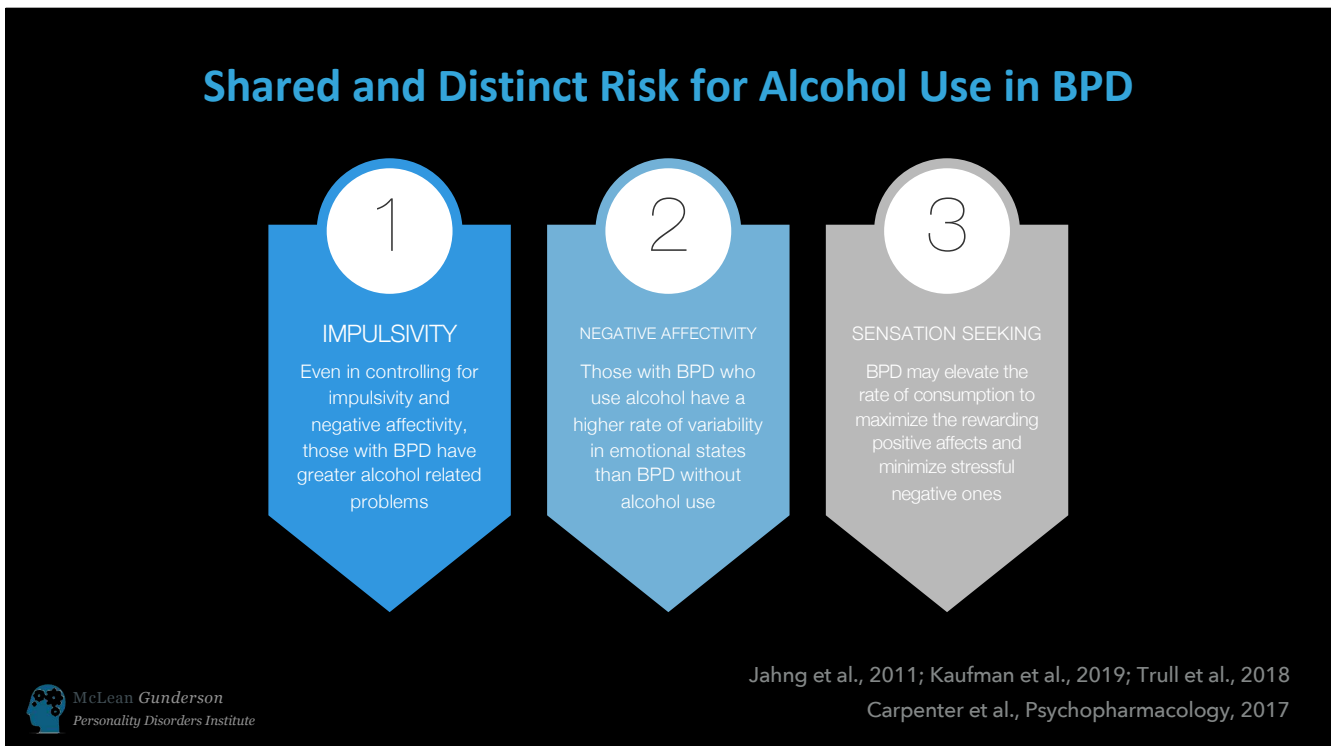
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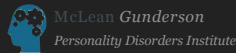


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GPM-BPD&AUD

BPD WORSENS SEVERITY AND COURSE OF AUD

- ▶ BPD predicts:
 - ▶ Earlier onset of drinking
 - ▶ Psychological problems related to drinking
 - ▶ Lifetime severity of alcohol dependence
- ▶ BPD and ASPD uniquely predicted a majority of alcohol symptoms and course variables, even controlling for co-morbidities and gender
- ▶ Increased rate of new onsets AUD in remitted and non-remitted BPD compared to OPD



Morgenstern et al., (1997) J Abnorm Psychol, Walter et al., (2009) Addiction

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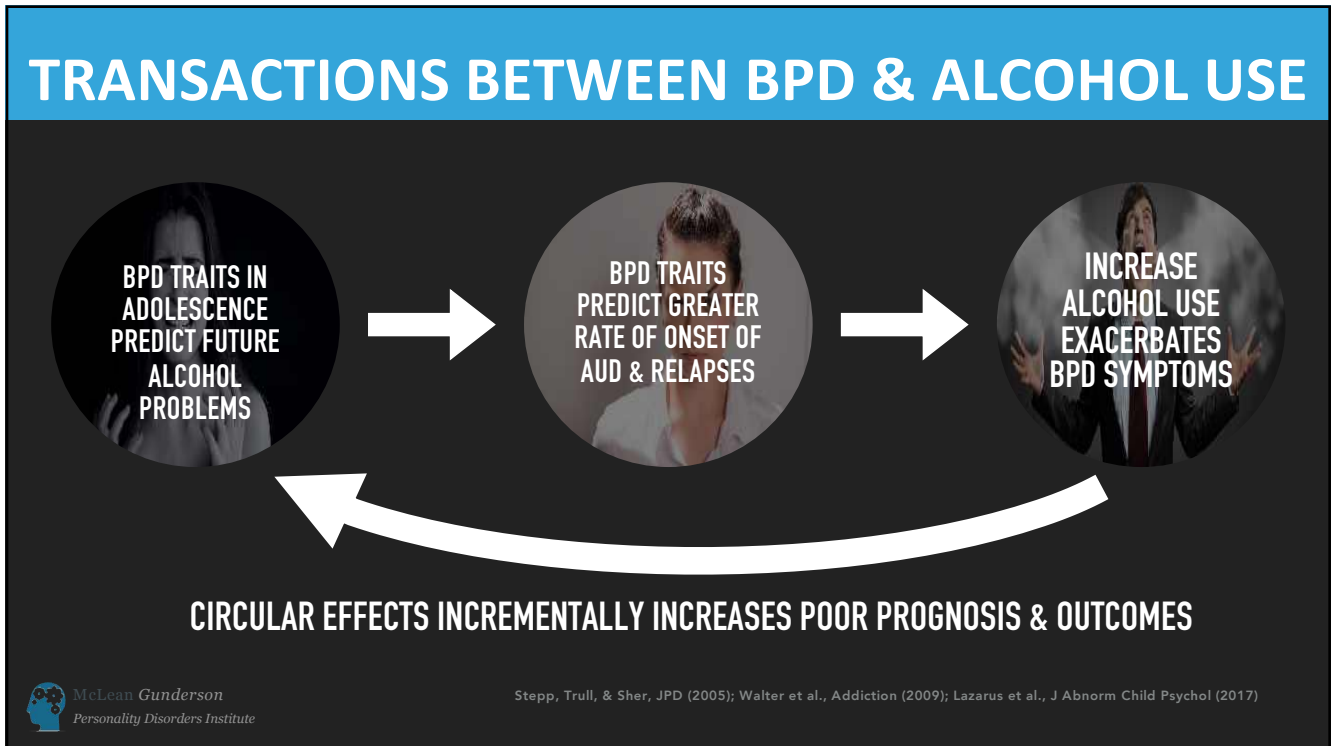


- ▶ LIMITED TREATMENT RESPONSE (RYLE & GOLYNKA, 2000)
- ▶ HIGHER DROPOUTS FROM TREATMENT (ALONG WITH OTHER AXIS I DISORDERS) WNUK ET AL., (2013)
- ▶ GREATER FUNCTIONAL PROBLEMS (UNEMPLOYMENT, LIMITED SCHOOL ACHIEVEMENT) THAN BPD WITHOUT AUD (MILLER ET AL., 1993)

AUD WORSENS BPD



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7

Alcohol Use Escalates Risk for Suicide

A major modifiable risk factor across psychiatric disorders

1

High Risk for Suicide

HR of 128 for women and 28 for men in predicting death by suicide in 5 years of follow up in large Swedish sample

Acute alcohol use associate with **OR of 6.97** for likelihood of suicide attempt. Even *low level use OR 2.71* and *high level use 37.2*

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Dose dependent risk

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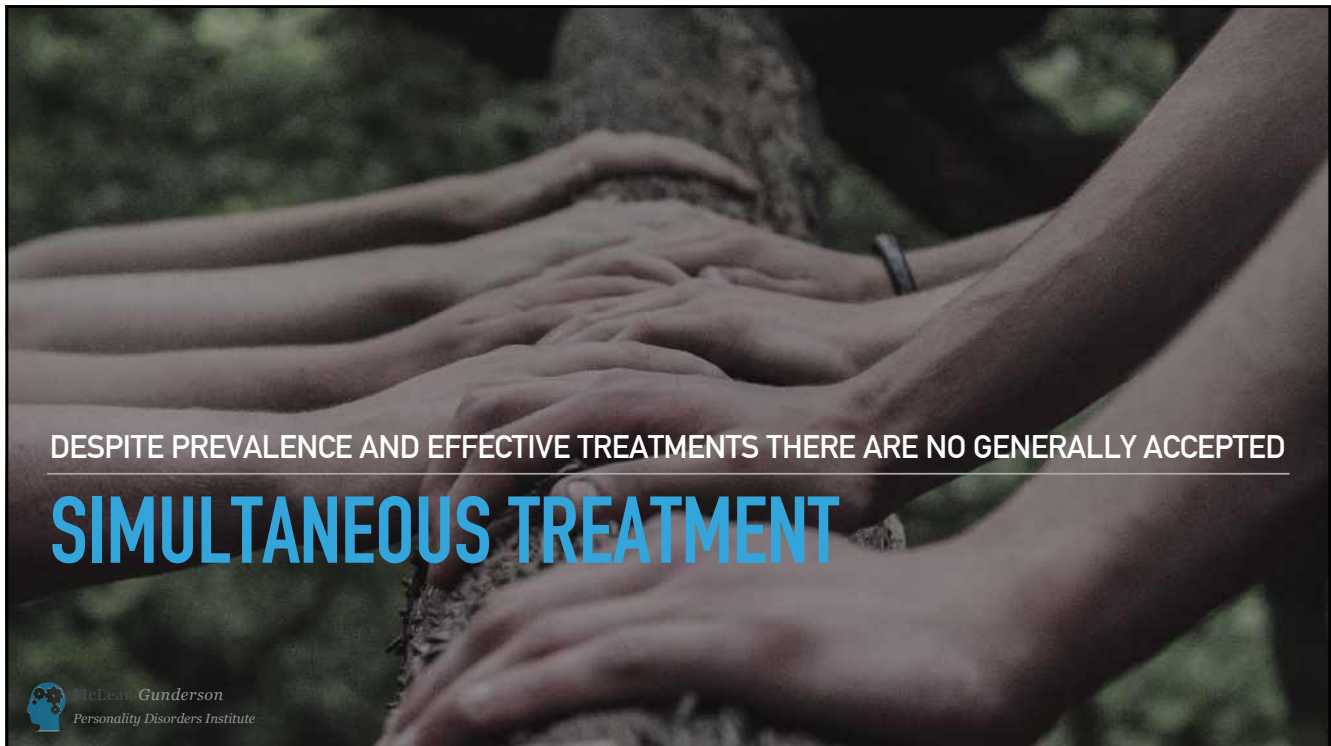
Responds to treatment

Naltrexone is a safe and effective treatment that can be combined with behavioral approaches that neither requires abstinence and targets priming responses.

McLean Gunderson
Personality Disorders Institute

Edwards et al., AJP 2020; Borges et al., Psychol Med 2016; Sinclair & O'Neill, 2020

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DESPITE PREVALENCE AND EFFECTIVE TREATMENTS THERE ARE NO GENERALLY ACCEPTED

SIMULTANEOUS TREATMENT

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GPM-BPD&AUD

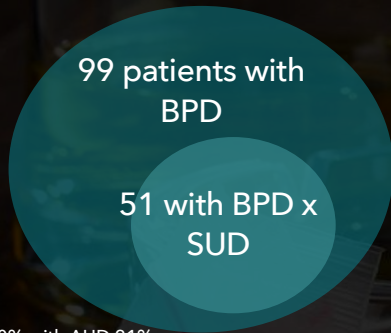
FEW RCTS ON BPD & SUD/AUD

- ▶ Dialectical behavioral therapy (DBT)
 - ▶ Linehan et al., 1999 (n= 12/15): DBT>TAU days abstinent
 - ▶ Van den Bosch et al., 2002 (n=27/31): DBT=TAU alcohol outcomes. DBT>TAU BPD related outcomes
 - ▶ Harned et al., 2008 (n=52/49): DBT> TBCE more alcohol free days, full or partial remission from SUD
- ▶ 3 Dual-focused Schema Therapy=> no difference from treatment as usual, not recommended



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10-SESSION GPM FOR CO-OCCURRING SUD



20% with AUD 21%
AUD+SUD

▶ In both BPD and BPD+SUD groups:

- ▶ ↓ general symptoms
- ▶ ↓ BPD symptoms*
- ▶ ↑ therapeutic alliance*

*significantly more so in BPD+SUD group

BRIEF GPM SEEMS TO BE EFFECTIVE FOR BPD INDEPENDENTLY FROM THE PRESENCE OF AN SUD

10-SESSION GPM FOR CO-OCCURRING SUD

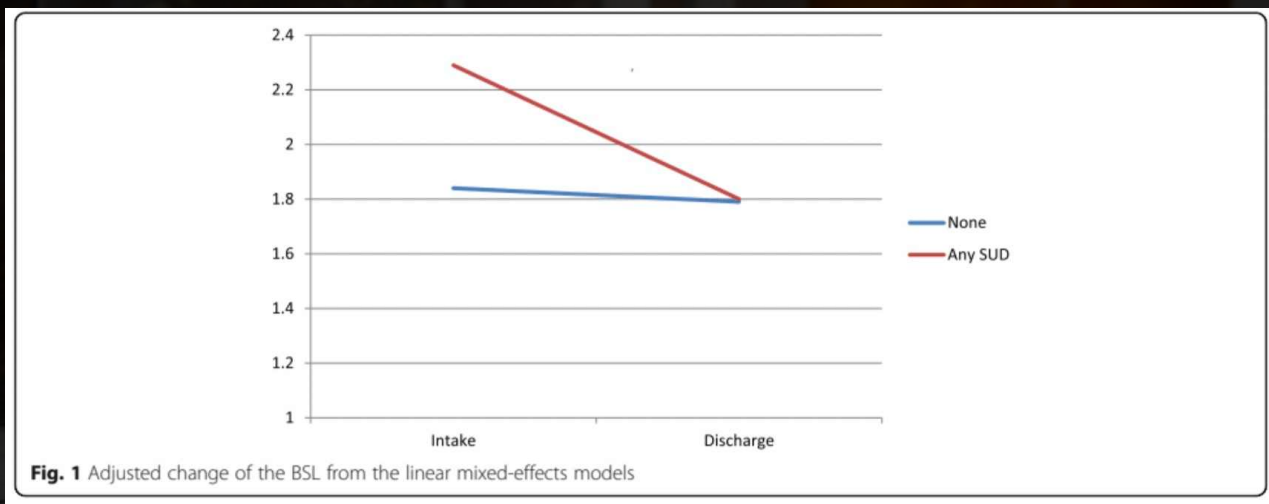
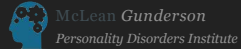


