

Generalizing GPM around the World, on the Internet, and Transcendentally



Afternoon May 5th

1:00 P.M. GPM in primary health care (US)

1:30 P.M. Teaching GPM to primary health care

1:50 P.M. Panel

2:00 P.M. Implementing GPM-A in Brazil

2:20 P.M. New Zealand – GPM Implementation

3:00 P.M. GPM and ICD-11 in Practice: Developing Group Treatment for Personality Disorders Beyond BPD

3:20 P.M. First data on GPM-internet treatment

3:40 P.M. Addressing spiritual and transcendent experiences in borderline personality disorder using Good Psychiatric Management and other evidence-based treatments

4:15 P.M. Summarizing Panel: GPM Future directions

GENERAL PRACTITIONER'S MANAGEMENT OF BORDERLINE PERSONALITY DISORDER (GPM-GP)

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Spectrum – specializing in personality disorder and
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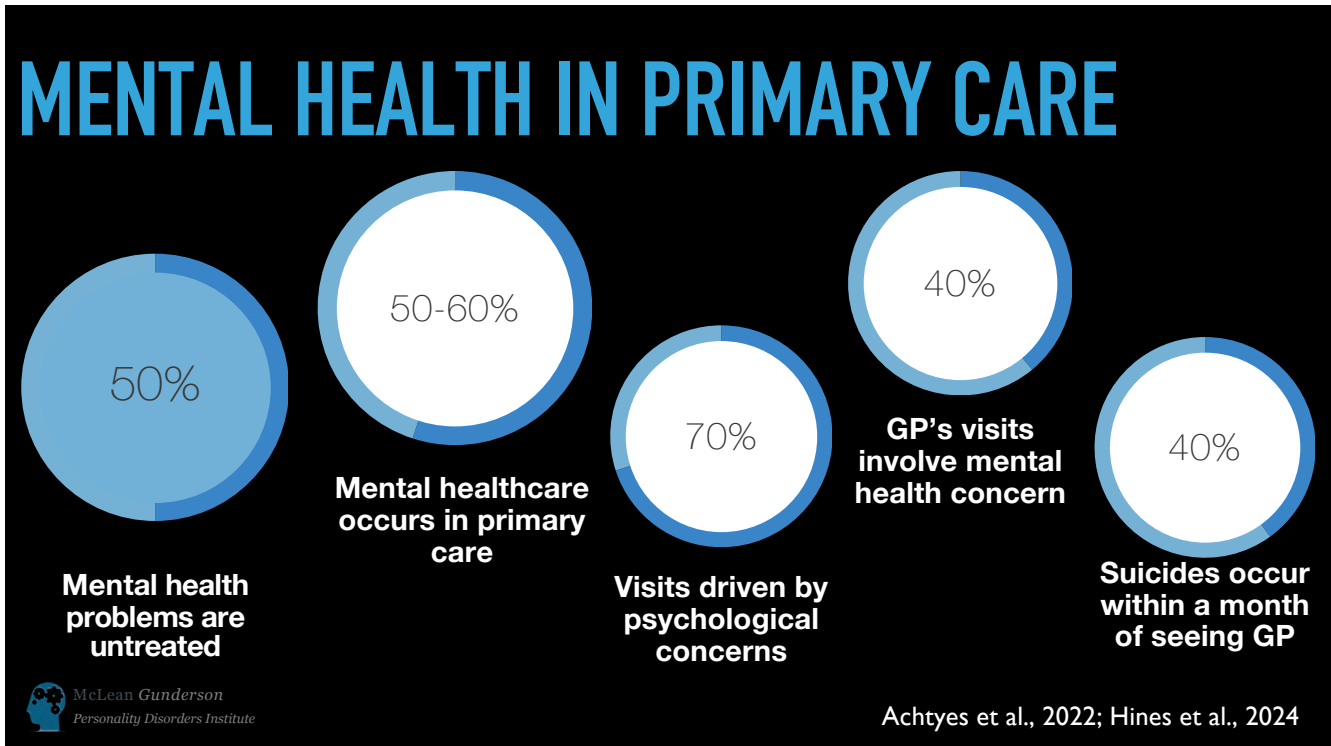
RELEVANT → CONFLICTS → OF → INTEREST

- ▶ American Psychiatric Association Publishing: Royalties for GPM books (LCK)
- ▶ Tetricus: Consultation (LCK)
- ▶ Foundational Curriculum Inventor Royalties (LCK)
- ▶ We will discuss off label use of

pharmacology and other brain-based therapeutics because there are no FDA indicated agents for personality disorders



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BPD is 4-6x more common in GP's caseload

- 18.5% to 26% via self-report
- 1/4 depressed patients
- 6% via structured interviews
 - 43% unrecognized by GP to have mental health problems
- 0.017% documented diagnosis

PREVALENCE OF BPD IN PRIMARY CARE

Aragonès et al., 2013; Gross et al., 2002; Hueston et al., 1996; Parsons, 1997; Wiederman & Sanstone, 1998; Riihimaki et al., 2014

McLean Gunderson
Personality Disorders Institute

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HEALTHCARE SYSTEMS

- ▶ General Practice sits at the **frontline**
- ▶ Fragmentation between GP settings and mental health services (Włodarczyk et al., 2018)
 - ▶ Funding (private business vs government funded), short consults
 - ▶ Communication and referral pathways
- ▶ Availability of public and private mental health services
 - ▶ Threshold for accessing mental health services
 - ▶ Capacity to deliver BPD-specific treatment and/or psychotherapy
 - ▶ Often time-limited and episodic
- ▶ GPs manage BPD across the full spectrum of severity
- ▶ Long-term continuity defaults to the GP



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**EVERY GENERAL
PRACTITIONER WILL MANAGE
THE CARE OF PEOPLE WITH
BPD ON A DAILY BASIS**

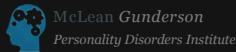
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**GENERAL PRACTICE IS WHERE
MOST BPD CARE ACTUALLY
HAPPENS**

**GENERAL PRACTITIONERS
NEED AND DESERVE GUIDANCE
ON HOW TO OPTIMALLY DO A
GOOD ENOUGH JOB, AS GP'S
(NOT AS SPECIALISTS)**

CLINICAL CHALLENGES

- ▶ **Greater complexity of medical care**
 - ✓ High utilization: consultations, phone calls, and requests for medications (Sansone et al, 2011)
 - ✓ Frequent missed appointments, follow up of laboratory and radiologic studies, and treatment recommendations
- ▶ **Greater complexity of mental healthcare**
 - ✓ Among depressed patients: double the risk for anxiety; 3x risk for SUD, suicidal ideation, 4x prevalence of suicide attempts; severe economic difficulties and unemployment
- ▶ **Greater complexity of practitioner-patient relationship**



Sansone et al., 2011; El-Gabalawy et al., 2010; Rithimaki et al., 2014



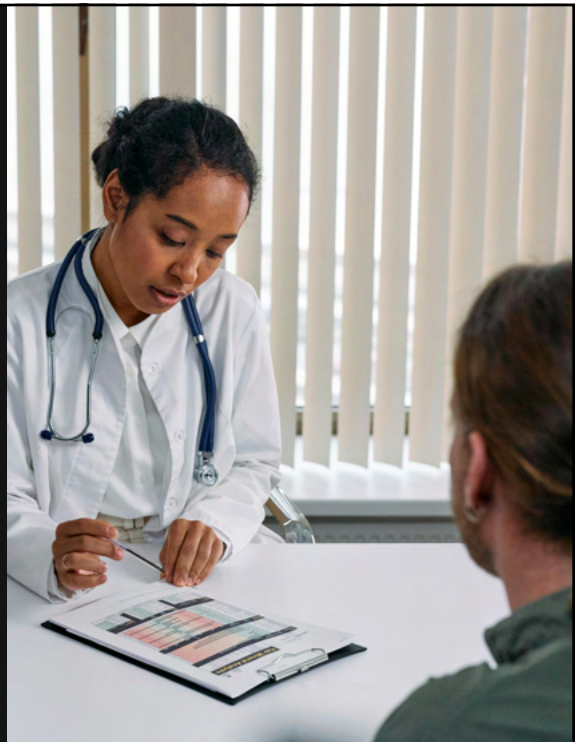
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BPD & PHYSICAL HEALTH

- ▶ National Epidemiologic Survey on Alcohol and Related Conditions (NESARC; n = 34,653)
- ▶ BPD significantly more associated with (adjusted for Axis I disorders and sociodemographics):
 - ✓ Hypertension, hepatic disease, cardiovascular disease, gastrointestinal disease, arthritis, STD, and any assessed medical condition
 - ✓ Greater likelihood of suicide attempts associated with co-morbid cardiovascular disease, STD, and any assessed medical condition
- ▶ GPs may be aware of risk for usual health conditions



El-Gabalawy et al., 2010



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BPD PREDICTS PHYSICAL HEALTH

BPD traits are associated with:

- ▶ Sleep problems
- ▶ ↑ obesity
- ▶ Chronic conditions/pain, arthritis
- ▶ ↑ physical disability
- ▶ ↑ outpatient and inpatient visits; use of medical services
- ▶ ↓ overall health-related functional status

Chronic BPD pts were more likely than remitted patients to:

- ▶ Chronic medical conditions (obesity, diabetes, hypertension, urinary incontinence, arthritis, chronic pain, multiple medical conditions)
- ▶ suffer from “poorly understood medical syndromes”
- ▶ use expensive forms of medical care (e.g. ER, hospitalization, radiologic studies)
- ▶ make poor lifestyle-related choices (smoking, alcohol, pain/sleeping medications, lack of exercise)
- ▶ quit work/lose job due to ill health

Frankenburg & Zanarini 2004; Keuroghlian et al., 2013); Sansone et al 2001a; Sansone et al 1998; Hueston et al. 1999; Power & Oltmanns, 2013; Cramer et al. 2006, Grant et al. 2008, Jackson et al. 2004

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BPD & CHRONIC STRESS SENSITIVE CONDITIONS

Polycystic Ovary Syndrome

- ▶ In primary care, PCOS is twice as likely in BPD
- ▶ More metabolic complications: obesity, DMII, cardiovascular dz
- ▶ Associated with mood/anxiety
- ▶ Management:
 - Exercise, nutrition
 - Mindfulness-based programs (for stress, anxiety, mood, healthy lifestyle changes)

Postural Orthostatic Tachycardia Syndrome

- ▶ Significantly associated with other psychiatric problems & conditions co-occurring with BPD, e.g., anxiety and mood disorders, sleep problems, CFS
- ▶ Management:
 - Hydration, increasing sodium intake, exercise programs, third-wave CBT
 - **AVOID:** meds that prolong QTc, MAOIs, tricyclics, opiates, quetiapine, ethanol

Migraines

- ▶ BPD => greater migraine severity, associated disability, lower response to usual headache mgt, higher medication overuse, more unscheduled visits
- ▶ Distinct population: more affected and treatment refractory
- ▶ Management:
 - Psychotherapy + medication, treatment contracts with pain control plans
 - Opioids may have adverse effects on BPD symptoms

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BPD & POORLY UNDERSTOOD STRESS SENSITIVE HEALTH CONDITIONS

Fibromyalgia

- ▶ Up to ~9% with BPD have fibromyalgia
- ▶ Negative emotions mediate pain experience
- ▶ History of abuse (physical, sexual, or emotional) increases risk for both dx
- ▶ Management: Exercise, sleep, psychotherapy, mindfulness

Chronic Fatigue

- ▶ ~2-7% also have BPD
- ▶ Psychiatric symptoms may lead to over attribution and coping that perpetuates it
- ▶ History of emotional trauma increases risk of both
- ▶ Management: CBT, graded exercise therapy

Temporomandibular Joint Pain (TMJ)

- ▶ More common in those with BPD, personalities more susceptible to life stress may express anxiety in somatic symptoms
- ▶ Management: CBT, emotion regulation and stress-tolerance skill-building, medications

Greater rates in non-remitted vs. remitted patients



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Personality Disorders Institute

El-Gabalawy et al., 2010; Frankenburg and Zanarini, 2004; Johnson et al., 2020; Martins et al., 2021; Mu et al., 2024; Penfold et al., 2016; Sáez-Francàs et al., 2015

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THEORIES: BPD & POOR HEALTH OUTCOMES

Chronic BPD pts were more likely than remitted patients to:

- ▶ More likely to have impairing and cumulative damaging health problems with complexity
- ▶ Poorer adherence to treatment and more distress/disability
- ▶ Greater life stress, poor stress management and support system, greater stress generation
- ▶ Hyperbolic temperament leads to amplified pain combined with need for others to recognize it
- ▶ More likely to lack emotionally sustaining relationships; therefore, more likely to seek care from professionals and social services
- ▶ Interpersonal style that leads GPs to order unnecessary tests and prescribe inappropriate treatments to avoid prolonged conflicts

Frankenburg & Zanarini 2004; Keuroghlian et al., 2013); Sansone et al 2001a; Sansone et al 1998; Hueston et al. 1999

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COMPLEX COMORBIDITY

❖ THE RULE RATHER THAN EXCEPTION

- Anxiety disorders most common
- Followed by PTSD which is common but not universal
- Impulse control disorders differ by gender: males with SUD and females with eating disorder
- Complex pattern of co-morbidity predicts BPD with sensitivity

Zanarini et al., (1998) AJP



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ISSUES IN THE PHYSICIAN-PATIENT RELATIONSHIP (PPR)

- ▶ BPD is among the top psychiatric diagnoses associated with poor PPR or difficult patient status
- ▶ Poor self-regulation and direction & dependency on others=> poorer social and health (i.e. pain) related outcomes
- ▶ Fear of abandonment and insecurity in caretaking relationships evoke reliance on actions to demonstrate care or provide reassurance, which disorganizes caregivers who vacillate between helpless and hostile positions
- ▶ Provider discomfort with emotional dynamic and unrealistic expectations
- ▶ GP's receive inadequate pragmatic training to manage BPD



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GENERAL PRACTITIONERS' VIEWS (WLODARCZYK ET AL., 2018)

"We're dealing with crisis, not diagnosis"

"There are 6-9 problems in one consult"

"It's overwhelming"

"Patients don't attend consistently"

"I feel frustrated"

"Are we doing the 'right thing'?"

GPs are willing but feel under equipped



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GENERALIST VS SPECIALIST EARLY INTERVENTIONS (15-25 YO)

Monitoring Outcomes of Borderline Personality Disorder in Youth (MOBY) RCT

HELPING YOUNG PEOPLE EARLY (HYPE) + COGNITIVE ANALYTIC THERAPY (CAT)
SPECIALIST MODEL + PSYCHOTHERAPY

VS

HELPING YOUNG PEOPLE EARLY (HYPE) + BEFRIENDING (BEF)
SPECIALIST MODEL + PSYCHOTHERAPY CONTROL

VS

GENERAL YOUTH MENTAL HEALTH SERVICE (YMHS) + BEFRIENDING (BEF)
GENERALIST MODEL + PSYCHOTHERAPY CONTROL

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HYPE + CAT
SPECIALIST MODEL
(16 SESSIONS)

vs.

HYPE + BEF
SPECIALIST MODEL +
PSYCHOTHERAPY CONTROL

vs.

YMHS + BEF
GENERALIST MODEL +
PSYCHOTHERAPY CONTROL

ASSESSED AT 3, 6, 12, & 18 MONTHS
PSYCHOSOCIAL FUNCTIONING (INTERPERSONAL PROBLEMS AND SOCIAL ADJUSTMENT), DEPRESSION, AND SUICIDAL IDEATION

SUSTAINED IMPROVEMENT IN PSYCHOSOCIAL FUNCTIONING, DEPRESSION, AND SUICIDAL IDEATION ACROSS ALL 3 INTERVENTIONS

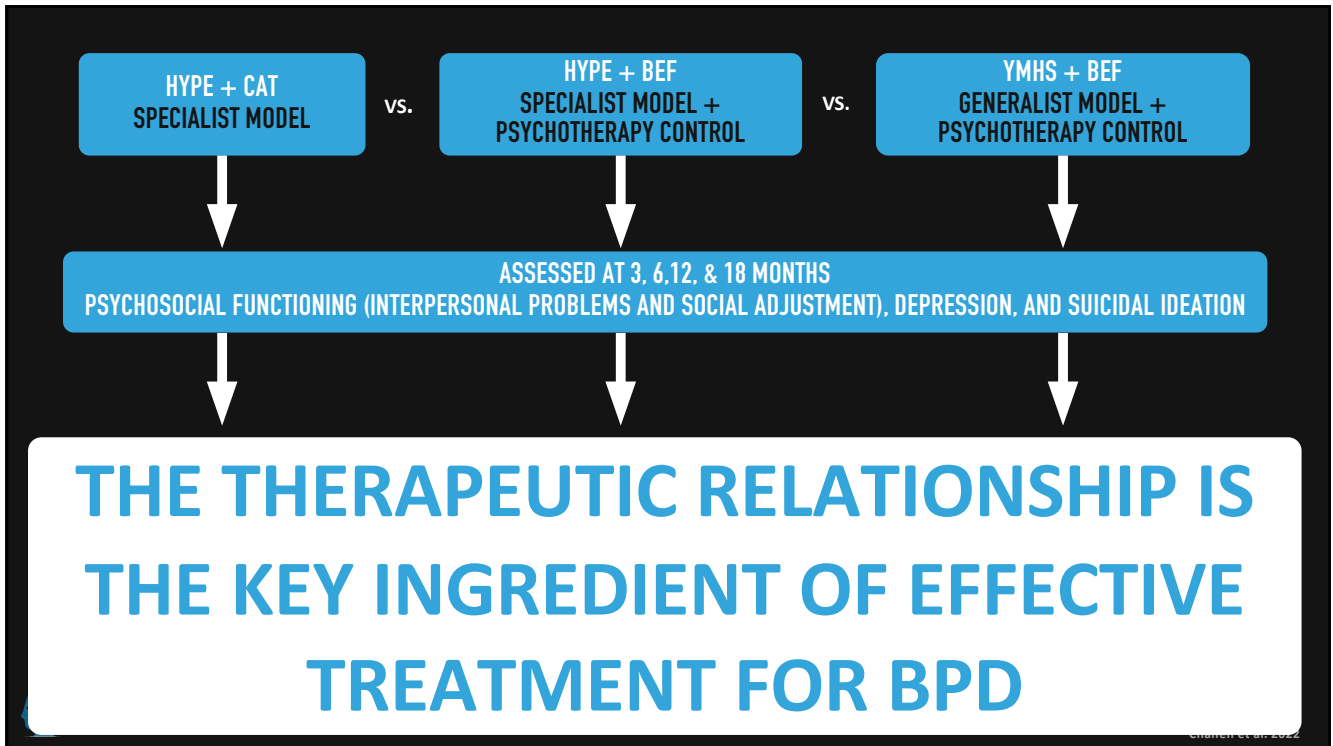
Psychotherapy is Not Essential:

- Individual psychotherapy is not required for effective early BPD intervention

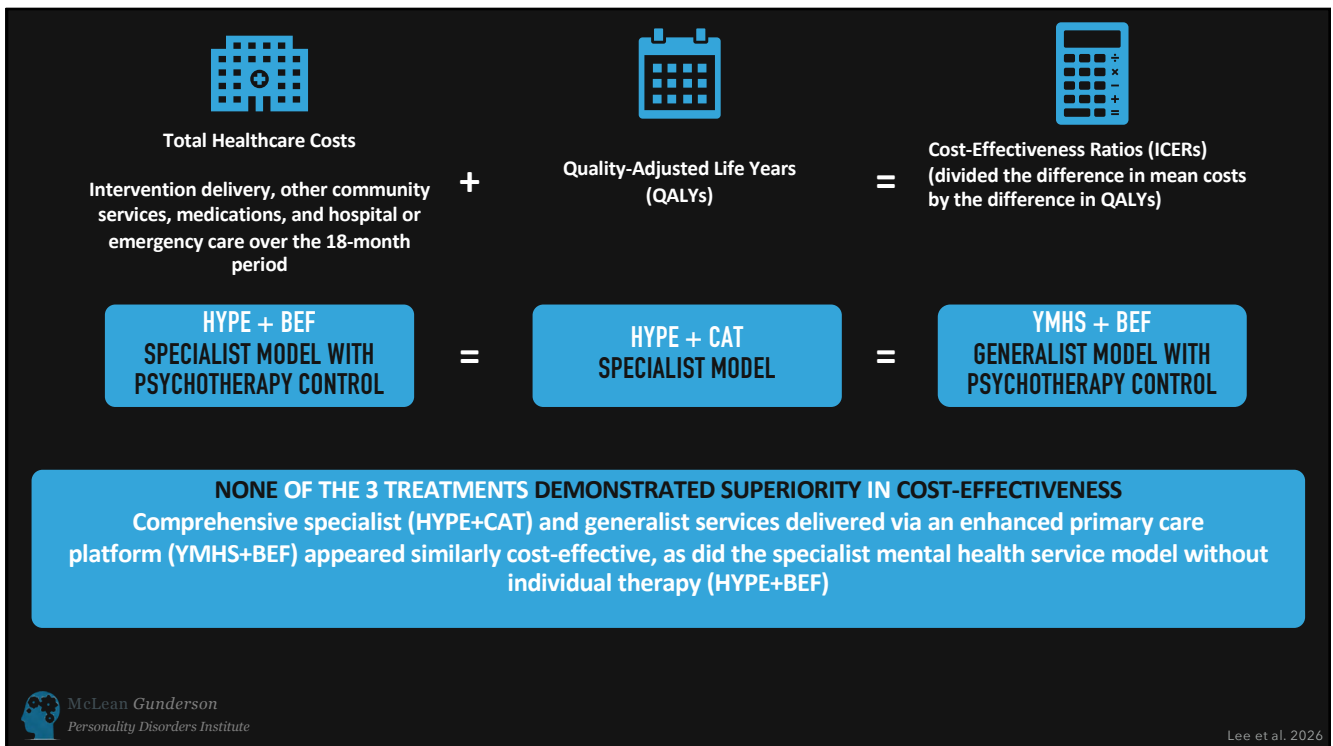
Generalist Care is Effective:

- Structured, high-quality general treatments perform similarly to specialized BPD therapies

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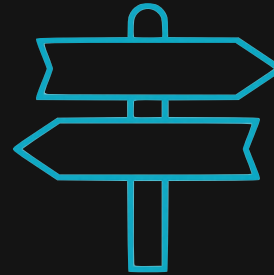


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EXISTING GUIDELINES FOR TREATMENT

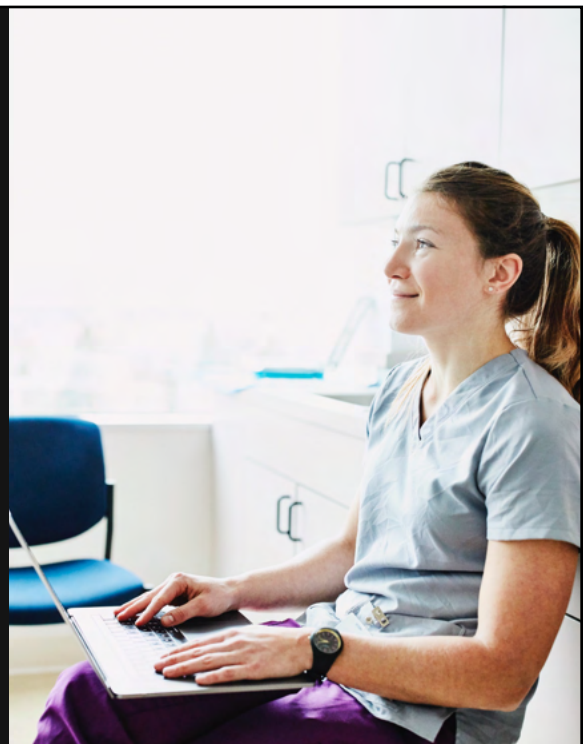


- ▶ Validate patients' discomfort
- ▶ Link patients' physical and psychological problems
- ▶ Reference the DSM criteria for diagnoses
- ▶ Using screening measures (McLean Screening Instrument for BPD: MSI-BPD)

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EXISTING GUIDELINES FOR TREATMENT

- ▶ Set clear boundaries
- ▶ Communicate with other providers and work as a team
- ▶ See patients for check-ins often—not just crises
- ▶ Providing psychoeducation without judgement
- ▶ Use DBT and GPM principles in your treatment approach
- ▶ Self-care to stay regulated