Fig. 1 Adjusted change of the BSL from the linear mixed-effects models

GPM-AUD



<p>1 Intro: Prevalence, Prognosis, Course, & Existing Treatments</p> <p>2 Overall Principles: Interpersonal Hypersensitivity</p> <p>3 DDP Integration with GPM</p> <p>4 Making the Diagnosis & Psychoeducation</p> <p>5 Setting the Framework</p>	<p>6 Managing Suicidality & Self-Harm</p> <p>7 Pharmacotherapy & Comorbidity</p> <p>8 Multimodal Treatments: Expanding Social Networks</p> <p>9 Levels of Care</p> <p>10 Putting It Altogether in Real World Settings</p>
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FUNDAMENTAL PRINCIPLES FROM DDP BASIC TO GOOD CARE IN RECOVERY

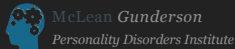


Table 1. Seven principles of DDP

Principle	Summary
Judgment-Free Zone	Clinicians can counteract the negative cycle of criticism and defensiveness in individuals with alcohol use disorders by providing a non-judgmental environment, promoting patient autonomy, and fostering reflective thinking for personal growth and understanding.
Build Narratives	Facilitating emotional connection and labeling in individuals with BPD and AUD can enhance higher-level emotion processing, relieve heightened arousal and cravings, promote reflection, and expedite recovery, while fostering self-development.
Support Self-Esteem	Promoting self-esteem and confronting denial in individuals with alcohol use disorders entails medicalizing their drinking, reframing relapse as a chronic medical condition. This alleviates guilt and motivates ongoing engagement in treatment and recovery.
Check-In Regularly	Clinicians should proactively address avoidance and misattribution in individuals with alcohol use disorders by regularly assessing their drinking behavior, even in the face of difficulty and shame, to ensure accurate evaluation and provide balanced education on the impact of alcohol on mental health.
Inform, Not Advise	In treating patients with co-occurring BPD and AUD, clinicians should limit advice-giving to avoid negative outcomes and instead offer psychoeducation as consultants, respecting patient autonomy in decision-making.
Integrate Splitting	Individuals with co-occurring BPD and AUD use dissociative splitting as a coping mechanism, making it challenging for them to make balanced decisions about drinking; clinicians must navigate this by exploring both positive and negative aspects of drinking while addressing polarized perspectives, anger, and shame.
Build Authentic Relatedness	Clinicians can address competing dependency needs and fears of vulnerability within patients by setting boundaries, fostering collaboration, promoting authentic disagreement, supporting autonomy, and checking in for ambivalence to enhance the therapeutic alliance.

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Strategies to balance attachment needs & autonomy

Clear boundaries, roles, and expectations

Agreed-upon goals and tasks

A “target” on the therapist- encourage disagreement

Support for autonomous decision making

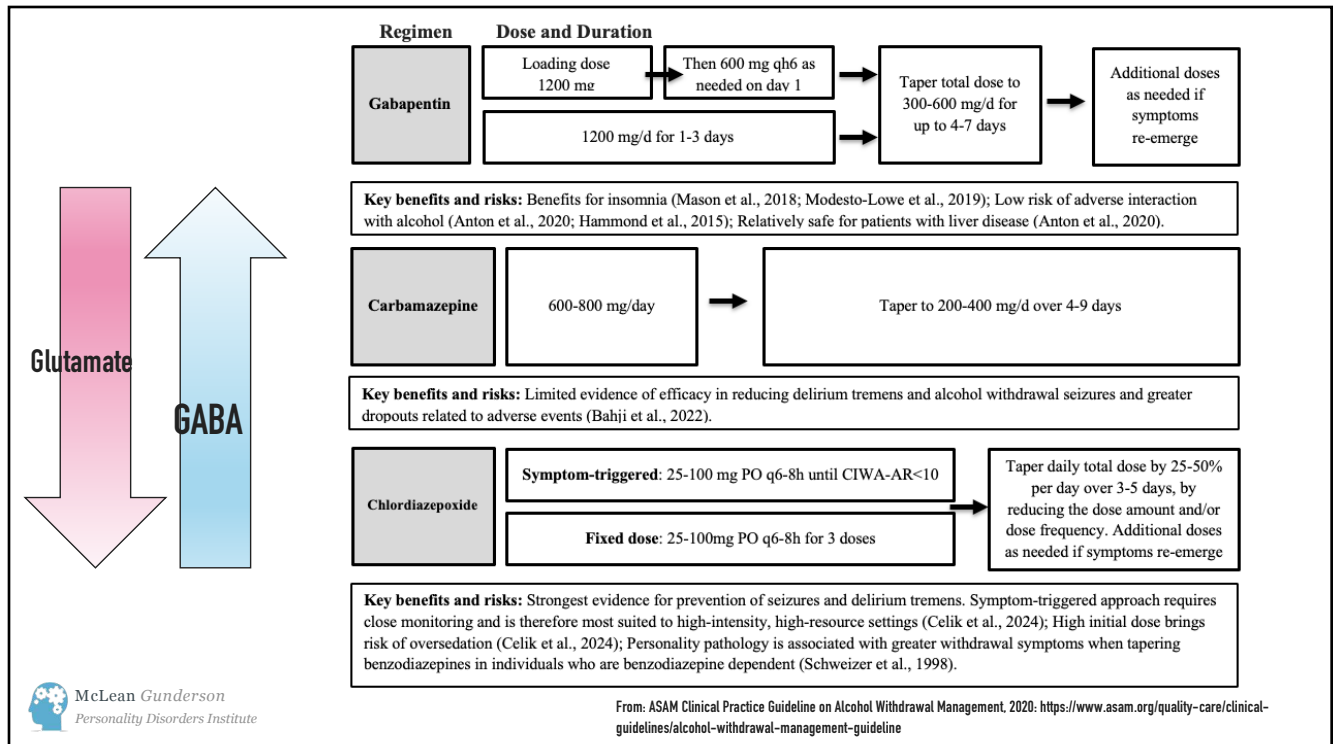
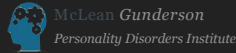
Normalization of ambivalence towards the treatment and clinician

GPM-AUD MEDICATION MGT OVERARCHING PRINCIPLE:

**INDIVIDUALS' PHYSIOLOGY IS THE SAME,
BUT THE STRATEGIC, INTENTIONAL, EMPATHIC CONTEXT WITHIN
WHICH MEDICATIONS ARE USED CAN SUPPORT BOTH SAFETY AND
THE BROADER GOALS OF GPM**

GPM-AUD MEDICATION MGT

- 1** Treat AUD and BPD simultaneously
- 2** Set framework with medical and 12-step model
- 3** Safety as a top priority
- 4** Keep patients in treatment
- 5** Encourage autonomy: Medications work if you take them
- 6** Prescribe medications by standards of care
- 7** Negotiate for behavioral change
- 8** Avoid polypharmacy



From: ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, 2020. <https://www.asam.org/quality-care/clinical-guidelines/alcohol-withdrawal-management-guideline>

MEDICATIONS FOR ALCOHOL USE DISORDER (MAUD)

Fear

- Disulfiram*

Stabilize PAW

- Acamprosate*
- Gabapentin
- Topiramate

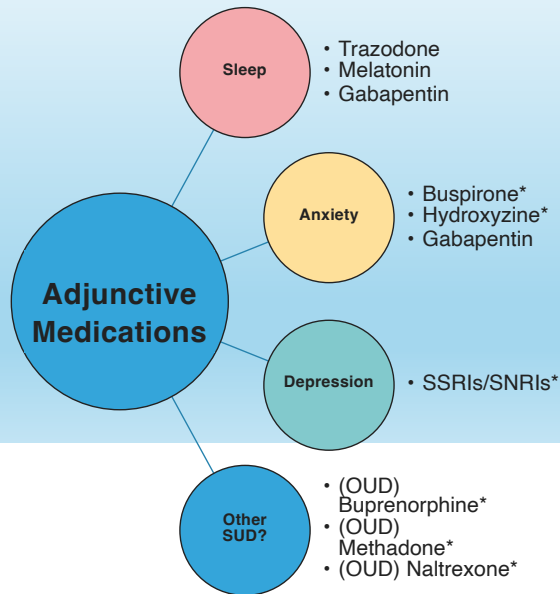
Decrease Reward

- Naltrexone*
- Nalmefene

* FDA Approved for AUD treatment

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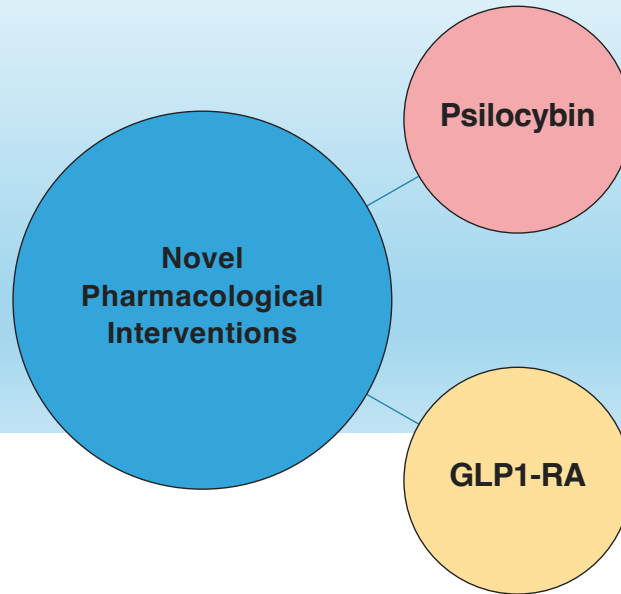
MEDICATIONS FOR ALCOHOL USE DISORDER (MAUD)



* FDA Approved for treatment of condition listed

20

NOVEL PHARMACOLOGICAL INTERVENTIONS FOR AUD



21

PSYCHEDELICS (BOGENSCHUTZ, 2022)

Reduced Alcohol Use

- Participants treated with psilocybin reported higher levels of abstinence than those receiving diphenhydramine.
- Participants treated with psilocybin reported less heavy drinking days (M = 9.71) than those receiving diphenhydramine (M = 23.57).

Reduced Alcohol Misuse

- Participants showed moderate to large reductions in alcohol related problems, even at the last follow up, 32 weeks later.

Adverse effects

- There were no serious adverse effects of psilocybin administration.


Bogenschutz et al., 2022 *JAMA*

22

JAMA Psychiatry

RCT: Psilocybin-Assisted Treatment of Alcohol Use Disorder


POPULATION
53 Men, 42 Women




Adults with alcohol dependence
Mean age, 45.8 y

SETTINGS / LOCATIONS
2 Academic centers in New York and New Mexico

INTERVENTION
95 individuals randomized




Psilocybin
Administered orally in 2 all-day sessions (dose range, 25-40 mg/70 kg)



Diphenhydramine control
Administered orally in 2 all-day sessions (dose range, 50-100 mg)

PRIMARY OUTCOMES
Percent heavy drinking days (scale, 0-100), assessed using the timeline followback interview, contrasted between groups over the 32-week period following their administration of study medication.

RESULTS
Percent heavy drinking days during the 32-week double-blind period was lower in the psilocybin group compared with the diphenhydramine group.



Bottom Row: Drinking Days
Psilocybin = 9.7%
Diphenhydramine = 23.6%
 Mean difference, 13.9 (95% CI, 8.0-20.7) P = .001

Dependence MH. *JAMA Psychiatry*. 2025;82(4):419-428. doi:10.1001/jamapsychiatry.2024.10000. Published online August 13, 2025. doi:10.1001/jamapsychiatry.2024.10000

23

GLP-1 (HENDERSHOT, 2025)

In Lab Alcohol Use

- There was a significant effect of medication on the amount of alcohol consumed in the laboratory self-administration task
- There was no group effect of either delay to drink or total abstinence.

Weekly Alcohol Use

- Weekly outcomes showed a similar effect with less drinks on drinking days over time, but no effects on the number of drinking days.
- Semaglutide significantly reduced weekly craving of alcohol and cigarettes.

Adverse effects

- No serious adverse events were reported..

Hendershot et al., 2025 JAMA

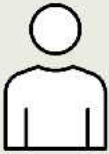
24

JAMA Psychiatry

RCT: Once-Weekly Semaglutide in Adults with Alcohol Use Disorder

POPULATION

14 Men, 34 Women



Non-treatment-seeking adults meeting criteria for alcohol use disorder

Mean (SD) age, 39.9 (10.6) y

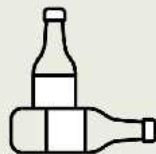
SETTINGS / LOCATIONS



1 US academic medical center

INTERVENTION

48 Participants randomized and analyzed



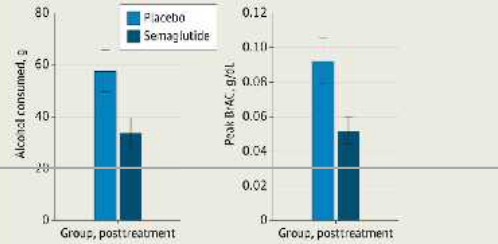
24 Semaglutide
Once-weekly semaglutide
24 Placebo
Placebo injections

PRIMARY OUTCOME

Estimated alcohol consumed over 120 min during laboratory self-administration (estimated alcohol consumed in grams and peak breath alcohol concentration [BrAC] in g/dL)

FINDINGS

Among participants consuming alcohol in a laboratory session following 8 wk of treatment, those in the semaglutide group drank significantly less alcohol than those in the placebo group



Mean (SD) alcohol consumed: Semaglutide: 33.62 (20.72) g; placebo: 57.19 (28.15) g

Mean (SD) peak BrAC: Semaglutide: 0.052 (0.029) g/dL; placebo: 0.092 (0.046) g/dL

Effect sizes: Alcohol consumed: β , -0.48; 95% CI, -0.85 to -0.11; $P = .01$; peak BrAC: β , -0.46; 95% CI, -0.87 to -0.06; $P = .03$

Hendershot CS, Bremner MP, Paladino NB, et al. Once-weekly semaglutide in adults with alcohol use disorder: a randomized clinical trial. *JAMA Psychiatry*. Published online February 12, 2025. doi:10.1001/jamapsychiatry.2024.4789

25

ADDRESS CO-OCCURRING DISORDERS

PRIORITIZE CO-OCCURRING DISORDER WHEN



COMORBIDITY PRECLUDES INVOLVEMENT OR ACTIVE LEARNING

NEURODIVERSITY
SUBSTANCE USE DISORDER,
ANOREXIA, MANIA,
PSYCHOSIS

PRIORITIZE BPD WHEN



COMORBIDITY IS UNLIKELY TO REMIT OR LIKELIER TO RECUR UNLESS BPD IS IN REMISSION

DEPRESSION, ANXIETY,
SOCIAL PHOBIA, NON-MANIC
BIPOLAR DISORDER (I OR II),
BULIMIA

STABILIZE BPD BEFORE ADDRESSING COMORBIDITY TO



INCREASE PATIENT'S ABILITY TO TOLERATE EXPOSURE THERAPY

PANIC DISORDER,
PTSD, OCD

26

THANKS TO TEAM GPM-AUD



Handbook Editors

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Hillary Connery, MD, PhD

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Julia Jurist	

Implementing at a SUD clinic

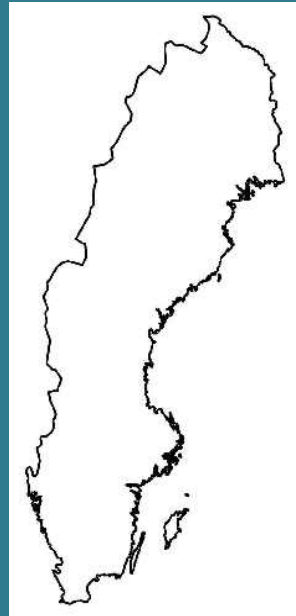
Susanna Krus - Specialist Nurse
Klara Schultz - Psychologist
Isabel Jadbäck - Specialist Psychologist



1

Addiction Clinic, Malmö

- ~ 700 patients
- Multiple sub-teams
- Complex clinical presentations
- Common diagnoses: BPD, ASPD, ADHD, PTSD



2

Comorbidity SUD - BPD

Important to recognize!

More severe symptoms

Reduced quality of life

Increased risk of death



3

Why GPM?

- Structured framework is necessary.
- Multiprofessional collaboration.
- Local guidelines – offer GPM as a first-line intervention following diagnosis.
- An intervention that all staff at the clinic can provide.
- There are knowledge gaps regarding effective treatment for BPD and SUD.

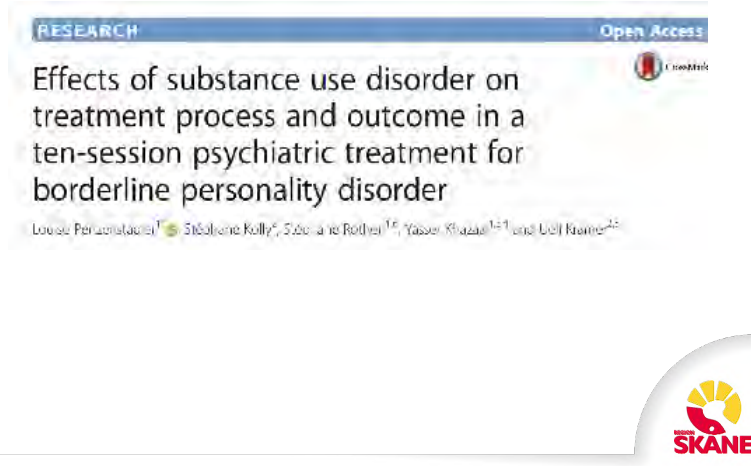


SBU. *Treatment and social support interventions for co-occurring substance use and other psychiatric disorders: A systematic review of interventions, health economics and ethics.* Stockholm: Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU); 2025. Available from: <https://www.sbu.se/372>

4

Why GPM?

GPM had been evaluated on a small scale in patients with BPD and SUD.



5

GPM-team



Jonas Berge
Senior Consultant,
Associate Professor



Klara Schultz
Psychologist



Susanna Krus
Specialist Nurse



Education



Team



External supervision



Stina Ingves
Specialist Nurse



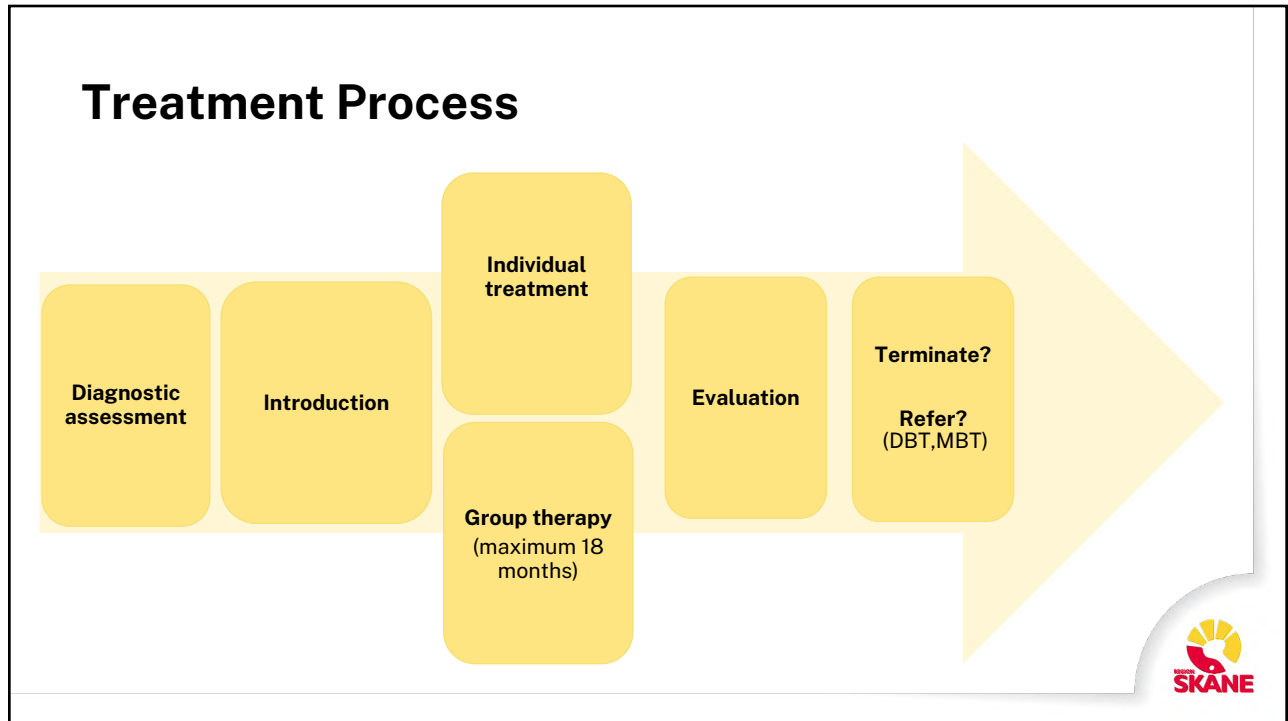
Emma Larsson
Social Worker



Isabel Jadbäck
Specialist Psychologist



6



7

Treatment Process

Diagnostic assessment

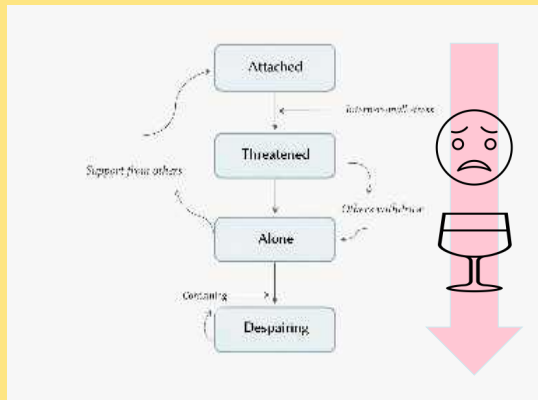
- Stability
- Joint assessment
- Cognitive ability

The SKANE logo is located in the bottom right corner of the slide.

8

Treatment Process

Introduction



9

Treatment Process

Individual treatment

- Goal
- Crisis plan
- Individual Placement and Support (IPS)
- Brief admission
- Treatment of comorbid conditions (PTSD)



10

Treatment Process

Group therapy

- Group rules
- Composition
- Theme



11

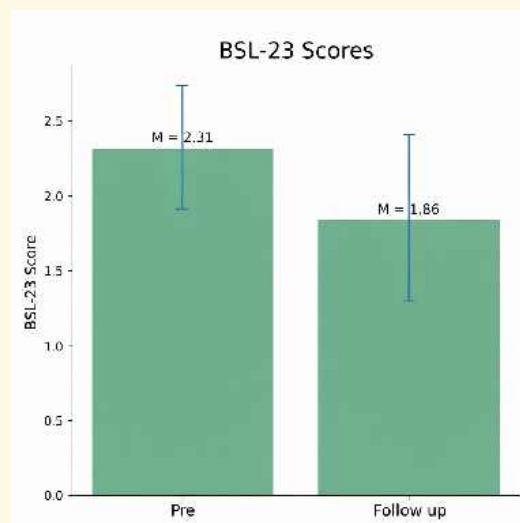
Results

Change in BSL-23 scores from pre- to follow-up (n = 11)

Mean duration of treatment at follow-up = 12 months.

Significant reduction in symptoms ($p = .041$)
Medium-to-large effect size ($d \approx 0.71$)

Most participants improve but have significant symptoms at follow up



12

Interview

What is GPM?

“GPM is for people with similar difficulties, and the idea is to help each other by sharing experiences.”

“It’s hard to describe, but you should feel less alone. You get support from others with the same diagnosis and from facilitators.”



13

Interview

What symptoms troubled you before starting treatment?

“My separation anxiety was the worst; I almost became obsessed with others.”

“Problems in relationships, unstable emotions and mood swings...”

“I had a lot of problems with anger directed outward. Strong emotions that were hard to control. I couldn’t put words to my feelings or connect them to my reactions.”



14

Interview

Is there anything you can do today that you couldn't before treatment?

"I can communicate better with people around me about how I am feeling."

"Setting boundaries – standing up for myself."

"I have become better at avoiding situations that can easily lead to relapse."



15

Interview

How much has the treatment helped you overall?

"Very much. I am a completely different person today. GPM motivates me to stay sober."

"Hard to see change during treatment, but I can see it now in hindsight. I'm more tolerant toward myself... something has changed, even if I can't say exactly what."

"My friends have noticed a positive difference – not just that I stopped using drugs."



16

Interview

Did you experience any disadvantages of the treatment?

“It didn’t feel like it was for me and it was hard to catch up on everything I missed at work”

“It’s a bit difficult that the group meetings are in the afternoon — I end up waiting all morning.”



17

Key Lessons

Challenges

Intake to the GPM team has been adjusted over time - patients need to be relatively stable and motivated.

Difficult to evaluate the intervention as a whole and to discharge patients considered fully treated.



18

Key Lessons

Advantages

Team-based work with a challenging patient group.

The method has a name and is time-limited.

Patients feel validated when difficulties beyond substance use are acknowledged.