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THE ROLE OF GPs IN DELIVERING EFFECTIVE CARE

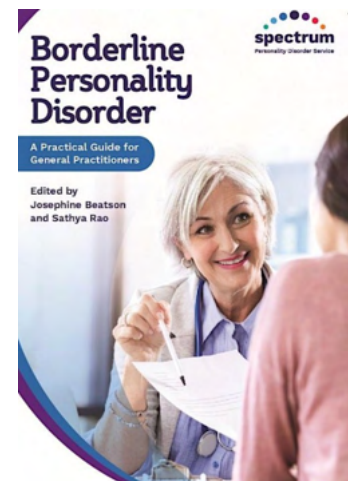
- ▶ GPs are well placed to provide holistic continuity of care (unlike many specialist services which generally have a time limit per episode of care)
- ▶ This continuity can mitigate the sense of abandonment that typically occurs when other psychological interventions end



SPECTRUM RESOURCES FOR GENERAL PRACTITIONERS

- ▶ BPD: A Practical Guide for General Practitioners
 - ▶ [BOOK ONLY - BPD - A Practical Guide for General Practitioners Tickets, Thursday 31 December • 00 - 23:30 AEDT | Eventbrite](#)
- ▶ Training projects - GPM for GPs across Australia
 - ▶ GPs are seeking a structured, practical, scalable model
 - ▶ Interpersonal difficulties with patients are central to the challenges faced by GPs
 - ▶ Emphasis on: medicalizing interpersonal difficulties, understanding countertransference, empowering GPs to treat BPD
 - ▶ Video series:

•psychoeducation	•working with crises
•explaining treatment for BPD	•working with frequent ED presentations
•working with self-injury and suicidality	•developing a safety plan
•prescribing in BPD	





GOOD CLINICAL CARE IS THE KEY... THE TYPE MAY NOT MATTER BUT RATHER THAT MANAGEMENT IS CONSISTENT, RELIABLE, AND ENCOURAGES AUTONOMY... MANUALIZATION IS PREFERABLE FOR A CLEAR MODEL FOR PATIENTS AND CLINICIANS TO WORK WITH.

Gask, Evans, Kessler BMJ 2013

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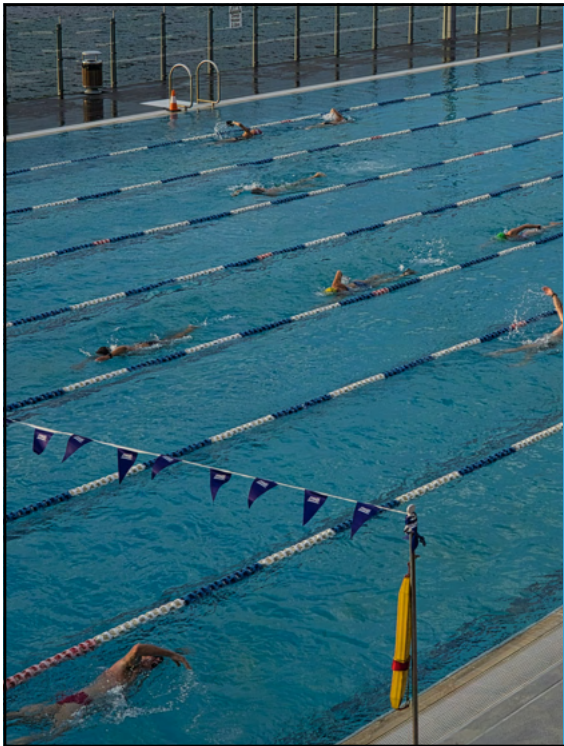
GPM for GPs



General or Good (enough) Practitioners Management
A preservation of the medical model in treating BPD



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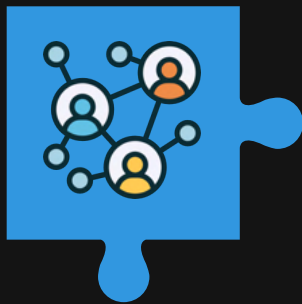


STAY IN YOUR LANE.

KNOW YOUR ROLE, & ITS LIMITS. RELY ON OTHERS AS NEEDED.

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CONFIGURATIONS OF CARE FOR GP'S



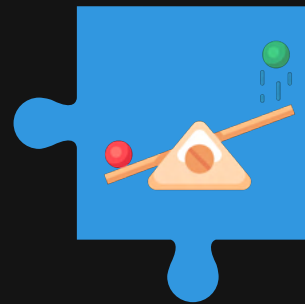
Collaboration with Speciality Team

Specialized BPD multimodal treatment team working in concert with GP's requires clinical coordination, but allows GP's to focus on medical health. Optimal but temporary.



Collaboration with Behavioral Health

Behavioral health services which are less intensive and brief compared to specialist services, can manage medications and determination of levels of care. GP's may need to still manage psychiatric medications



GP WITHOUT Mental Health Support

GP is managing all medical and mental health care due to lack of resources, history of either treatment responsive or unresponsive mental health care, lack of fit or access

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PRINCIPLES OF GPM



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GPM'S SIX PRINCIPLES

Be active (responsive & curious) not reactive

Support via listening, interest, selective validation

Focus on life outside treatment (time outside visits)

Professional but real (i.e., honest) relationship (as GP)

Change is expected (quality of care depends on it)

Multimodality: broaden the social safety net

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HOW TO'S OF GPM

Be active (responsive & curious) not reactive

Establish a contract (who does what, when, where, how)

Set and agenda together every visit, stay within time

Support via listening, interest, selective validation

Focus on life outside treatment (previsit and follow up)

What can the patient and a network of resources do



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HOW TO'S OF GPM

Patient-centered care is longitudinal...

- Goals are achieved over time
- Priorities change
- New events require new decisions



...but consists of multiple discrete episodes

- Patient-provider interactions
- Communication
- Decisions taken and plans made

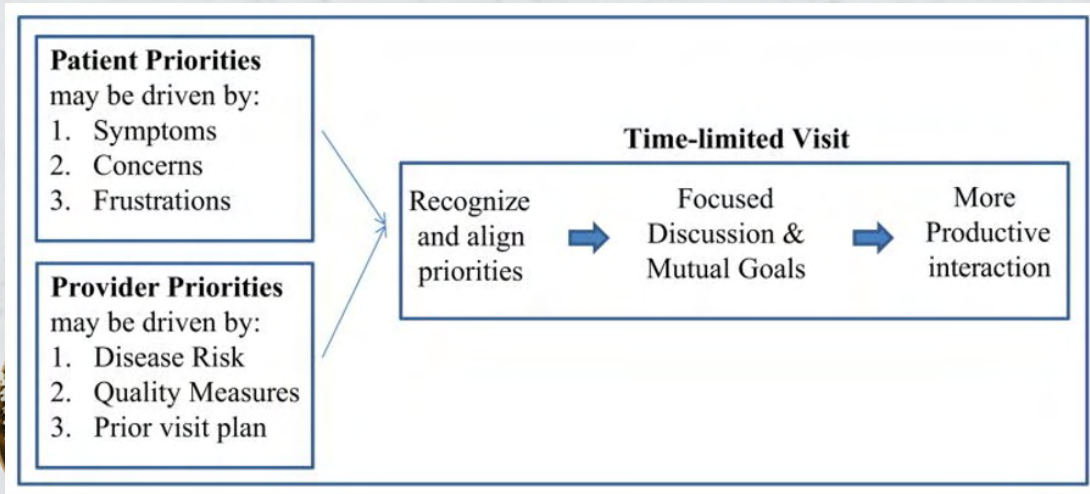
- Pre-Visit**
Phone call,
On-Line Tools
- Visit**
- After-Visit**
Follow-up
Letter or E-mail

The Visit remains the key interaction: Real-time, 2-way communication



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HOW TO'S OF GPM




SETTING GOALS FOR ACCOUNTABILITY

LOADING...

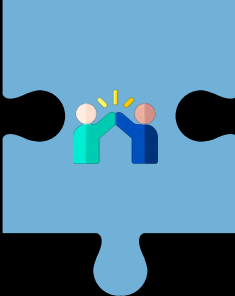


BUILDING AN ALLIANCE SEQUENTIALLY




CONTRACTUAL
(Goals, Roles)

Setting the framework (schedule, fees, confidentiality). Goals and roles structure interpersonal hypersensitivity to promote agency in patient and expectations in treatment



RELATIONAL
(Affective, Empathic)

Liking and understanding the patient. Clinician seen as caring, understanding, genuine, and likable. Should develop by 6 months. If sustained, it is a corrective experience



WORKING
(Cognitive, Motivational)

Patient as a reliable collaborator who can recognize painful observations by the clinician being well intended. This form grows most slowly and is relevant to most therapies

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JUDICIOUS AND CONSERVATIVE

PSYCHOPHARMACOLOGY

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THE STATE OF KNOWLEDGE ABOUT PHARMACOTHERAPY OF BPD

FEW, INADEQUATELY POWERED, RCTS WITH REPLICATED FINDINGS

NO DRUG LICENSED BY ANY REGULATORY AGENCY FOR BPD

OVER 90% ON AT LEAST ONE MEDICATION,
APPROXIMATELY ONE IN FIVE PEOPLE ARE ON 4+

APA GUIDELINES FOR VOTE IN 2024 OMIT DOMAIN TARGETED PRESCRIBING (E.G. AFFECTIVE INSTABILITY, IMPULSIVITY)

AVOID A DICHOTOMOUS STANCE

“I AM NOT CERTAIN IF MEDICATIONS WILL WORK.
THEY MAY BE HELPFUL.
IT IS IMPORTANT WE MONITOR.”

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*

Dose dependent risk

2

3

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.

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

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GPM LINKS PUZZLE PIECES OF HEALTHCARE

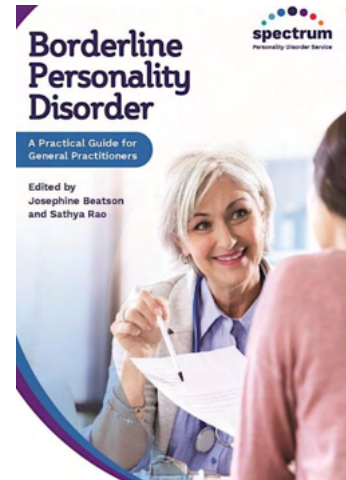
Combining treatment of BPD with care of other medical and psychiatric conditions

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Personality disorders in primary care

What do we know?

What can we do?



Mats Adler

Doctor of Medicine, Specialist in Psychiatry and General
Medicine, Affiliated Researcher in the Department of
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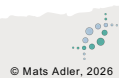
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Disclaimer

Mats Adler has received speaker fees from Janssen-Cilag AB
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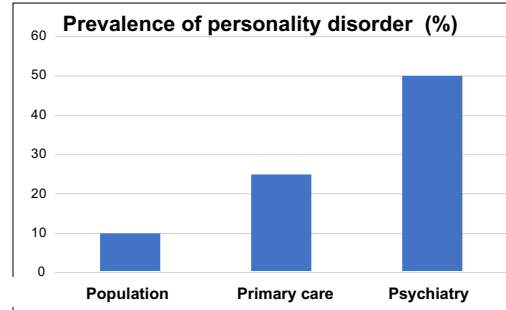


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Prevalence

- Prevalence estimates in the general population range from 4% to 14.7% across studies^{1,6}
- Primary care – very few studies
 1. London primary care study: ~24% prevalence²
 2. Swedish RCT in common mental disorders: 29.9% met criteria for personality disorder; most common were obsessive–compulsive (13.7%) and avoidant (12%)³
 3. Borderline personality disorder: estimated at ~6% in primary care⁷
- In psychiatric outpatient settings, the prevalence is approximately 50%.^{4,5}



1. Torgersen S. *Scandinavian journal of psychology* 2009; **50**(6): 624-32.
2. Moran P et al. *Acta Psychiatr Scand* 2000; **102**(1): 52-7.
3. Ejeby, K. (2017). Doctoral thesis, Karolinska Institutet, Stockholm.
4. Beckwith et al. (2014). *Personal Ment Health*, **8**(2), 91-101. doi:10.1002/pmh.1252
5. Ekselius L. Personlighetssyndrom - kliniska riktlinjer för utredning och behandling. Svenska Psykatriska föreningen, 2017.
6. Shadid J et al. *The lancet Psychiatry* 2025; **12**(12): 932-46.
7. Dubovsky et al. *The Medical clinics of North America* 2014; **98**(5): 1049-64.