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isabel.jadback@skane.se





Borderline Personality Disorder Collaborative

GPM Complex: implementation of a systems approach to the treatment of BPD

Laura Cooke-O'connor | Advanced Clinician Coordinator
Cathy McLeod Everitt | Service Development Manager

1

South Australia

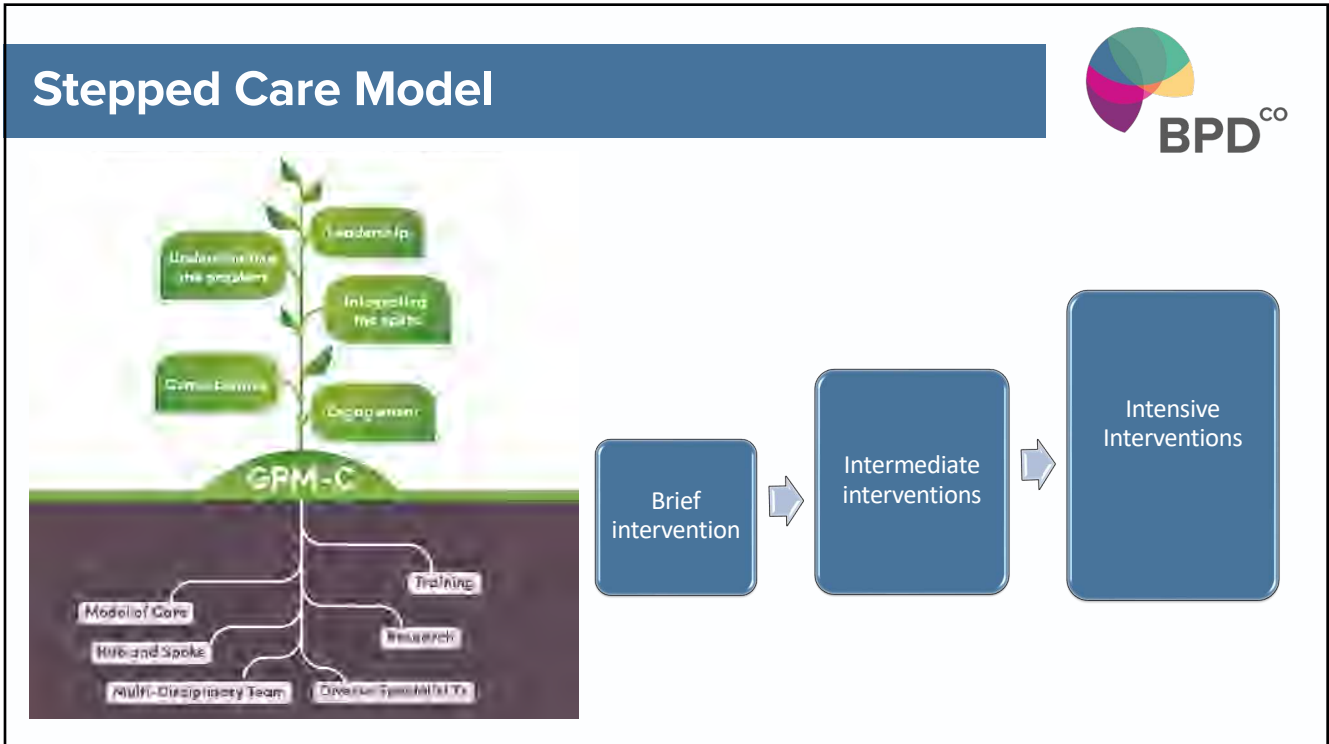


Population: 2m
Area 983, 482km²

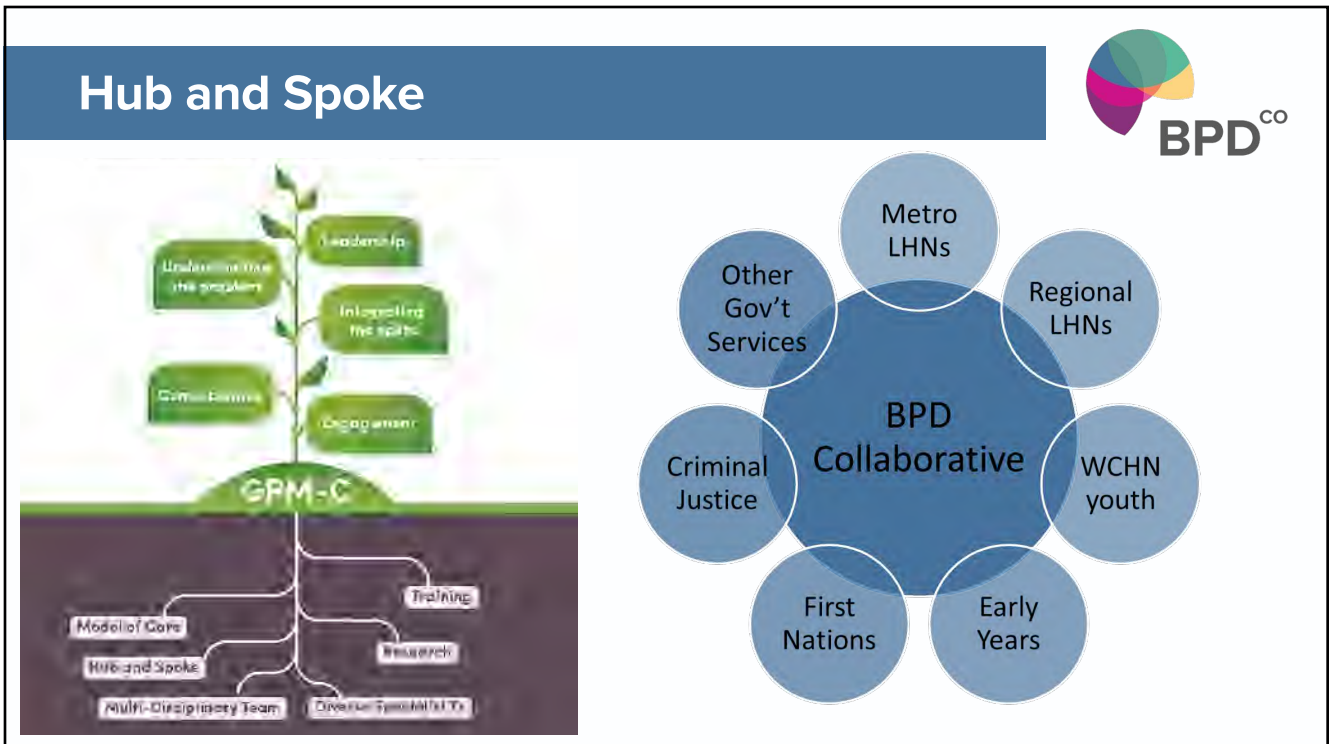
BPD pop est:
17,700 – 70,800

BPD Co: 12.5
Clinical FTE

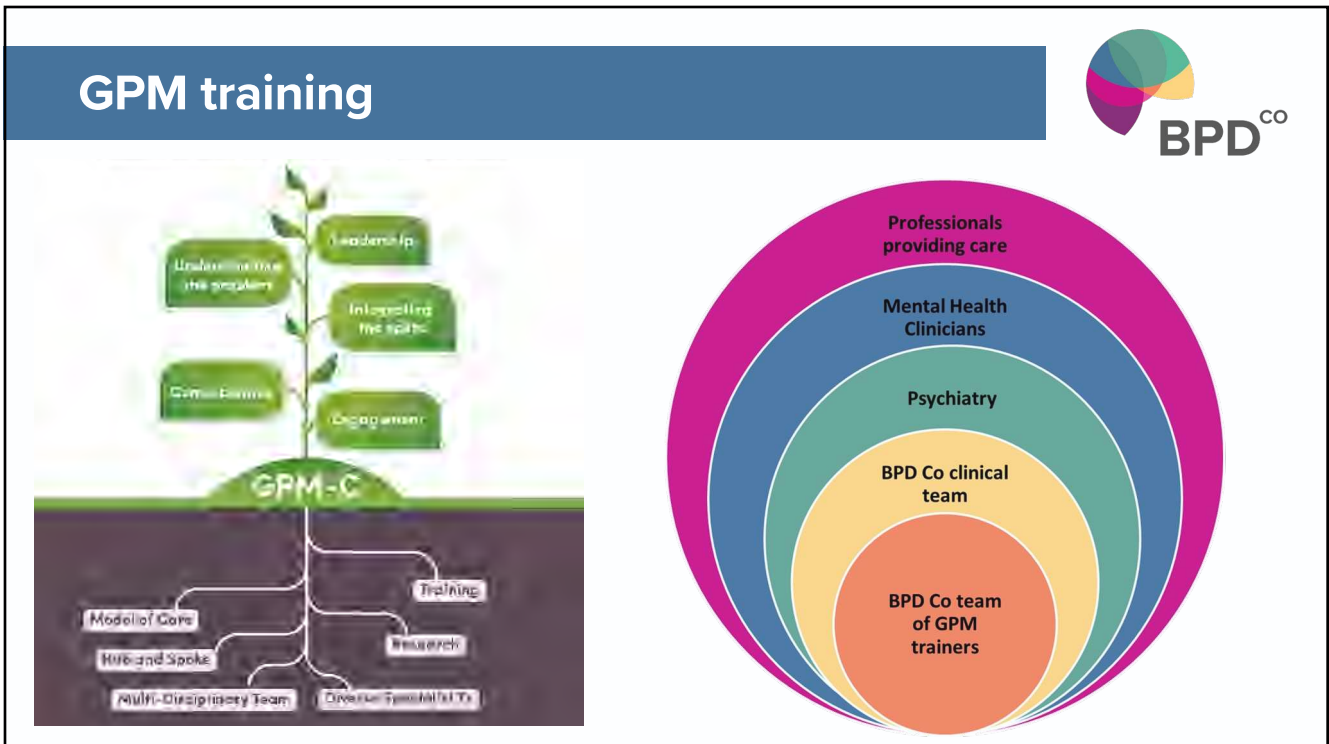
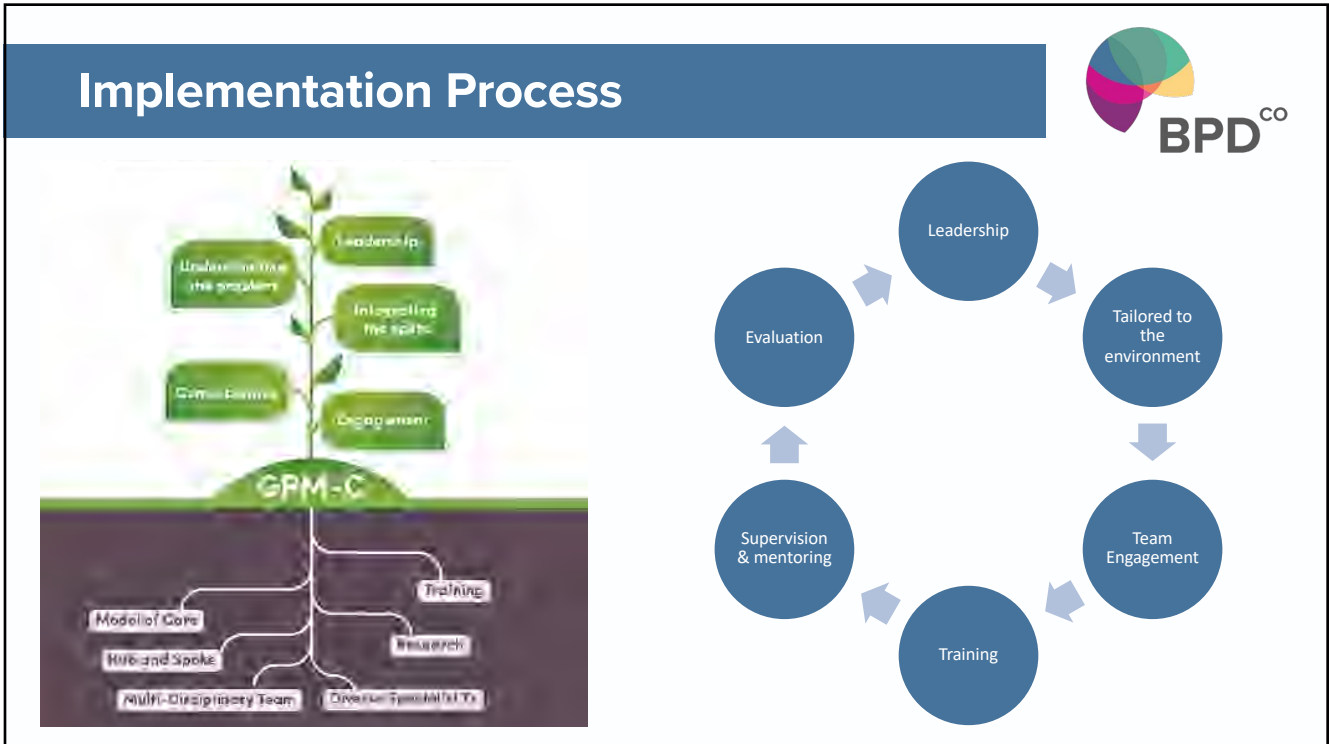
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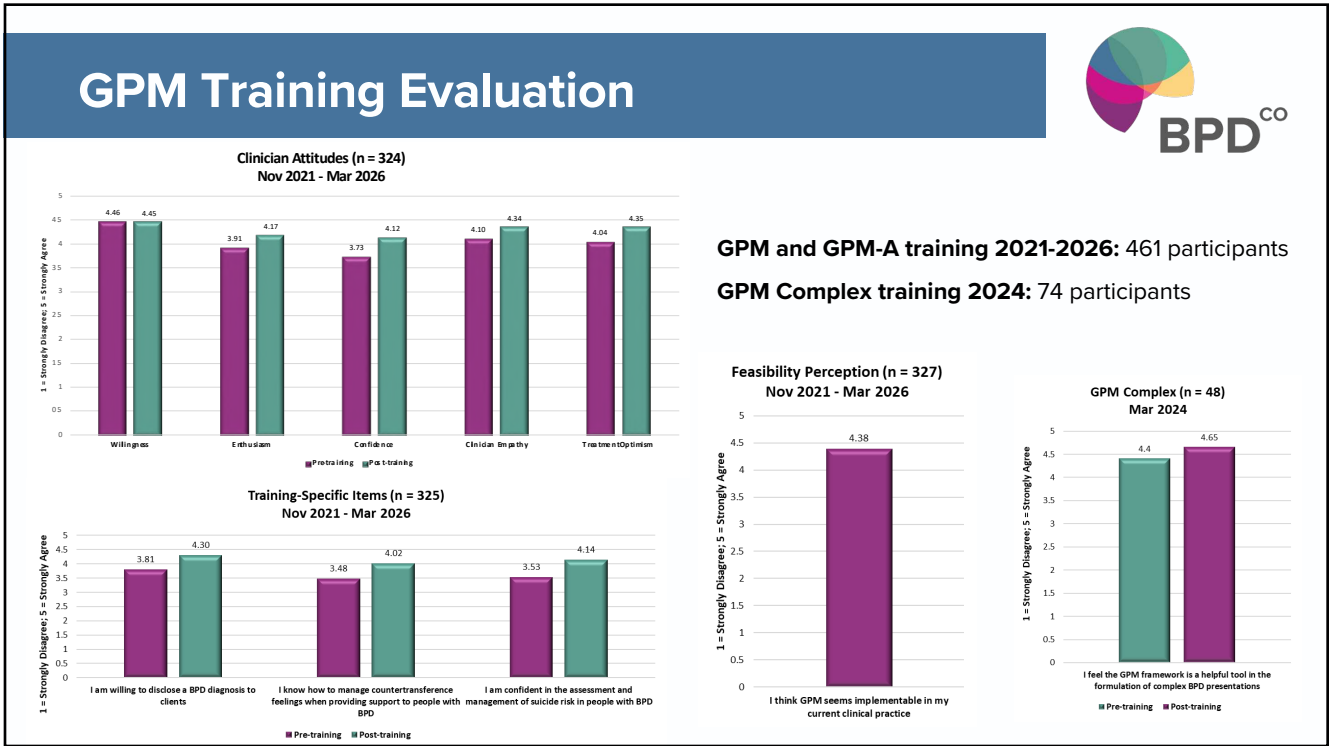


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4





7

Complexity



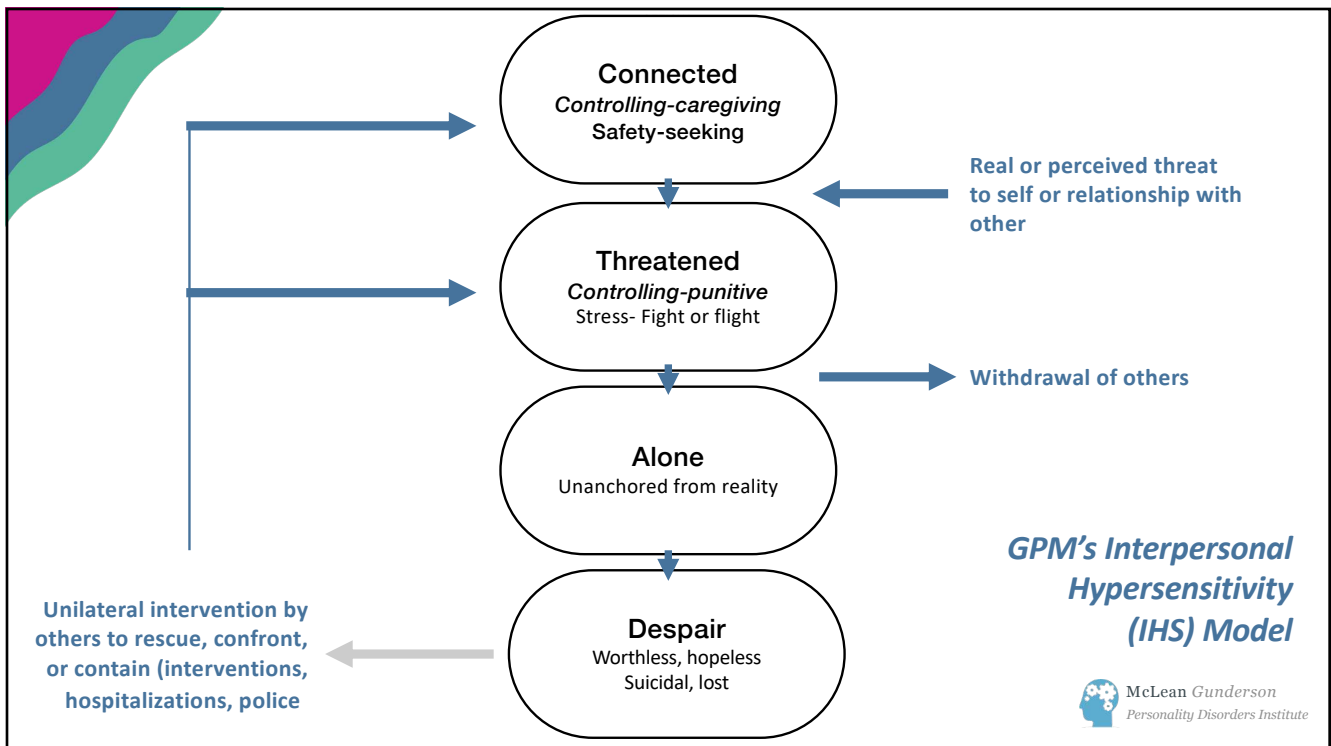
- 3 or more comorbid psychiatric diagnoses
- Frequent acute service utilisation
- Presenting with high risk
- Requiring support from multiple systems (Mental Health, Acute hospital/ED, First Responders, NDIS)

8

GPM – COMPLEX CARE PRINCIPLES



9



10

GPM: Therapeutic approach

- **Education is essential** – especially for the social safety network
- **Non-specific factors are central** – reliability, listening, concern
- **Relational issues are central** – attachment, trust
- **Situational changes can be essential** – advise, assist
- **Pragmatism** – every patient is different; forego theory if it isn't working; if not now, wait

11



Case Study



12

Background

Name: Lenora

Details: 16 yo female

Background: Complex developmental trauma, disrupted attachment. Removed from parents as a child, placed in care with grandparents, then returned to live with mother age 14yo. Removed from mother's care by Child Protection Services, placed in residential care with multiple placement changes and breakdowns.

Maladaptive care seeking behaviour, frequent presentations to Hospital following self harm and presenting with physical issues to elicit admission, some complaints fictitious.



13

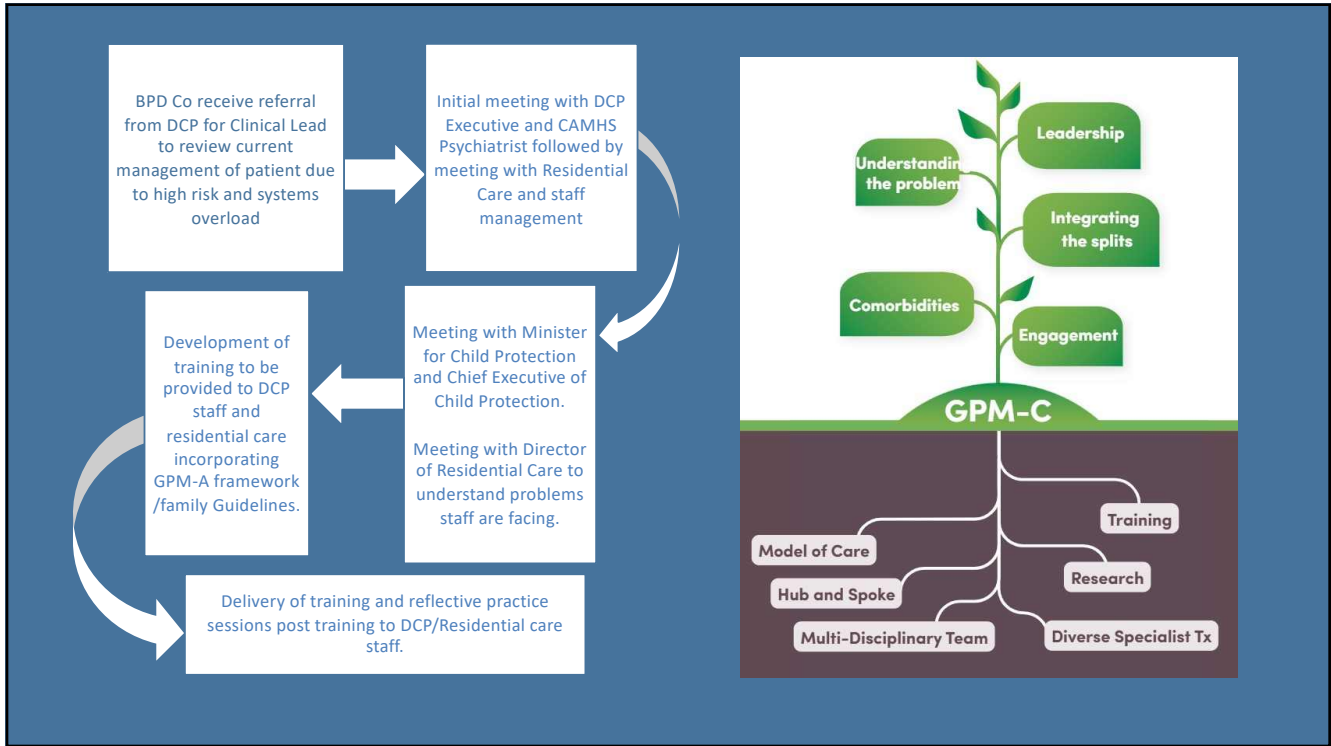
Symptoms: emotional dysregulation, auditory/visual hallucinations, suicidal/homicidal ideation, severe self-harm ingestion of glass, razor blades, self starvation.

Diagnosis : BPD, C-PTSD, FND, ADHD, ID.

Services involved: Department of Child Protection, Residential Care, CAMHS Guardianship team, Children's Hospital ED, Adolescent inpatient ward, RAH surgical team, RAH consultation/liaison team, SAAS, SAPOL, Education, NDIS



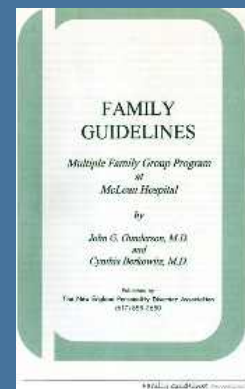
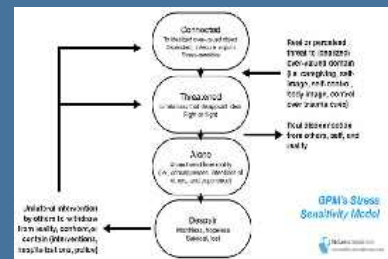
14



15

Training the residential care team

- Introducing the ICM as a framework to help increase understanding
- Exploring how to lean in, to be active and not reactive, to get them more organised, responsive, predictable, consistent and reliable
- Using the principles in the family guidelines to:
 - Providing care not treatment
 - Keeping things cool and calm
 - Change is difficult and fraught with fears – go slowly with setting goals
 - Being realistic about expectations
 - Not getting defensive in the face of accusations and criticisms
 - Listening to negative feelings
 - Paying attention to self destructive acts



16

Feedback from staff after training and reflective practice sessions introducing GPM framework;

They acknowledge they were not responding to Lenora but to the system needs/demands. That the high number of staff/services involved was more about how many people it takes for staff to feel safe.

They tell you they have reduced the care team and have noticed there is less interpersonal noise in the house.

They are focusing on spending time with Lenora, instead of filling in forms about her, taking the time to lean in and have noticed their tolerance for risk has increased. That there is a focus on consistent behaviour from staff.



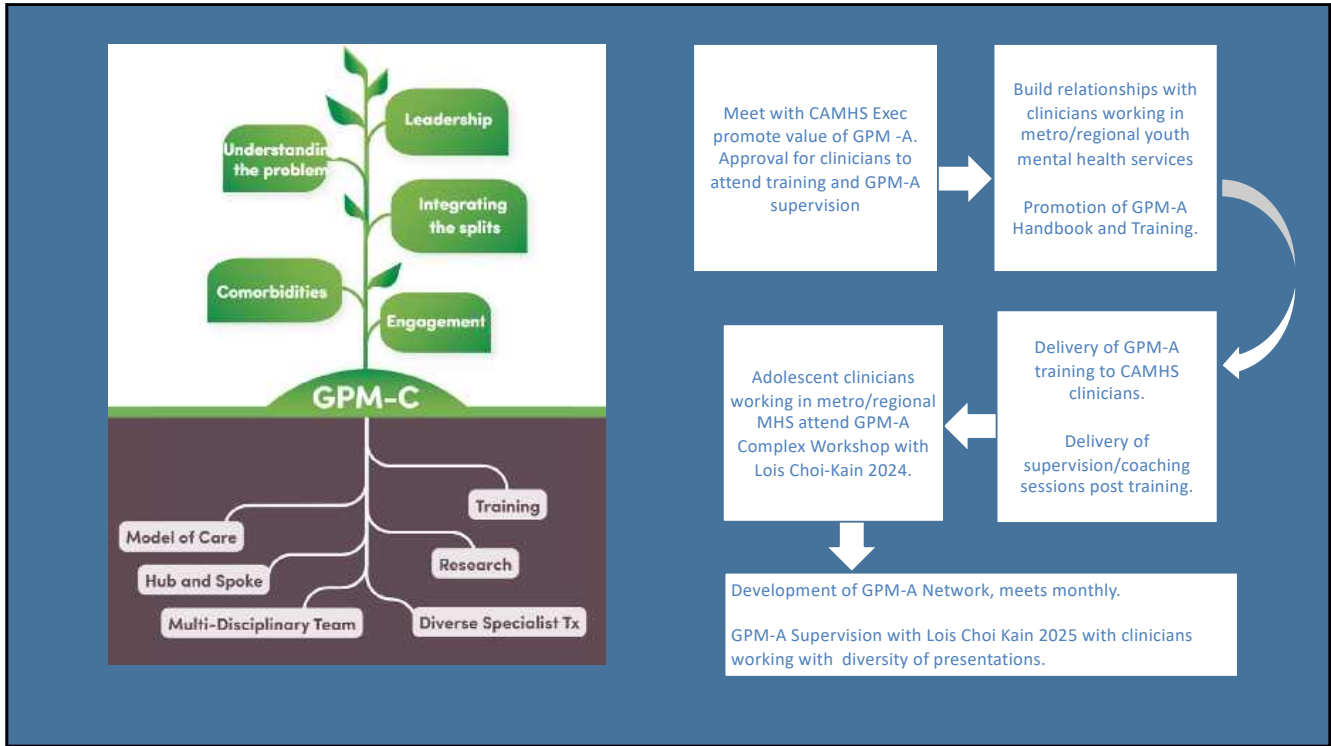
17

You meet with the CAMHS clinician to provide GPM-A coaching until they can attend training and supervision:

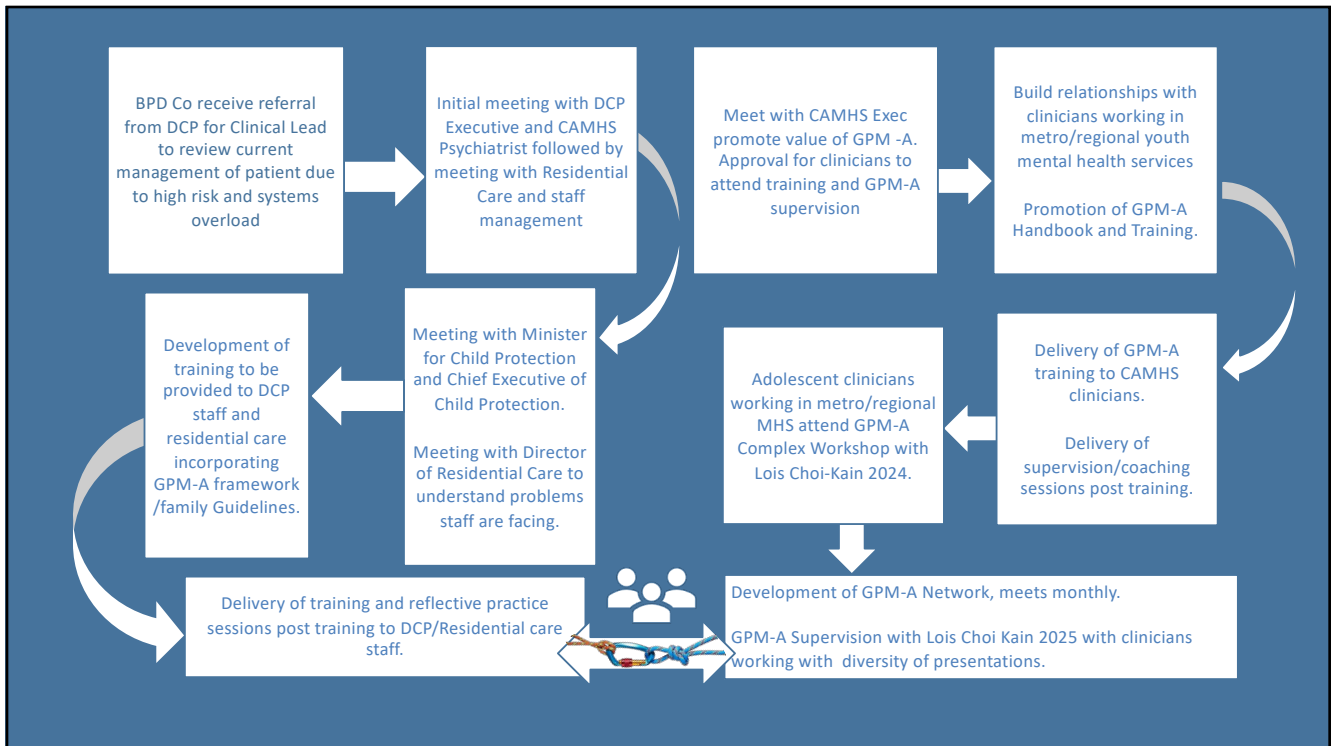
- They let you know the GPM-A approach is helping them manage their own anxiety from the daily emails coming in from multiple services, which cause them to step out of their lane.
- They are focusing on their job of maintaining a therapeutic alliance with Lenora and instilling hope and encouraging agency



18



19



20

Reflective practice session to the residential care team and supervision to CAMHS clinicians.

Feedback from staff attending the reflective practice highlights how they feel:

- They have been on a BPD learning journey together
- They are being more of a detective about what is going on for the young person
- They have a greater understanding of connection rather than attention
- Senior staff have been modelling leaning in to new staff
- They are staying in their lane
- Getting back to basics and keeping it simple
- Communication is improving, providing consistent messaging as a team and initiating restorative conversations when things have cooled down
- Less punitive in approach
- Learning how to hold risk that it is all helping with the next young person they will be working with



21

GPM framework for BPD Co Team



Organising framework

- Shared language
- Scaffolding and integration of diverse specialist therapies
- Clarity of roles and responsibilities
- Realistic expectations
- Helps manage countertransference
- Maintaining limits



22

THANK YOU



BPD^{CO}

HEALTH.BPDSERVICE@SA.GOV.AU



McLean Gunderson
Personality Disorders Institute

GUNDERSONPDI@PARTNERS.ORG



23

END of presentation

24

GPM in the psychiatric emergency services of Australia

Adj. Professor
Melissa Casey

Karolinska Institutet
4th May 2026
International Conference on
Good Psychiatric Management
for Personality Disorders

Acknowledgments - Agile team members

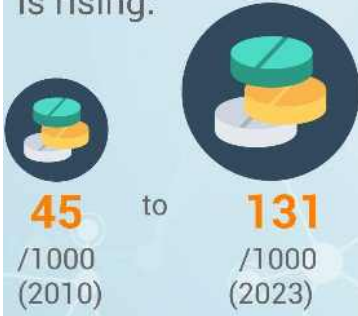
Published papers



THE NEED

Old methodologies have not been able to change mental healthcare...

Antidepressant use
is rising:



Daily Defined Doses
Increasing (in 2023, OECD
ave is 77).¹



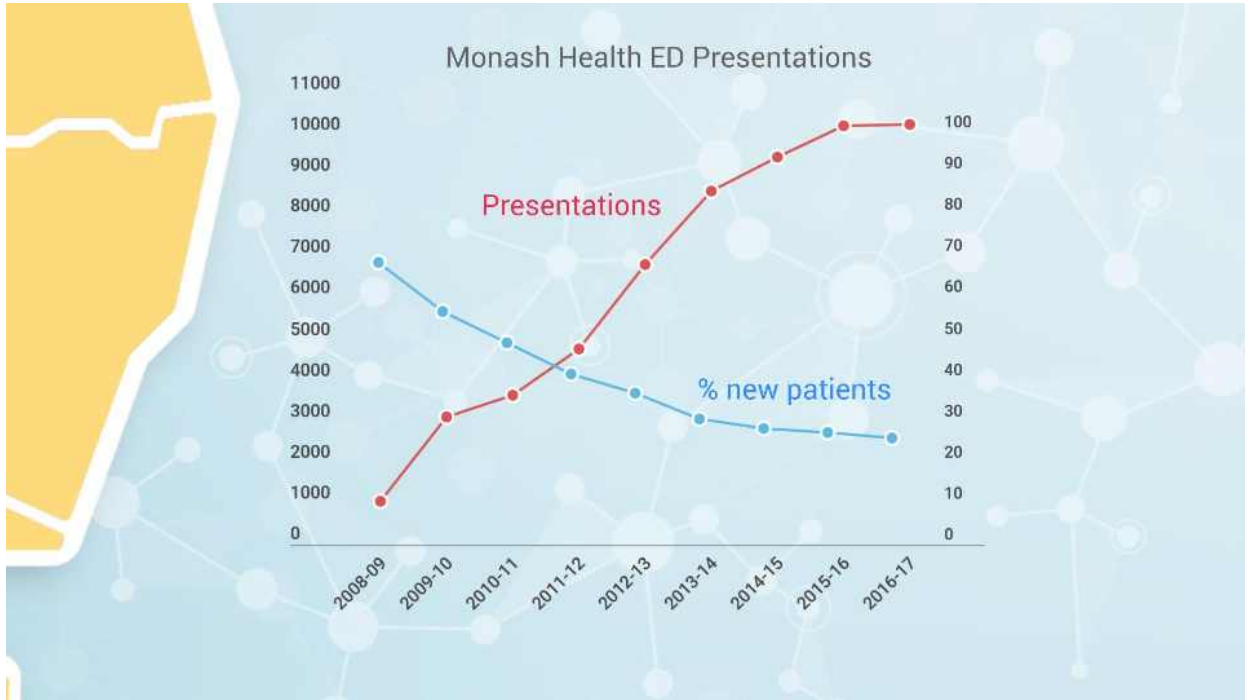
¹ Whiteford et al., 2014
² OECD, 2015
³ ABS, 2016

Australians are accessing more
services than ever before.¹

Presentations to our emergency
departments are on the increase...



¹ Whiteford et al., 2014
² OECD, 2015
³ ABS, 2016



Conclusion

Despite **service increase**,
research studies show
no improvement
in adult mental health
from 1995 to 2011.

(Jorm & Reavley, 2012)

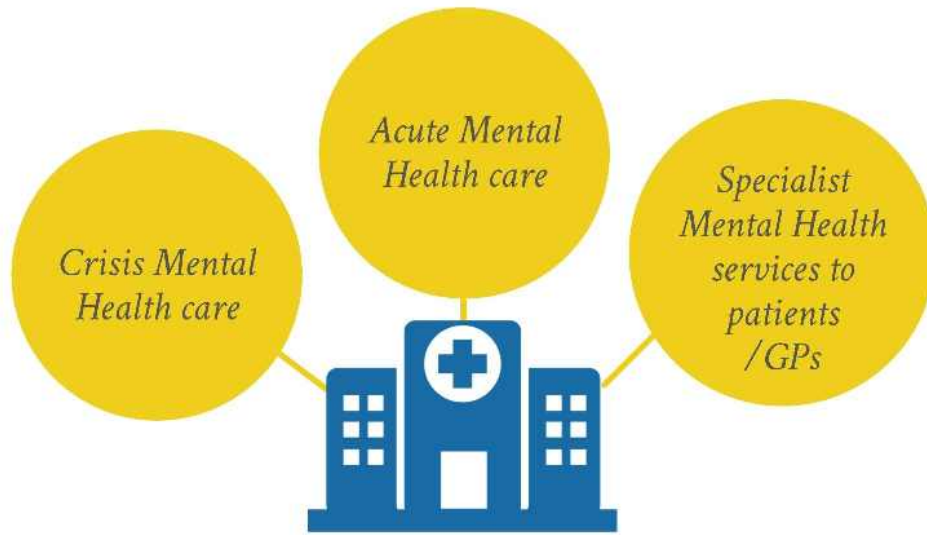
We wondered about our
re-presentations.

*Are our patients getting
the treatment they need for
their recovery journey?*

*"Healthcare may be the most entrenched
change-averse industry in the United States."
- Professor Clayton Christensen*

How do we recover?

What do we need to provide?



Our Strategic and Value Propositions

We need to understand...

WHAT *do our patients need and want?*

WHY *are they presenting?*

HOW *are they accessing services through our systems of care?*

and **WHY** *are they re-presenting?*

How to empower Patients...





170 adults accessed treatment from our front end.

*Is this low number contributing to our
Emergency Department presentations?*

Top 5 Diagnoses:

- Depression
- Schizophrenia
- Suicide Risk (not attempted)
- Borderline Personality
- Psychotic Episode

Tom's Story

May 2005 – July 2005



Tom's Story





Did this really represent the best clinical care for Tom?



"We must redesign around patient demand and care pathways."

DESIGN INCEPTION

DESIGN HOT SPOTS

Our front door - access

Do people need to present in crisis to get treatment?...

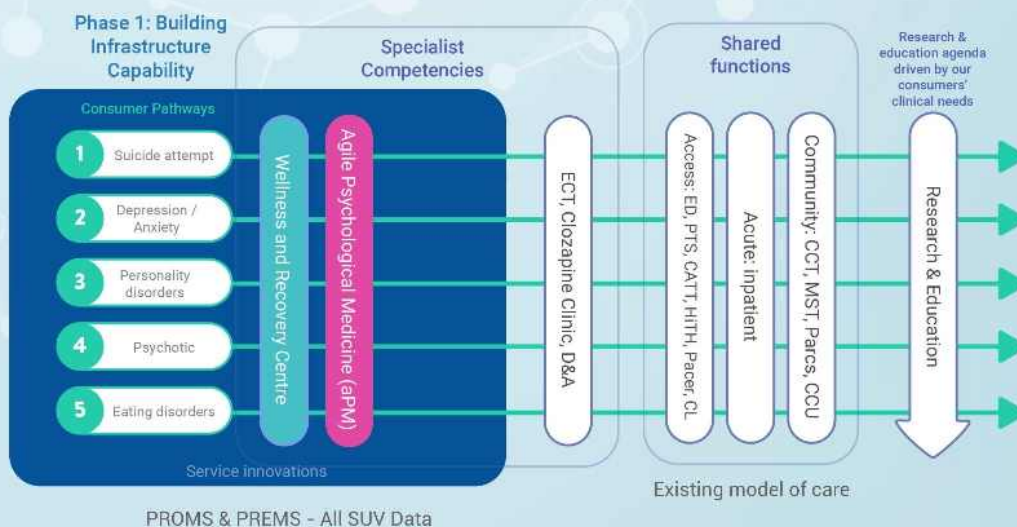
...and what treatment are they getting?

SERVICE PROTOTYPE

We want to get people *properly assessed* and treated as *early* as possible.

We want to stop the endless triaging and handoffs that occur without proper *pause for treatment and planning.*

Building a new organisational model around patient pathways (2014)



PROTOTYPE

Agile Psychological Medicine

CLINIC'S ETHOS

OUR VISION

Agile Psychological Medicine
Improvement in Clinical Outcomes



CLINIC'S ETHOS

*Work collaboratively with patients,
deliver timely, brief psychological and
medical treatment to people in distress
and experiencing situation crisis.*

Clinicians (suppliers of service)

Clients (users of service)

OUR VISION

Provide short term solution focused therapy to enable our patients with mental illness to stay well and live a contributing and meaningful life.*

"To live, love and work."