3

Diagnosis

Prevalence in the over 18 population¹

Personality disorder	5-10,5% ^{1,3}
Specific phobia	6-9 %
Alcohol use disorders ² (Sweden)	8 %
Depression	5-7 %
Social anxiety disorder	2-7%
Panic disorder	2-3%
Generalized anxiety disorder	3 %
ADHD	2,5 %
Bipolar disorder	1,8 %
PTSD (Europe)	1%
Autism spectrum disorder	1 %
Disorders of intellectual development	1%
Tic disorders (in school age)	0,3-0,8 %
Schizofrenia	0,3-0,7 %
Delusional disorder	0,2 %

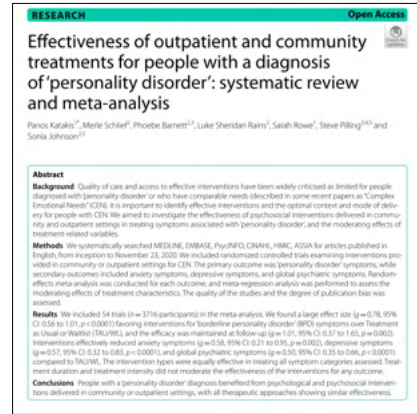
1. Kupfer DJ, Regier DA. Diagnostic and statistical manual of mental disorders: DSM-5. – 5th ed. Arlington, VA, USA.: American Psychiatric Association; 2013.
2. Larsson G. Bättre insatser vid missbruk och beroende - Individ, kunskapen och ansvaret. Stockholm: Regeringskansliet, 2011
3. Shadid J et al. *The lancet Psychiatry* 2025; **12**(12): 932-46.



4

Treatment

- Summary of outpatient treatments¹
- Most were delivered by specialized teams or within specialist psychiatric outpatient care
- Many different interventions: CBT, DBT, MBT, psychodynamic therapy, and less common therapy formats
- Most often compared with waiting list or “treatment as usual”
- All showed good and comparable effects



1. Katakis et al. *BMC Psychiatry* 2023; **23**(1): 5



5

Good Psychiatric Management (GPM)

- Shows that GPM ≈ DBT in effectiveness on key outcomes for borderline personality disorder (e.g., self-harm)^{1,2}
- Why is GPM of interest for primary care?
 1. Aligns with the tradition of generalist models that have shown comparable effectiveness in other studies
 2. Does not require specialized expertise
 3. Can be taught in a shorter training
 4. Builds on knowledge that healthcare staff already have



1. McMain SF et al. *The American journal of psychiatry* 2009; **166**(12): 1365-74.
2. McMain SF et al. *The American journal of psychiatry* 2012; **169**(6): 650-61.

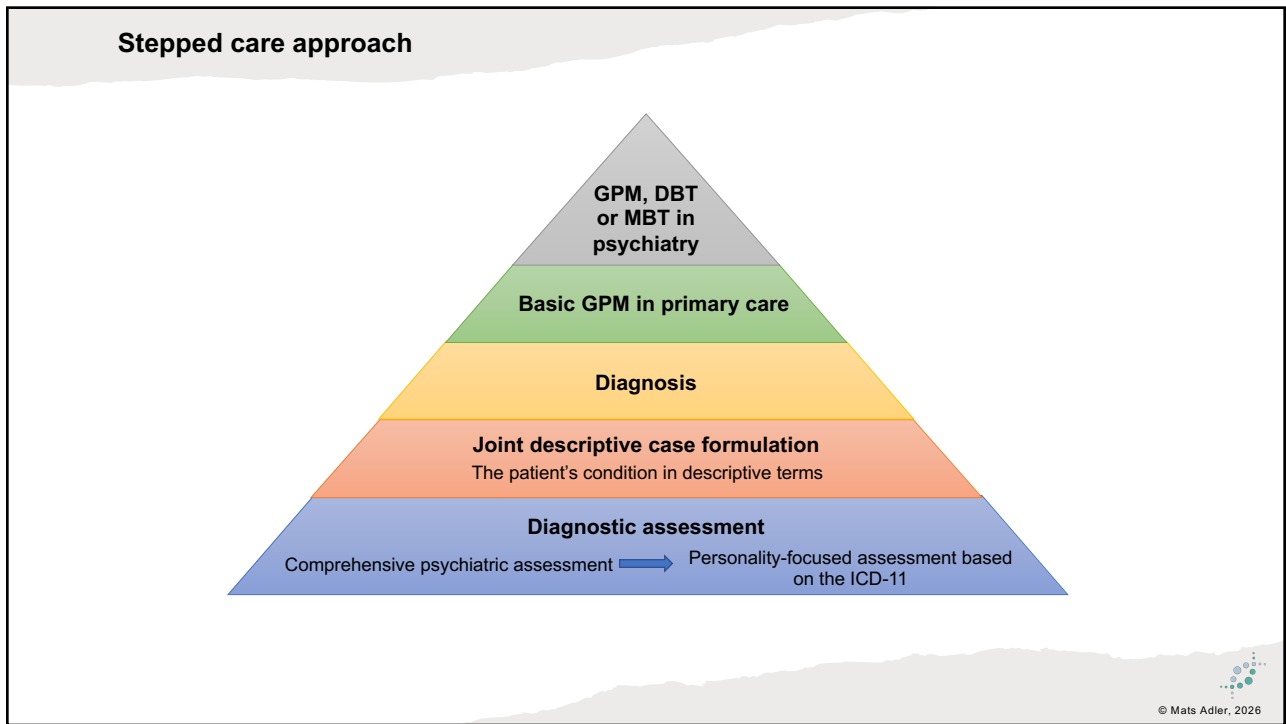


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Problems related to personality disorder in primary care in Sweden	

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GPM TRAINING IN PRIMARY CARE

JOSEFIN RASHIDI
Licensed Psychologist
Adult Psychiatry Clinic
Emotional Instability, Malmö



1

Background

A shared problem:

lack of continuity and unclear transitions for patients moving between primary care and psychiatry

Our approach:

use GPM as a shared clinical framework across levels of care



2

The Training Program

- Voluntary and free program
- Open to all primary care staff
- Special focus on physicians, nurses, and general medicine clinicians

Content:

- Basic knowledge of personality disorder
- The Coherence Model
- Core principles in GPM
- Practical training



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Personality Disorder in Primary Care

Strong reactions to perceived criticism
 Emotionally over- or under-reactive
 Rapid shifts in emotional state



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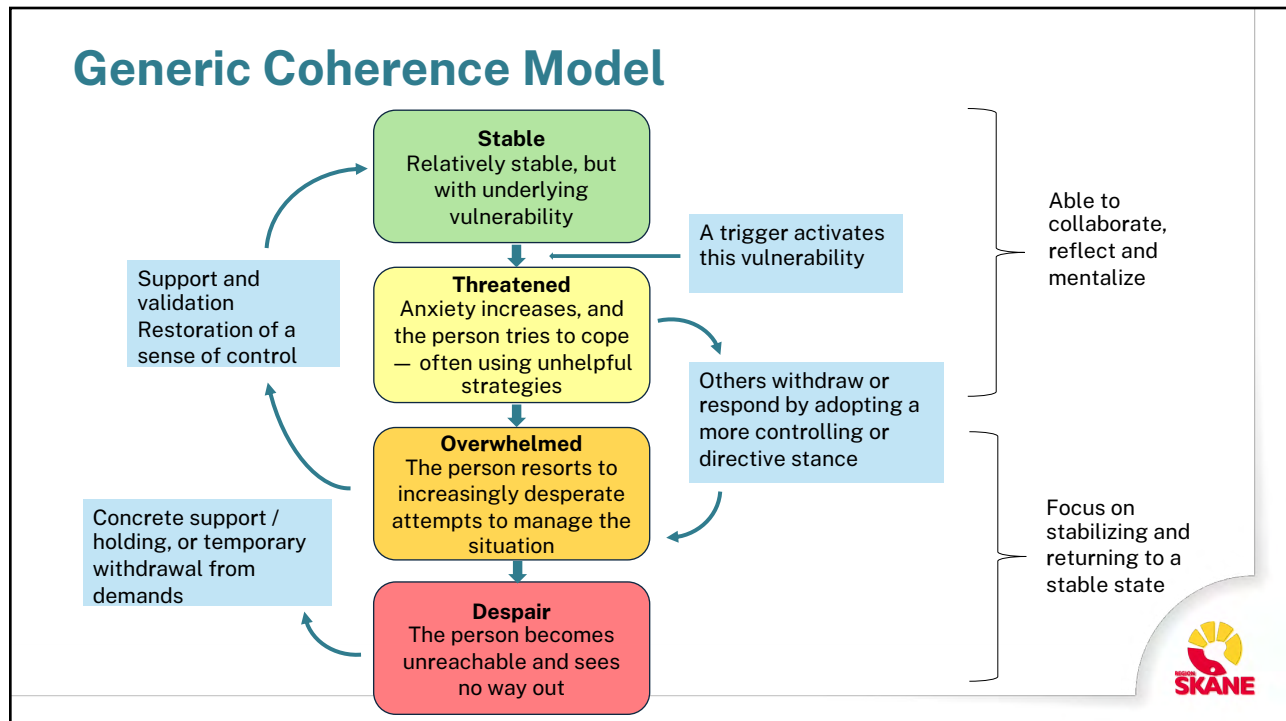
Repeated conflicts with staff
 Recurrent feeling of being misunderstood, mistreated, or rejected by healthcare staff

Difficulty following treatment plans
 Frequent missed appointments or irregular attendance
 Difficulty prioritizing or focusing on one problem, with many simultaneous concerns

Repeated reassurance-seeking or urgent contact with healthcare staff
 Confusion or instability in boundaries (e.g., expectations of availability or emotional involvement)



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Case Vignette

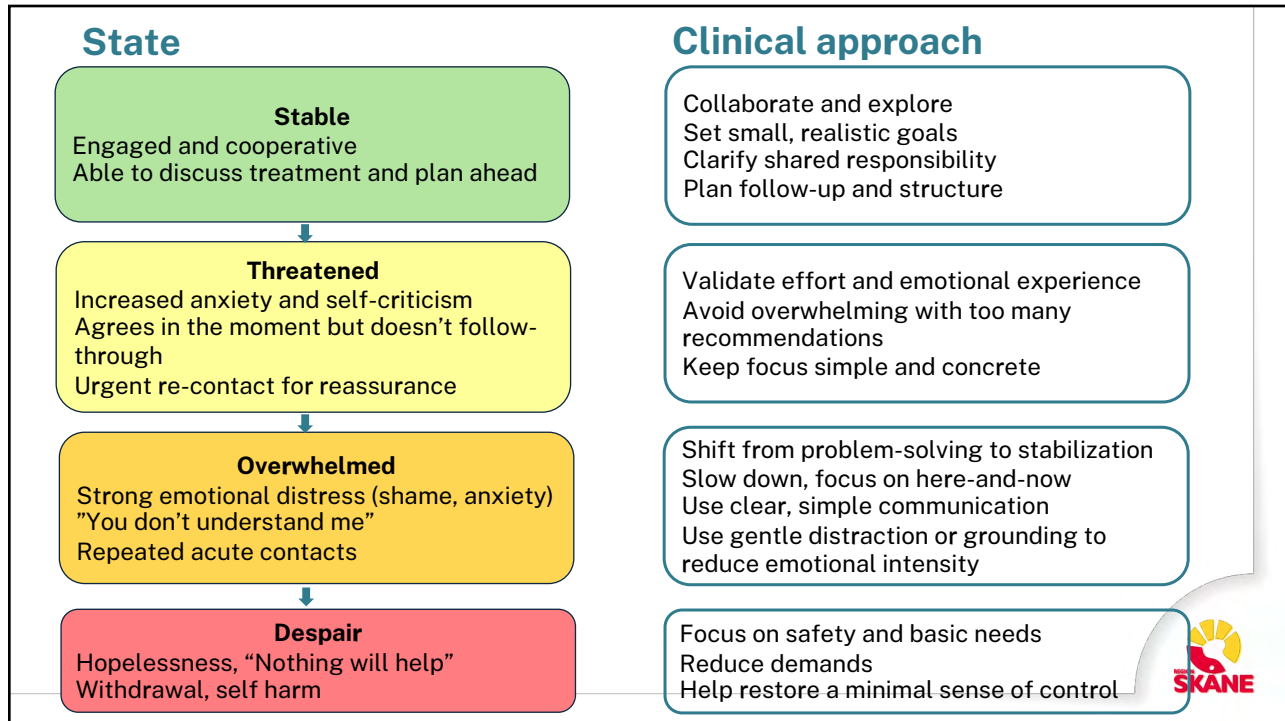
Amanda is a 38-year-old patient who has been registered at the primary care center for several years. She has type 2 diabetes, recurrent depressive episodes, and long-standing stress-related problems. She has had multiple contacts within primary care over time. Her HbA1c levels have consistently remained high despite repeated interventions.

Amanda often presents with strong emotions. She describes that she is “trying but keeps failing.” When healthcare staff discuss diet, exercise, or medication adjustments, she appears to agree, but adherence is limited. After consultations, she sometimes makes urgent contact again, expressing that she has not been understood or taken seriously.

Staff experience her as difficult to help. Her shifts between being highly engaged and then losing hope completely often evoke feelings of helplessness and frustration in the team.



6




7

Evaluation of Training Program

Item	Mean (1-5)
The training was at an appropriate level for my prior knowledge	4.43
I will be able to use the content in my clinical work	4.55
After the training, I feel better equipped to meet patients with personality disorders	4.4

Scale: 1 (Not at all) → 5 (Very much)
In total about 120 participants



8

Evaluation of Training Program

“It confirmed that we are often already doing the right things — and that basic human compassion goes a long way.”

“Everyone in primary care should attend this training!!!!”

“Engaging and highly rewarding”

“I think the training is really aimed at all professions except the psychosocial teams, as it wasn't new to me”



9

What we've learned and future directions

- The understanding of personality disorders is increasing
- We're working towards a shared language and a shared understanding across primary care and psychiatry
- Emphasizing teamwork is crucial
- We will continue offering brief, one-day training sessions
- Need for more in-depth training in ICD-11 for psychologists and physicians



10

THANK YOU!

Josefin.rashidi@skane.se



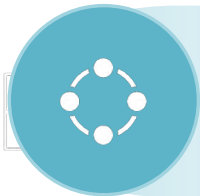
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Background



A shared problem:

lack of continuity and unclear transitions for patients between primary care and psychiatry



Our approach:

use GPM as a shared clinical framework across levels of care



12

2nd International Conference on GPM for Personality Disorders
Karolinska Institutet • 5 May 2026



GPM-A

General Psychiatric Management for

**Adolescents With BPD —
*Brazilian Implementation***

Marcos S. Croci, MD | Marcelo Brañas, MD, PhD

- Co-directors, ADRE-USP
- Collaborators, GPMI, McLean Hospital

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Disclosures

Financial conflicts of interest

Marcos S. Croci, MD
No personal financial conflicts of interest.

Marcelo Brañas, MD, PhD
No personal financial conflicts of interest.

Both authors receive royalties from Manole Publisher (unrelated to this work; section editors of clinical psychiatry textbooks).

GPM-A • 2 / 26

2



3

The scale of the problem in Brazil

A population-level demand that specialist care cannot meet

Demand	Supply
<ul style="list-style-type: none"> • 6.8% any PD in São Paulo (<i>Santana et al., 2018</i>) • 1.8% BPD in São Paulo and Porto Alegre (<i>BHRC*</i>) • 20–30% of outpatient mental-health attendees · 35–40% in <i>CAPS</i> (specialized community mental health centers) • 17.4% adolescent NSSI rate (<i>Angelo, Pan, Miguel, Brañas & Croci, 2026, in submission</i>) 	<ul style="list-style-type: none"> • 6.39 psychiatrists per 100,000 — OECD average 17.83 (<i>Scheffer et al., 2025</i>) • 61.4% of psychiatrists concentrated in state capitals • ~1.25 DBT therapists per 10,000 people with BPD • Mental health: 2.54% of the federal health budget (WHO recommends 5%)

80% of PD patients do not receive any care — specialist BPD care cannot scale to the demand.

Santana et al., 2018 · Scheffer et al., 2025 · Angelo et al., 2026 (in submission)

GPM-A • 4 / 26

4

Brazilian healthcare — two parallel systems

Most professionals work in both

Public — SUS

Entirely free at point of service
for any person — including foreigners

Primary, secondary, and tertiary
levels of care

Where psychiatry residents are trained
— residency programs are based in SUS hospitals and clinics

Tertiary care = HC-FMUSP / ADRE

Private

Insurance-based
offered by employers or purchased individually

Out-of-pocket
access to private hospitals, labs, and clinics

Specialist BPD care is almost entirely private and out-of-pocket; virtually 100% of DBT, TFP and SFT practitioners operate outside SUS.

Healthcare professionals usually work in more than one system

GPM-A • 5 / 26

6

BPD adolescents scatter — myths block proper care

Patients fall between clinics while institutional beliefs delay treatment

Scattered across clinics

- Patients migrate between symptoms and clinics
- Mood, impulsivity, and substance-use labels obscure BPD
- No coherent framework for BPD's core symptoms
- Frequent, unnecessary, prolonged hospitalizations

Institutional myths

- ✗ *“Can't diagnose BPD in adolescents”*
- ✗ *“BPD is untreatable”*
- ✗ *“Let them mature by themselves”*
- ✗ *“General training is enough to treat BPD”*

Delaying well-informed BPD care worsens long-term outcomes — we need a curriculum update.

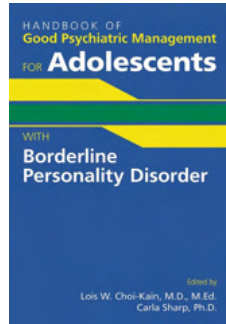
Unruh & Gunderson, 2016 · Ilagan & Choi-Kain, 2021

GPM-A • 6 / 26

7

Generalist models: long needed, now available

Theory, clinical manual, and Portuguese translation make GPM-A deliverable in Brazil



Clinical manual

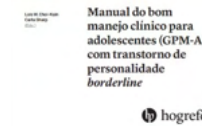
*Choi-Kain & Sharp, Eds.
APA Publishing, 2024*

Handbook of Good Psychiatric Management for Adolescents with Borderline Personality Disorder — the training text behind GPM-A implementation.



Portuguese translation

Hogrefe (Brazilian ed.)



Manual do bom manejo clínico para adolescentes com transtorno de personalidade borderline — removes the **language barrier** for SUS-wide dissemination.

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8

Why generalist-first — and why GPM-A

At population scale, only structured generalist care can reach most patients

Why generalist-first — and why GPM-A

- **As effective as EBTs** — structured generalist care is non-inferior to CAT and DBT-A

Ilagan & Choi-Kain, 2021

- **Feasible workforce & sustainable cost** — deliverable by general-psychiatry residents under supervision and less resource-intensive than specialist EBT programs

Unruh & Gunderson, 2016; Choi-Kain, 2016

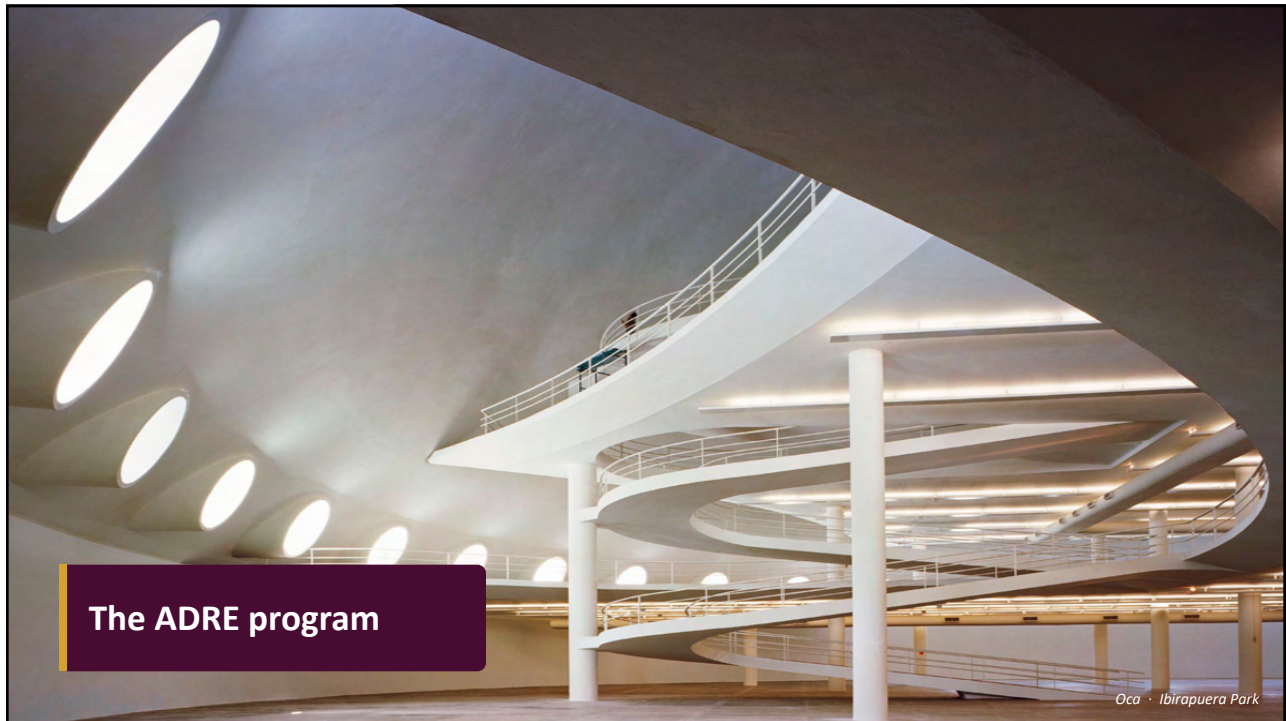
- **Common language** — shared framework across therapy schools (behavioral, cognitive, psychodynamic)

Kramer et al., 2017

- **Scalable** — one clinician can deliver one treatment or coordinate care across providers

GPM-A • 8 / 26

9



11

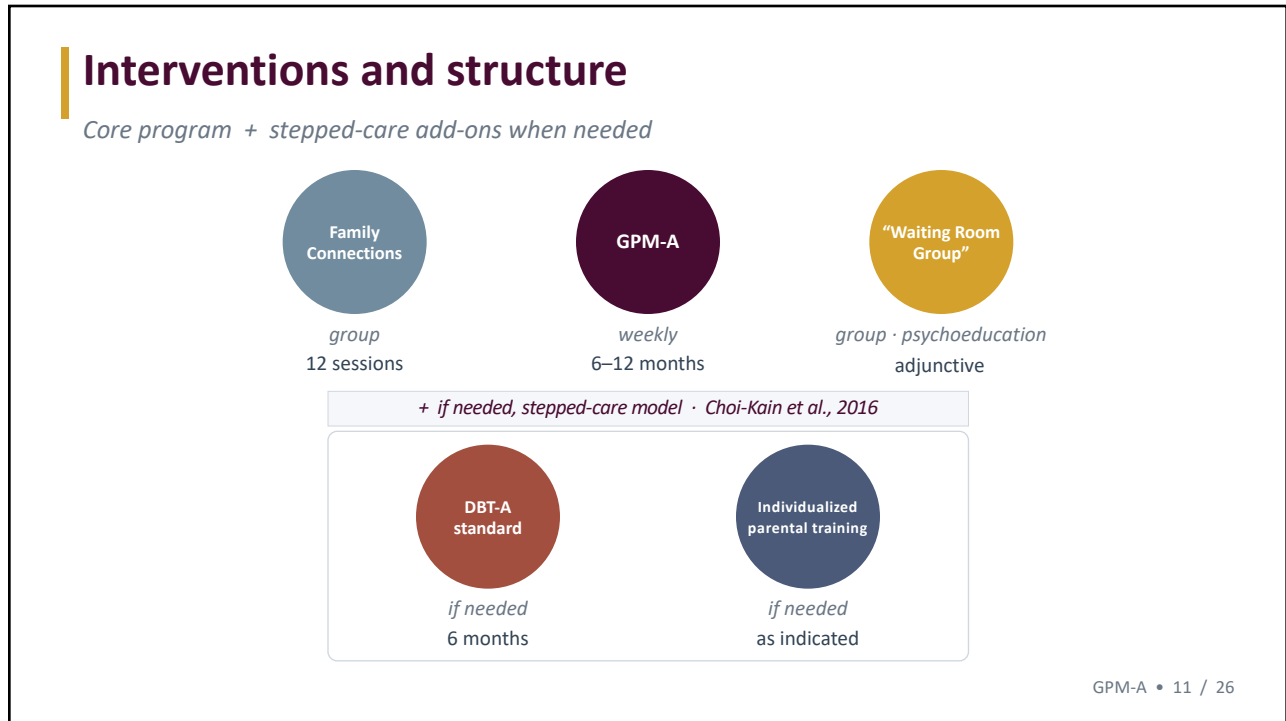
University of São Paulo · Hospital das Clínicas