*Aspects from GPM...but we didn't know it then

Agile Psychological Medicine

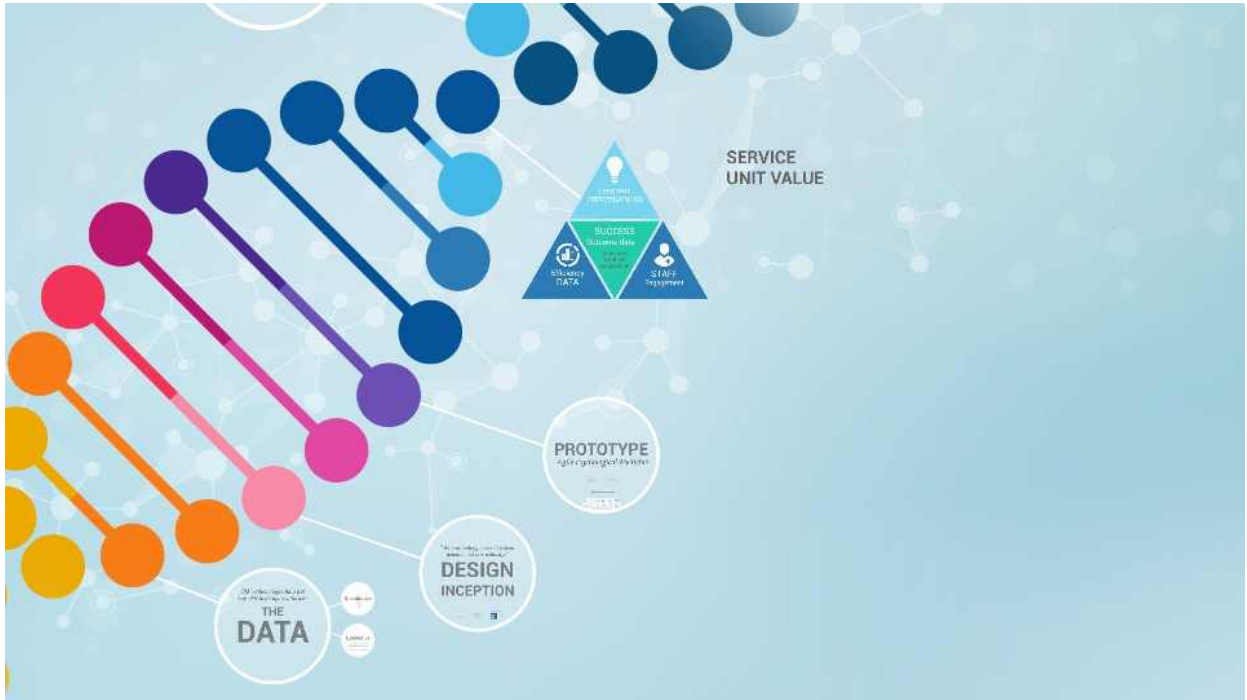
Improvement in Clinical Outcomes

N=368

2+ sessions

Feb 2014 - Jan 2016







Long term EFFECTIVENESS

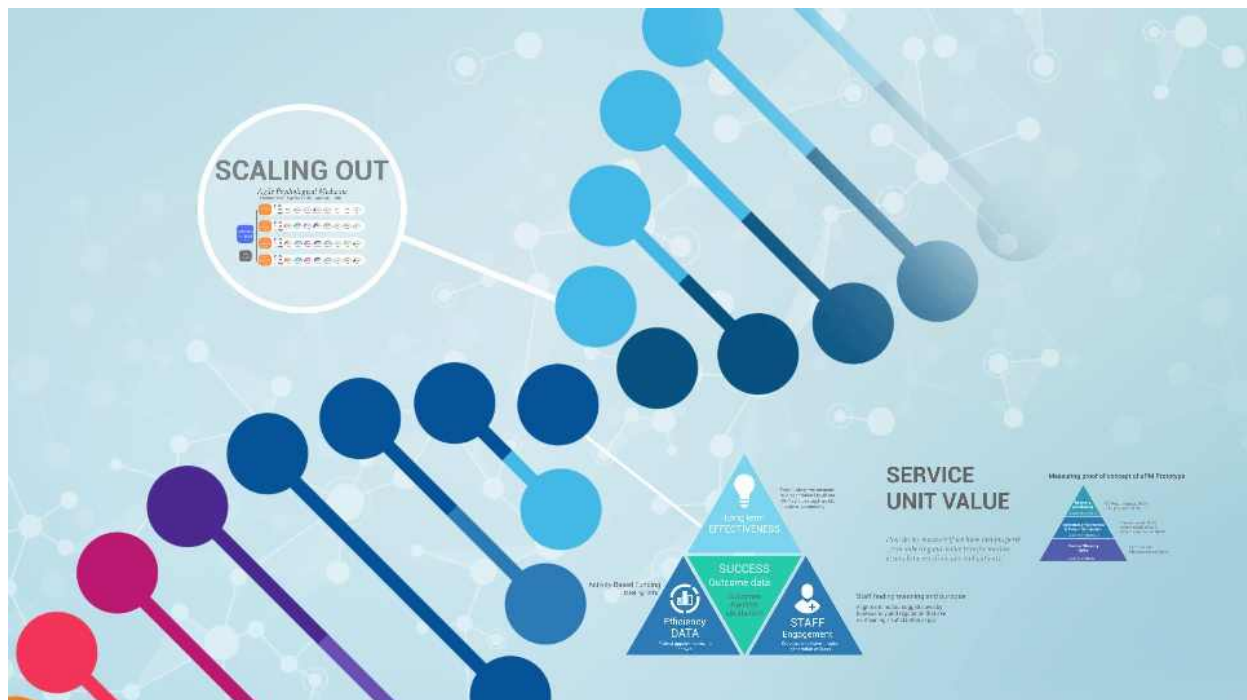
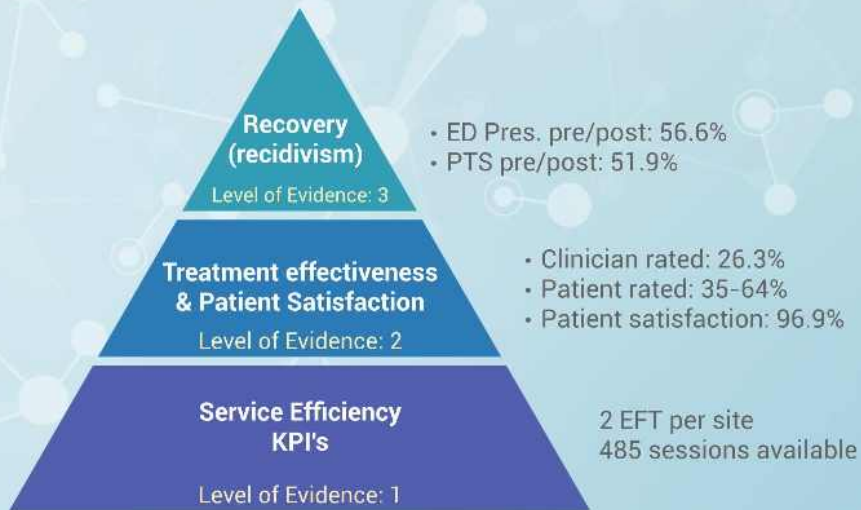
This is where we measure re-presentations to all our MHP services such as ED, inpatient, community

SERVICE UNIT VALUE

*How do we measure if we have met purpose?
...remembering our value transformation
occurs between clinicians and patients.*



Measuring proof of concept of aPM Prototype



SCALING OUT

Agile Psychological Medicine

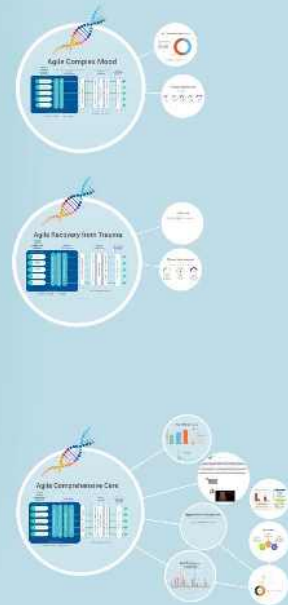
February 2014 - September 2021, Monash Health



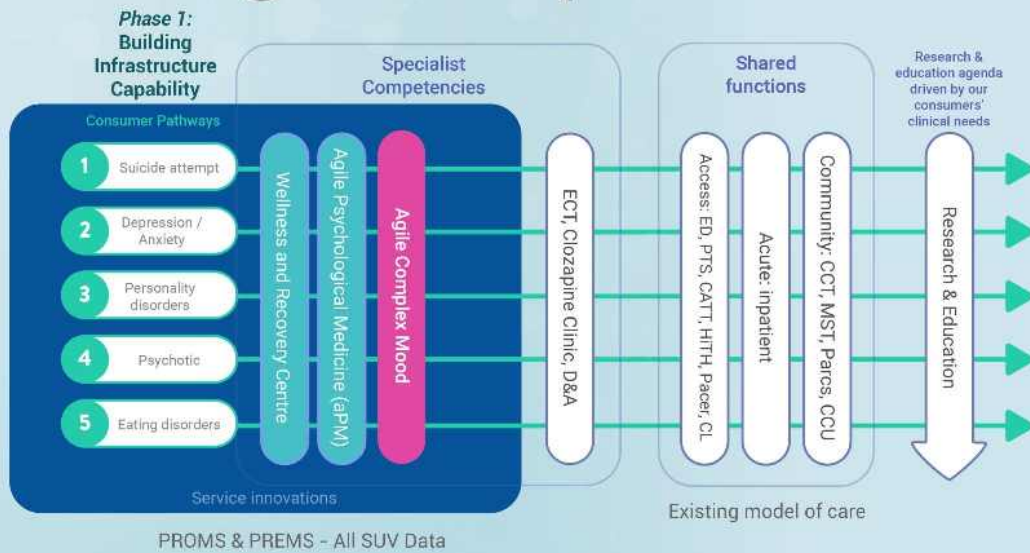
Our Re-Representers...



We have a learning opportunity to improve our quality of care where our evidenced based interventions didn't work.

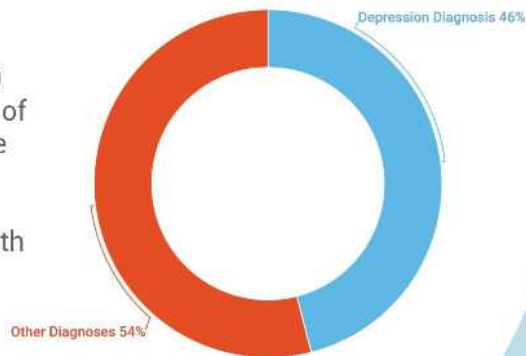


Agile Complex Mood



No.1 presentation: Depression

92 of the top 200 had a diagnosis of Major Depressive Disorder at the point of contact with Mental Health in the ED.



Remaining comorbidities: BPD, PTSD, Schizoaffective, schizophrenia

Clinical Improvement

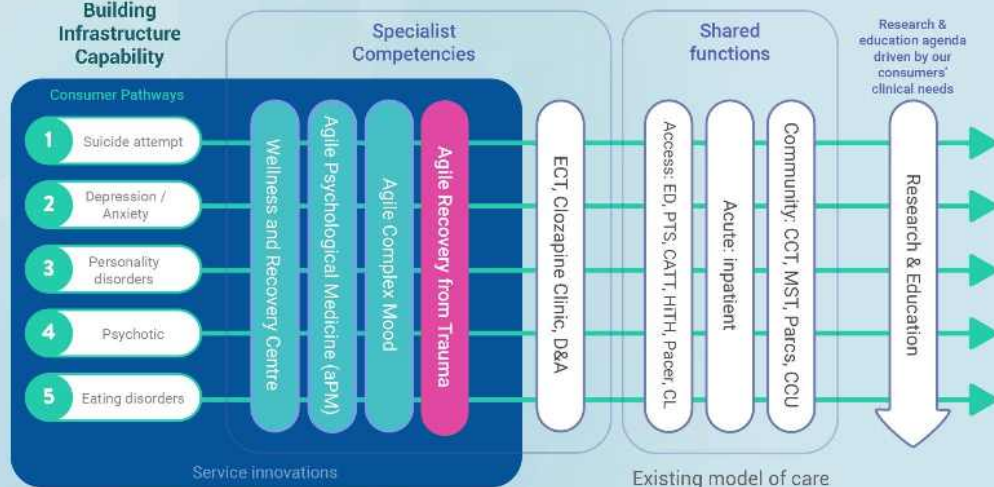
April 2015 - July 2017

N = 242



Agile Recovery from Trauma

Phase 1:
Building
Infrastructure
Capability



Research & education agenda driven by our consumers' clinical needs

Ash's story

Ash's voice was not heard.
He was treated for **8** years with antipsychotics.

He slept for 12-16 hours every day and was living in an abusive relationship with a son with severe developmental disabilities.