The largest university-hospital complex in Latin America

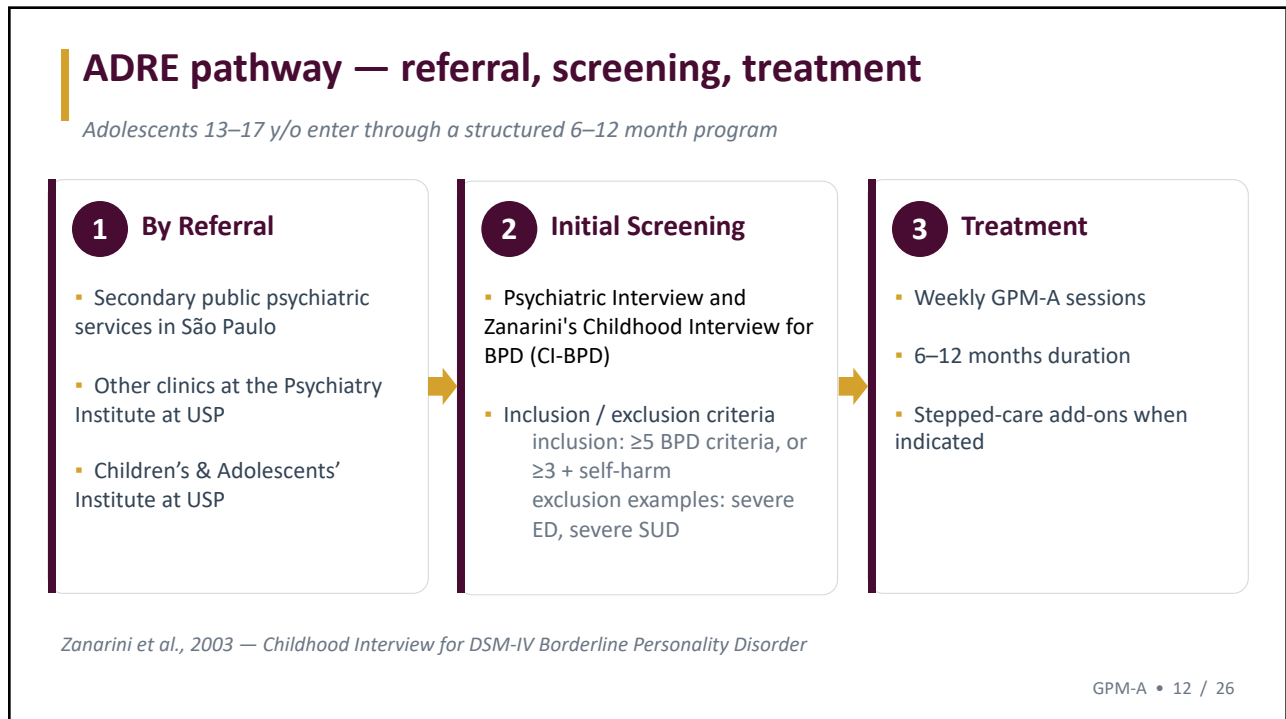
- HC-FMUSP**
Teaching, research, and specialized care — the reference tertiary-care center for the state
- Institute of Psychiatry (IPq)**
Hosts the Department of Child & Adolescent Psychiatry
- ADRE — Dual mission**
Clinical care for moderate/severe cases + residency training for the next generation

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ADRE patient profile — baseline measures

Sample (n = 79). Age 15.2 (SD 1.2). **Sex at birth** female 77%; **Schooling** currently enrolled 68%; **Clinical** antidepressants 65%, antipsychotics 33%, mood stabilizers 24%; ever used drugs 38%; family psychiatric history 68%; previous psychiatric hospitalizations M=1.25 (SD 1.62).

Instrument	Sample value	Severity bands (sample value range in bold)
BPFSC-11 <i>Borderline features in children</i>	Total 32.5 (SD 6.98)	<25 below sub-clinical · 25–29 at-risk · 30–33 elevated · ≥34 Sharp cut-off (full-threshold BPD) · ≥38 BPD inpatient mean
BSL-23 <i>Borderline symptoms</i>	Mean item 2.81 (SD 0.96)	Low <0.3 · Mild <0.7 · Moderate <1.7 · High <2.7 · Very high 2.7–3.5 · Extremely high > 3.5
LPFS-BF 2.0 <i>AMPD Criterion A</i>	Total 34.3 (SD 9.92)	Healthy <26 · Mild ≥26 · Moderate ≥31 · Severe ≥36 · Extreme ≥41
DSHI-9 <i>NSSI</i>	Mean total score 22.81 (SD 14.09)	Chronic-repetitive pattern; cutting was the most common method
YQOL-R <i>General quality of life</i>	Mean 40.4 (SD 24.8)	Community adolescents ~73 (Salum et al., 2012) · Social Anxiety Disorder ~59 (Isolan, 2007)

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Teaching the GPM model

Spreading the model across clinicians, residents, and trainees

Introductory lectures	Annual workshop	ADRE supervision
<ul style="list-style-type: none"> • All PGY-1 and PGY-2 residents attend • Foundations of personality disorders • Introduction to the GPM approach 	<ul style="list-style-type: none"> • Held annually in Portuguese • Mandatory for clinicians joining ADRE • Open to Brazilian clinicians and residents 	<ul style="list-style-type: none"> • Weekly supervision at ADRE • Hands-on application of GPM in real cases • Continuous calibration with the multidisciplinary team

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Weekly supervision

How the team stays calibrated and residents stay supported

Case discussion	Reducing resident anxiety	Supervisor sees the patient
<ul style="list-style-type: none"> Weekly supervision GPM fidelity — drift from GPM-A principles flagged and corrected early. 	<ul style="list-style-type: none"> Contained worry — residents bring high-risk cases to the team instead of carrying them alone. Prevents defensive medicine — non-reactive resident, clearer decisions, fewer reactive hospitalizations. 	<ul style="list-style-type: none"> Threshold for direct review — any diagnostic uncertainty, safety escalation, or therapeutic impasse. Joint session — supervisor joins a session with resident and patient, modeling GPM-A stance.

GPM Adherence Scale (GPM-AS) — subscale means (n=34)

Subscale	Mean	SD
1 — Assessment procedures	3.97	0.54
2 — Establishing treatment contract	4.17	0.56
3 — Ongoing case management	4.10	0.59
4 — General principles of psychotherapy	3.91	0.38
5 — Focus on feelings	3.67	0.79
6 — Specific therapeutic issues	3.48	0.67
TOTAL GPM-AS (adjusted)	3.90	0.42

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Keeping GPM-A on the rails

Two simultaneous drifts — residents and supervisors

Framework drift

Residents (or supervisors) drift in two directions: **too passive/only validation-based interventions** or **narrowed onto crisis and skills** — often shaped by other models from private practice.

Response: Redirect the team to the GPM-A principles-based and interpersonal hypersensitivity model.

Diagnostic drift

Residents tend to reframe the BPD diagnosis as one of its comorbidities, such as **ADHD or cPTSD** (due to stigma and difficulty in navigating complexity in comorbidity and BPD heterogeneity)

Response: BPD can coexist with ADHD/PTSD instead of being replaced by them; GPM hierarchy approach to comorbidities; GPM myth busters.

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Diagnosis & differential diagnosis

BPD comorbidities are heterogeneous — patients present with distinct symptom profiles

Patient A

- **Interpersonal hypersensitivity**
- Anger issues
- **ADHD symptoms**

Patient B

- **Interpersonal hypersensitivity**
- NSSI
- Suicidality
- **Chronic Depression**

Patient C

- **Interpersonal hypersensitivity**
- Dissociative & paranoid symptoms
- Withdrawal
- **Substance use**


Trainees default to whichever comorbidity is loudest at the moment. **Reorienting them** is daily work.

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Resident Workbook

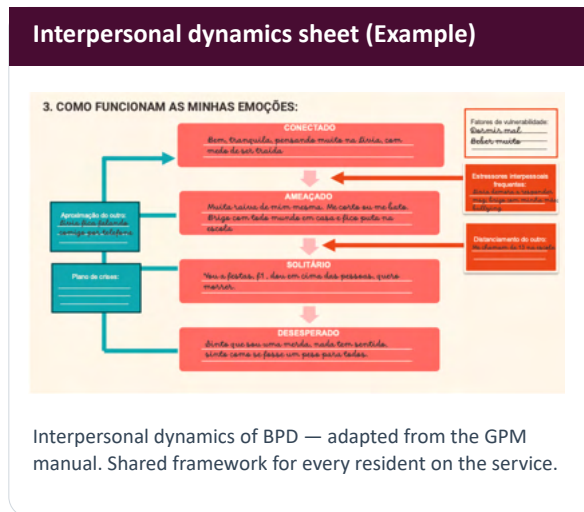
Resident Workbook



Cover page. Orientation, team structure, treatment phases, admission criteria, and rotation calendar for incoming residents.

Interpersonal dynamics sheet (Example)

3. COMO FUNCIONAM AS MINHAS EMOÇÕES:



Interpersonal dynamics of BPD — adapted from the GPM manual. Shared framework for every resident on the service.

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Diagnostic challenges and limits of GPM-A

Comorbidities at ADRE

- **Eating disorders** — GPM-A for ED + USP partner clinic; severe restriction needs disorder-specific care first.
- **Substance use disorder** — Perdizes Institute at USP, specialized center for SUD.
- **Autism** — GPM-A + the B-for-autism adaptation (Dudas & Cheney, 2025).
- **Complex PTSD** — DBT-PE / DBT-PTSD elements (Choi-Kain, 2021).
- **ADHD** — important to treat concurrently to benefit from BPD treatment.
- **Gender dysphoria** — collaboration with a specialized USP clinic.

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GPM-A — five key adaptations from GPM

- 1 Subthreshold inclusion**
≥3 BPD criteria suffice (vs. full-criteria adult diagnosis)
- 2 Age-appropriate language**
Relatable framing for psychoeducation; three developmental scripts (younger / mid / older teens)
- 3 Amplified family involvement**
Family is structural, not adjunctive — e.g., joint sessions, sibling support, *Family Connections*
- 4 Time-limited treatment**
Shortened, planned termination — focus on life outside, avoid interrupting normative development
- 5 Explicit developmental focus**
Identity formation, school engagement, autonomy, peer relationships

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The waiting-room problem

Long commutes, unpredictable arrivals

Many adolescents and their parents travel hours by public transit and arrive well before their appointments — leaving patients gathered together in the same waiting room.

Serious peer contagion incidents

Covert NSSI behaviors went undetected — on one occasion adolescents **shared shaving blades** in the waiting room. Substance exchange also occurred, and one adolescent developed a significant **MDMA intoxication** requiring emergency department transfer.

Our response: the Waiting-Room Group

A semi-structured group held by **two clinicians (psychiatric nurses)** while adolescents wait for their resident appointment. In parallel, parents attend family interventions such as **Family Connections**.

Nation-wide dissemination

ADRE graduates move into services where GPM is unknown, “spreading the word”.