He received several diagnoses including **schizophrenia, depression, anxiety, borderline personality disorder, Post-Traumatic Stress Disorder, Obsessive Compulsive Disorder, schizoaffective disorder with bipolar, gender dysphoria.**

Clinical Improvement

N=24

March 2016 - February 2017 Completed



● Beck Depression Inventory

53%

Consumer rated

Measures severity of depressive symptoms



● PTSD Check List

66%

Consumer rated

Assessing symptoms of PTSD

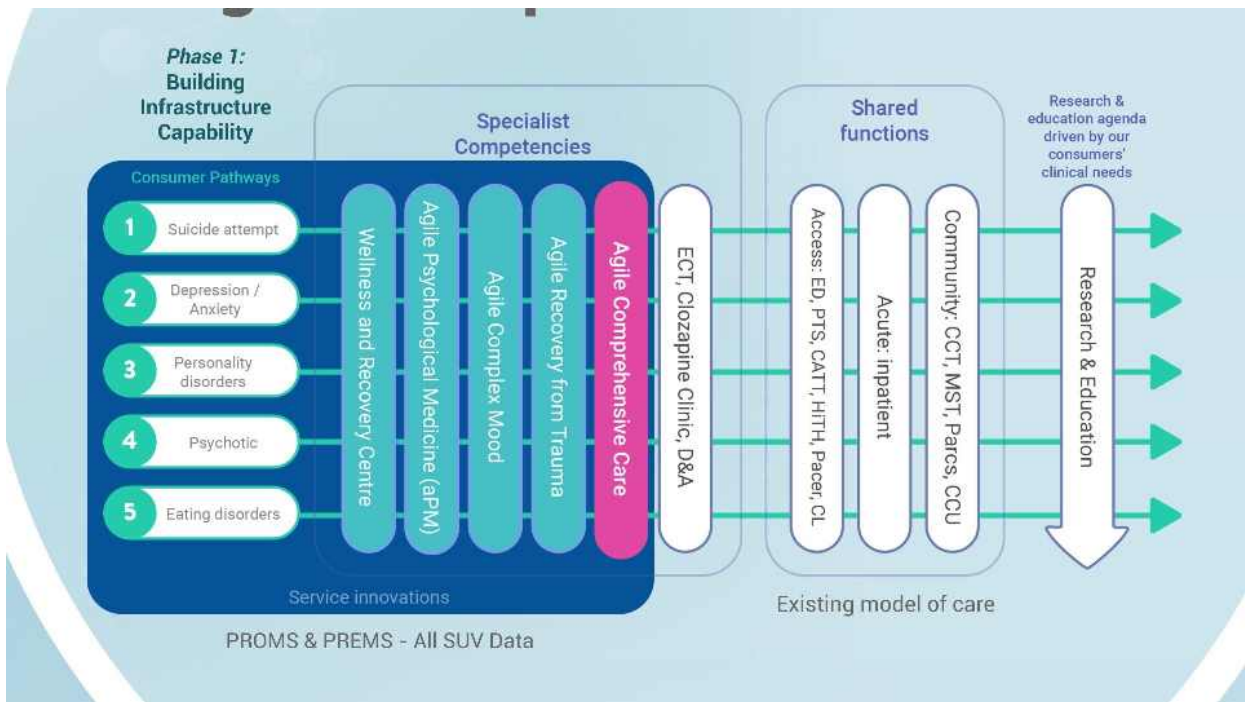
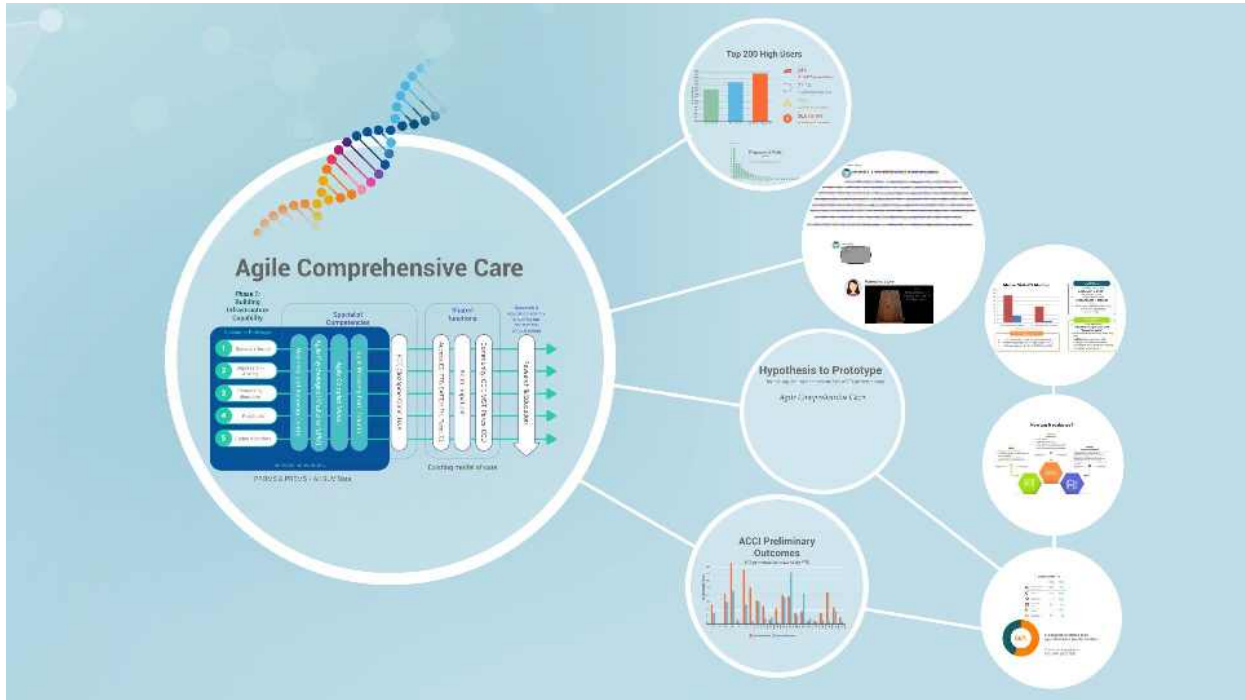


● SRS

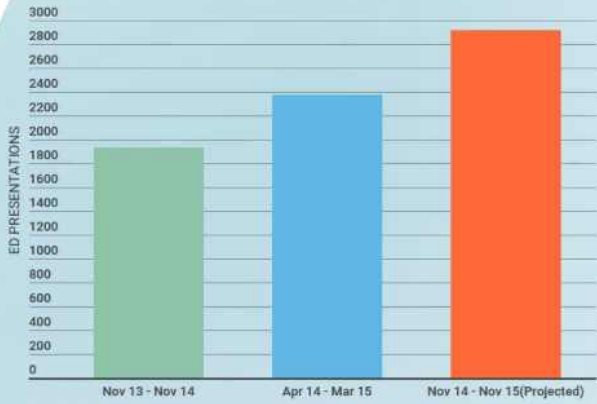
78%

Consumer rated

Therapeutic alliance (relational bond), agreement on goals & tasks of therapy



Top 200 High Users

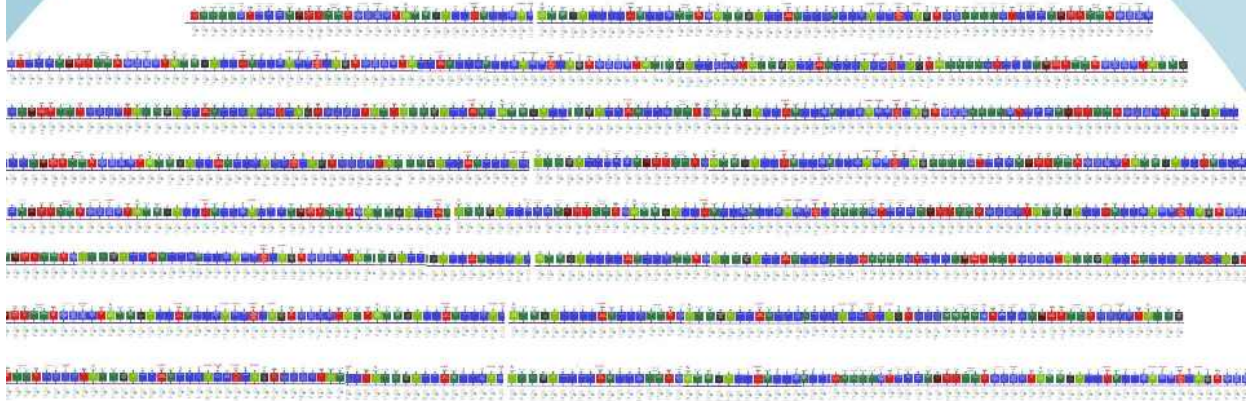


-  **24%**
of total ED presentations
-  **71.9%**
re-presented in 28 days
-  **75%**
Community managed
-  **\$8,818,491**
12 months cost to service

Visits per year



Ben's story



Hannah's story



Hypothesis to Prototype

for the top 200 who represent 24% of ED presentations

Agile Comprehensive Care



Using GPM at a systems and individual level - good outcomes for patient and hospital system



Stabilising the functioning of the system - the relationship between patient and hospital system



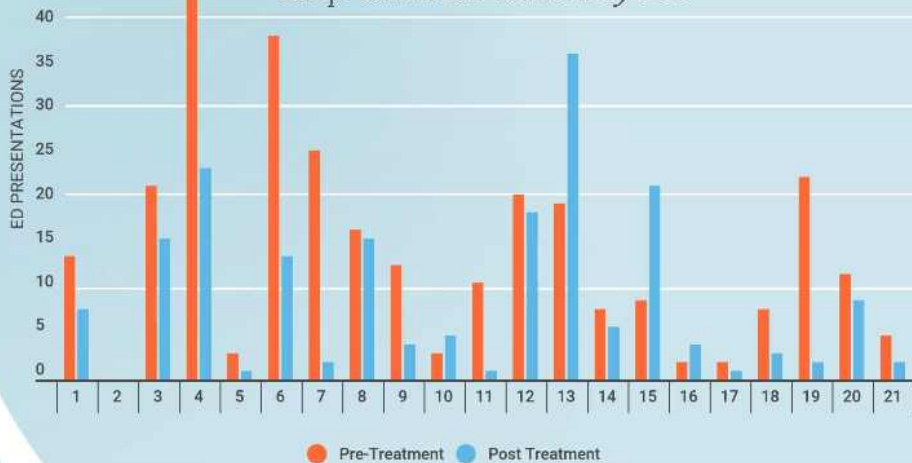
Once the relational system is stabilised, the patient will start to function differently including engaging in 1:1 therapy



Present less frequently in crisis and use less acute tertiary services

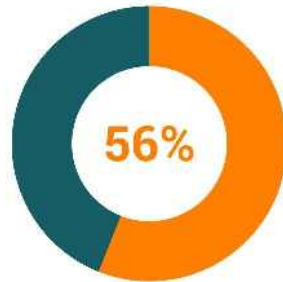
ACCI Preliminary Outcomes

ED presentation reduced by 50%



Improvements







	Feb 2014 March 2015	April 2016 July 2017
 ED Mental Health Presentations	33%	72%
 PTS calls	33%	60%
 Admissions length of stay	-127%	60%
 CATT length of stay	6%	76%
 CCT length of stay	-127%	60%
 Community length of stay	4%	19%



of consumers referred to an agile Clinic have suicidal ideation

Consumer experience
98% aPM (N=2,754)

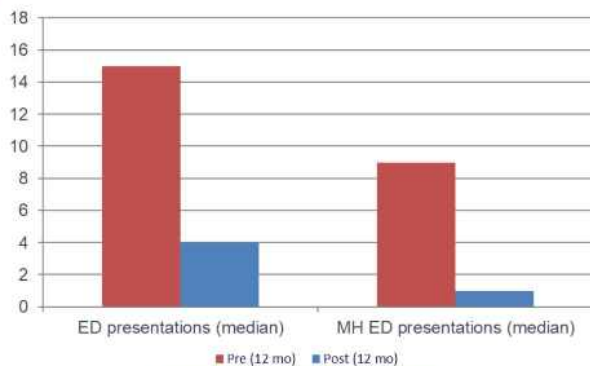
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How was it evaluated?



Median Visits (12 Months)



Statistically Significant Reductions (Wilcoxon)

- ED Presentations: 15 → 4 ($p=0.014$, $r=4.8$)
- MH ED Presentations: 9 → 1 ($p=0.018$, $r=0.46$)
- MH Admissions: 3 → 0 ($p=0.0005$, $r=0.68$)

Costs (12 Month Follow-up)

- Median total cost: **AUD\$64,921 → \$19,329** ($p=0.000184$, $r=0.68$)
- Total sample cost: **AUD\$2,707,069 → \$859,428** (-68.3%)
- Emergency medical and nursing costs also decreased (both $p=0.003$)

Staff Feedback $n=25$

- CSP Usefulness: **73.9% "Extremely Useful", 17.4% "Somewhat useful"**
- **95.2%** reported following/enacting CSP
- **65.2%** said contact with aCC changed their practice (more consistent, more confident holding clinically indicated risk)

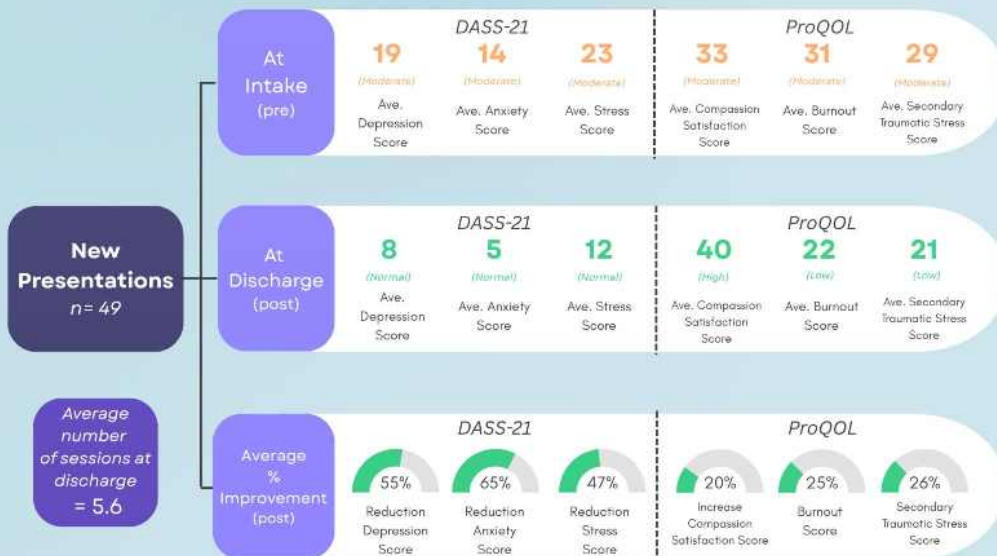
AGILE MENTAL HEALTH

GPM Outside of Tertiary Healthcare

Employee Mental Health Service Data, Q1 2026



Employee Mental Health Service Data, Q1 2026



New Presentations
n = 49

Average number of sessions at discharge = 5.6



GPM in the psychiatric emergency services of Australia

Adj. Professor
Melissa Casey

Completed from 2018
International Experience as
Lead Psychiatric Subgroup
for Parity of Care
Agile Mental Health - Agile team
members
Agile team support



Our Re-Representers...



We have a learning opportunity to improve our quality of care where our evidenced based interventions didn't work.



Our Agile journey led us to GPM - given our experience of what the active ingredients were that facilitated effective mental health care

Empathic listening
Joint formulations
Agree on what to work on
Focus on improving functioning

GPM can be effectively used across the spectrum of mental ill health / psychological distress. In stand alone clinic (s) or a large health service

Many forces maintain the status quo. So innovation must **integrate** organisational interventions at the people, process, and system levels.

Have any questions? Please connect with me!



Agile Mental Health