Materials

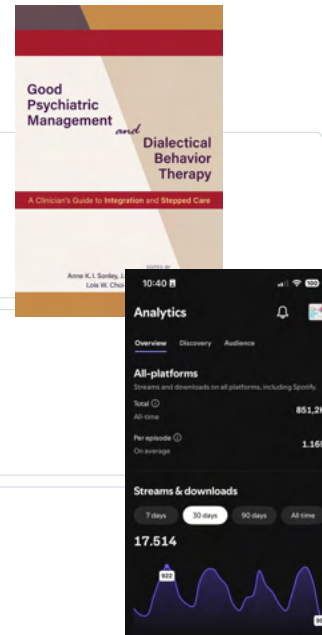
- **GPM and GPM-A Manuals** translated to Portuguese
- **Harvard Medical School** online course
- **GPM+DBT** book translation in final stages

Publications

- **Original article publications** — PT, ES, EN
- **Book chapters** on BPD / GPM
- **Free podcast episodes** for clinicians






National Events

- **Brazilian Psychiatric Association** Annual Meeting
- **Brain, Emotions and Behavior** Congress
- **Workshops** at partner universities and services



Implementation partnerships & next frontier

ADRE-trained clinicians seeding GPM programs — and pushing beyond clinicians to leadership

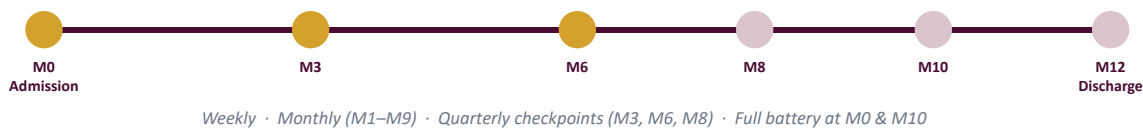
CESUPA → GPM-A <i>Belém, Brazil</i>	FAMERP → GPM <i>São José do Rio Preto, Brazil</i>	Périgueux → GPM-A <i>Centre Hospitalier Périgueux, France</i>
 	 	
Yasmin Nascimento, MD Silvana Costa, MD	Larissa Fares, MD Bruno Soleman, MD	Vinicius Freitas, MD

Next frontier: leadership-level work — hospital directors, residency coordinators, and the health ministry.
BPD Awareness Day: ongoing project in the Brazilian Senate.

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Research protocol — assessment timeline

Instruments by domain across the 6- to 12-month GPM-A program



Diagnoses and personality functioning	CI-BPD · LPFS-BF 2.0
Repeated assessment	BSL-23 Main & Supplement (monthly) · BPF5-C (quarterly) · ZAN-BPD liability 1-item (weekly)
Trauma / eating / medical	QUESI-CTQ · EAT-26 · Medical Questionnaire (admission & discharge)
Emotional regulation / dissociation	DERS-16 · DES
General psychopathology	CBCL/6-18
Suicidality / self-harm	C-SSRS · DSHI-9 · RSS
SES / functioning / quality of life	SES · WSAS (monthly) · CGI · YQOL-R
Therapist-patient / alliance / stigma	GPM Principles · WAI-SR · GPM-AS · Attitudes toward BPD · Acceptability/Feasibility

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Take-home

- 01 Adolescent BPD is a valid, treatable diagnosis**
 Under-diagnosed despite severity comparable to adult BPD.
- 02 Generalist-first where specialists are scarce**
 GPM-A is deliverable in a tertiary-care public system.
- 03 Local adaptations matter**
 FC + individualized parent training when needed + structured waiting room group
- 04 Residency is the implementation lever**
 Training the next generation of professionals is how GPM-A spreads through a public system.
- 05 Systemic change requires institutional work**
 Leadership-level engagement + dissemination + partnerships.

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Tack!
 Thank you!

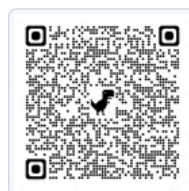
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Karolinska Institutet · 5 May 2026

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- Yasmin Nascimento



GPM for Latin America paper

Major Collaborator

Lois W. Choi-Kain, MD, Med, DFAPA
 Director, Gunderson Personality Disorders Institute,
 McLean Hospital / Harvard Medical School

33



Implementing Good Psychiatric Management: Early Experiences from a Qualitative Study

Dr Sonja Quan
Consultant Psychiatrist

Te Kāwanatanga o Aotearoa
New Zealand Government

Health New Zealand
Te Whatu Ora

1



Collaborators

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- Dr Lilian Ng, Forensic Psychiatrist and Senior Lecturer, University of Auckland
- Dr Rodrigo Ramalho, Psychiatrist and Population Health Scientist, University of Auckland
- Dr Sonja Quan, Psychiatrist

2

Te Toka Tumai (Auckland District Health Board)

- Covers a population of approximately 498,000 residents
- Approximately 3.6% of the total ADHB population access mental health services
- Māori are most likely to access services (19.6 % of the general population)
- Access to a 58-bed inpatient unit

3

Assertive Community Outreach Service

- Provides assertive treatment and support to service users with psychotic and mood disorders who have a pattern of problematic engagement with services and/or treatment recommendations and a history of high-risk behavior during periods of relapse
- Caseload of about 100 patients
- Staff consisted of 1 psychiatrist, 1 psychologist, 5 nurses, 3 social workers, 1 occupational therapist, 3 community support workers, and team leader (social work background)

4

Healthcare Improvement : Quadruple Aim

1. Improve patient experiences
2. Improve population health
3. Reduce cost
4. Improve staff experiences

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: care of the patient requires care of the provider. *Annals of family medicine*, 12(6), 573–576

5

Methodology and Methods

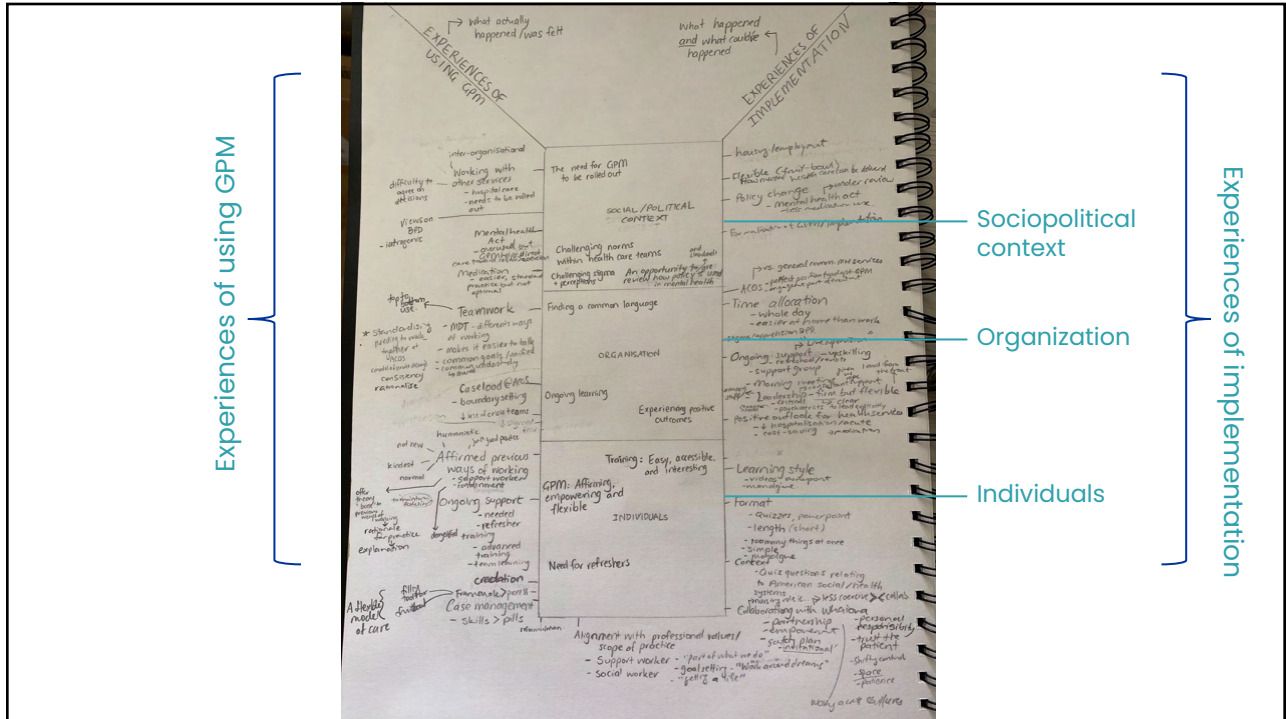
Data collection:

Semi-structured interviews (about 45 minutes)

Data analysis:

Reflexive thematic analysis informed by interpretative phenomenological analysis

6



7

Findings

1. GPM is a pragmatic, structured, and flexible model of care
2. GPM empowers practitioners and patients
3. Leadership is instrumental for implementation

8

1. A Pragmatic, Structured, and Flexible Model of Care

- GPM is **complementary** to practitioners' **values**
- An **intuitive model** that affirms understanding of good practice
- Increased **compassion** towards patients

9

- Provides **structure** and a **common language** for staff
- **Flexibility** that supports culturally safe and person-centered care

10

2. Practice that Empowers Practitioners and Patients

- Enhances individual and collective confidence
- Restoring patient's agency in the therapeutic relationship

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3. Leadership is Instrumental in Implementation

- Contextual fit of GPM
 - Complex patients
 - Assertive outreach model
- Wider health care contexts
 - System push back

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Moving Forward

- GPM as baseline standard of care
- Integration with the DBT program
- Integration with Māori cultural practice

13

GPM offers a shared language and ethical stance that supports both staff wellbeing and patient agency

Thank you

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GPM & ICD-11 in Practice

Integrating generalist frameworks

Manne Frankenstein
Erik Ydrefelt



1

Agenda

- Background
- Conceptualizing GPM in dimensional terms
- GIT-PD group
- Ongoing study



2

Background Malmö-Trelleborg

- Two parallel projects related to PD:
- Training and supervision in GPM, initiated in 2020
- Early preparation for the transition to ICD-11, involving online training and in-person workshops since 2023.
- Between 2022-2025: 280% increase in F608 (other specified PDs).
- From 18 to 69 patients.



3

3

Guidelines for personality disorder treatment

- Adapt and apply treatment for BPD to other personality disorders.
- BPD criteria primarily reflect general personality dysfunction and severity rather than forming a distinct syndrome, suggesting they capture core aspects of impaired personality functioning across disorders.

(Ekelius, 2017; Bateman et al., 2015; Sharp et al., 2015)



4

Implementation & Development:

- **Psychoeducation:** 6-session group implemented.
- **GPM Workshop:** Adapted for ICD-11.
- **Group Intervention:**
 - Standalone for milder cases.
 - Foundation for team-based GPM in severe cases.



5

Key components of the dimensional system

ICD-11/ AMPD	GPM
Personality functioning (PF): Ability to understand/regulate self and manage relationships Stable <i>and</i> fluctuating.	Impairments interact with hypersensitivity. Principles: strategies for addressing impairments. Overlap with mechanism of change.
Personality traits: Enduring, maladaptive patterns. Largely genetically determined. Resistant to change, including from treatment.	Hypersensitivity Specified and dynamic conceptualization of traits.
Severity in terms of PF.	Increased severity: more triggers <i>and</i> stronger reactivity to triggers.

(Allen et al., 2022; Blay et al., 2023; Miskewicz et al., 2015; Sinnavee et al., 2021; Wright et al., 2015)



6

Introduction to GIT-PD

- GIT-PD based on DSM-5 AMPD, aligned with our development work.
- Generalist approach: no specialist expertise required.
- Access to materials from Joost Hutsebaut.
- Pilot project started in 2025.

(Hutsebaut, J., Willemsen, E., Bachrach, N., & Van, R. (2020). Improving access to and effectiveness of mental health care for personality disorders: the guideline-informed treatment for personality disorders (GIT-PD) initiative in the Netherlands. *Borderline Personality Disorder and Emotion Dysregulation*, 7(1), 16.)



7

The GIT-PD Group Model

- Organized around Personality Functioning:
 - 4 Modules (Identity, Self-Direction, Empathy, Intimacy)
 - 8 sessions per module
- Added: A fifth module for skill consolidation.
- 90 minutes:
 - Review of homework.
 - Introduction of the day's theme (mixed methods: reflection, discussion, role-play).
 - Assignment of new homework.



8

8

Patient Group, pilot.

- All patients diagnosed with moderate personality disorders (ICD-11) with the following traits:
- Detachment (4 patients) – comparable to avoidant personality disorder (DSM-5).
- Anakastia (ICD-11)/ Rigid perfectionism & perservation (AMPD) (4 patients) – comparable to obsessive-compulsive personality disorder; two of these also narcissistic traits.



9

Patient Evaluations, pilot.

Metric	Module 1 Identity	Module 2 Self-direction	Module 3 Empathy	Module 4 Relationships
Sessions Quality (mean value) <i>How useful was the session?</i>	4.0	3.6	4.1	3.8
Utility <i>Will it help you in daily life?</i>	4.0	4.2	4.5	4.2
Peer Learning <i>Did you learn from others?</i>	4.4	4.4	4.3	4.5

Scale: 1 (Not at all) → 5 (Very much)



10

Experiences and Adjustments

- GIT-PD v GPM: More psychologizing, focus on the formation of maladaptive patterns in interaction with the environment and upbringing factors.
- In our group (not inherent to GIT-PD): At times a drift from addressing shared features of personality disorders to examining universal difficulties inherent to human experience.
- Adjustments:
 - Earlier focus on Self-Direction
 - More focus on coherence-models

(Sharp, C., & Wall, K. (2021). DSM-5 level of personality functioning: Refocusing personality disorder on what it means to be human. *Annual review of clinical psychology*, 17(1), 313-337.)



11

11

Ongoing study - background

- Paradigm shift → therapeutic void
- RnD funding (FOUU)
- 8 patients diagnosed with PD other than BPD, as defined by ICD-11. Moderate difficulty levels. Aim was n 8-11 and moderate to severe difficulty
- Patients are recruited from a 6 sessions psychoeducational group intervention on personality disorders
- No selection based on trait domain specifiers (apart from borderline as an exclusion criteria for main problem formulation)



12

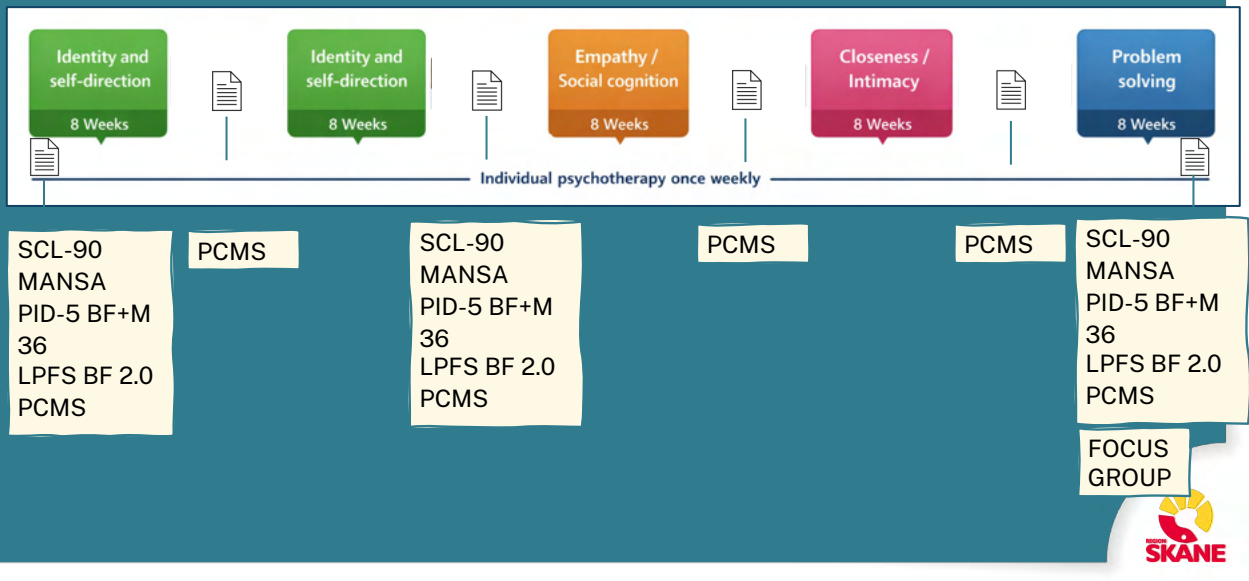
Ongoing study - outcomes

- Main purpose: is it a reasonable intervention to offer?
 - Patients experienced benefit, relevance, and comprehensibility (focus group interview)
 - Feasibility
- Tendencies toward change in regards to
 - Personality function and prominent traits (LPFS BF 2.0, PID-5 BF+M 36)
 - Symptom levels (PCL-90)
 - Life quality (MANSA)
 - Motivation to change (PCMS)



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Ongoing study - layout



14

Thank you!

Manne.Frankenstein@skane.se
Erik.Ydrefelt@skane.se

The SKANE logo is located in the bottom right corner of the teal slide. It features a stylized sun icon with yellow and red segments above the word "SKANE" in a bold, red, sans-serif font.

A Pilot Study of GPM-I in Routine Care

Feasibility, refinement, and the clinical logic of GPM-I, phase II

Dan Bengtsson, Licensed Psychologist, PhD Candidate

Linnaeus University · Personality Disorders Unit, Huddinge University Hospital · Region Stockholm

GPM International Conference Stockholm · May 2026



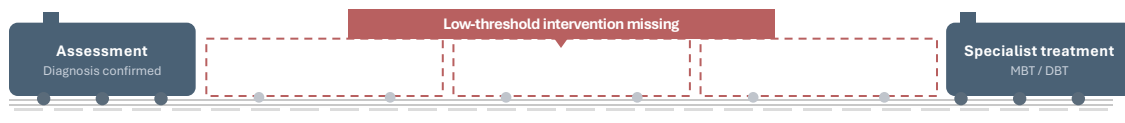
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02 GPM-I: What & why

GPM was working – but the same three gaps kept showing up. We built GPM-I to close them.

STARTING POINT

- **No low-threshold option** for patients outside specialist programs
- **GPM thinking doesn't travel** beyond personality specialists
- **Yet the psychoeducational core is transmissible** – shouldn't need a specialist slot



OUR RESPONSE · GPM-I AT A GLANCE

FORMAT

Digital guided self-help
8 weeks · weekly written feedback

STRUCTURE

Core modules + optional modules
Psychoeducation on personality mechanisms

PLATFORM

Stöd och Behandling
Sweden's national digital care platform

TARGET

Personality disorders & related problems · ICD-11

Based on GPM principles, adapted for digital delivery in routine care



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03 Pilot study: Design & sample

Study design		Outcomes & pathways	
Design	Naturalistic open feasibility study	Clinical pathways	<ul style="list-style-type: none"> Assessment Unit ADHD / Neuropsychiatry Units Personality Disorders Unit
Setting	Outpatient psychiatry, Psykiatri Sydväst	Primary feasibility outcomes	<ul style="list-style-type: none"> Uptake and completion Acceptability (CSQ-8) Negative effects (NEQ)
Recruitment	Aug 2023 – Dec 2024	Secondary outcomes	<ul style="list-style-type: none"> Weekly CORE-10 (mixed-effects model) Pre–post symptom measures (DERS, PHQ-9, GAD-7, WHODAS)
N	131 offered → 78 initiated		

DIAGNOSTIC GROUPS

Personality syndrome <i>ICD-11 personality disorder</i>	Personality difficulties <i>Sub-threshold / co-occurring</i>	Related problems <i>Emotion dysregulation, ADHD overlap</i>
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Naturalistic open feasibility study · Psykiatri Sydväst · N = 78 initiated



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04 Key findings

Feasibility indicators · Table 1. Acceptability & completion

Measure	n	%
Program initiated (≥1 module)	78	59.5
Standard completion (M1–2)	40	51.3
All modules completed (1–6)	13	16.7
CSQ-8 satisfaction	28	85.7
Willingness to return	28	78.6
Helped deal more effectively	28	67.9
≥1 negative effect (NEQ)	25	32.1

Note. Initiation row: 78/131 offered. CSQ-8: n = 28 respondents. NEQ: n = 27 respondents; 25 endorsed ≥1 negative effect. Other percentages are based on N = 78 initiators.

Exploratory outcomes · Table 2. Pre-post by diagnostic group

Measure	PD Pre	PD Post	PSP Pre	PSP Post	MDG Pre	MDG Post
DERS-16	53.67	47.67	56.53	52.33	52.86	50.86
BSL-23	1.43	1.27	1.46	1.25	1.46	1.50

Note. Values shown as means. PD = personality disorder, PSP = personality problems, MDG = mixed diagnostic group. Exploratory outcomes; descriptive group comparisons.

Feasibility results with exploratory pre-post outcomes · N = 78



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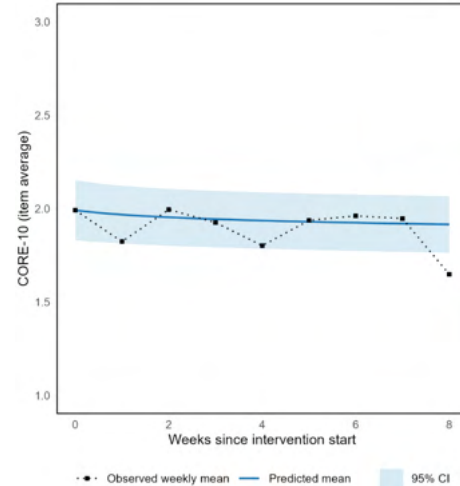
05 Weekly CORE-10 trajectory

CORE-10 trajectory · Linear mixed-effects model

Parameter	Estimate	SE	p
Intercept	1.52	0.08	< .001
log(week+1)	-0.074	0.033	.031

Note. Random intercept by initiator; fixed effect of log(week+1). N = 581 observations. Satterthwaite df. AIC = 692.4 (log-time) vs 693.5 (session).

Interpretation. Over 8 weeks, the estimated reduction was small: ≈0.15 points on the 0–4 mean scale (≈1.5 points on 0–40 total). This suggests modest group-level change and considerable between-participant variability.



Feasibility results · N = 78 · CORE-10 weekly self-report

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06 What the pilot taught us

INSIGHT 1 · REBALANCING

The program was structurally overloaded

- 2 core modules: concepts stacked without space to process
- 4 optional modules: deeper content reached too few



Restructure: 4 modules as the full program

- Every participant receives the complete intervention
- Elective deep-dive modules extend – not supplement – the four

INSIGHT 2 · THEORETICAL SPINE

The program lacked a theoretical anchor

- GPM-informed ≠ GPM-anchored
- Psychoeducation present but loosely connected



Anchor in hypersensitivity model

- Already central to GPM – becomes the organizing principle
- Transforms disparate content into coherent intervention

INSIGHT 3 · FEASIBILITY

Delivery worked in routine care

- Implementable by regular clinical staff
- Results imperfect, but feasibility was demonstrated



Refine and scale

- Update program with feedback & lessons learned
- Move toward larger, powered study

This led to → GPM-I 5.0

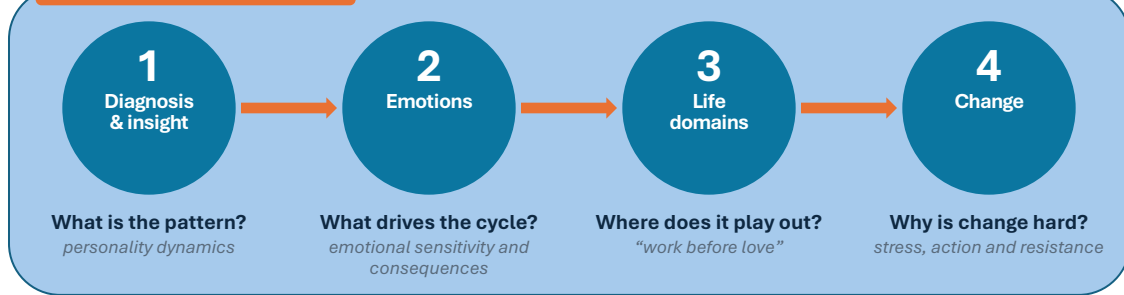
The pilot gave us three lessons: the program had to become lighter, more coherent, and more scalable.

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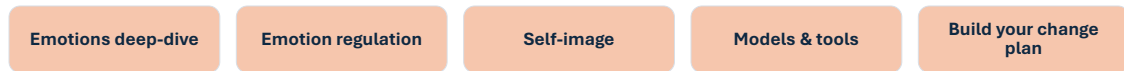
07 The logic of GPM-I 5.0

Four modules, one clinical logic: understanding and working with the hypersensitivity cycle

4 MODULES — 100% GPM-I



+ OPTIONAL ADVANCED DEEPENING · adds depth to the core modules, not new content

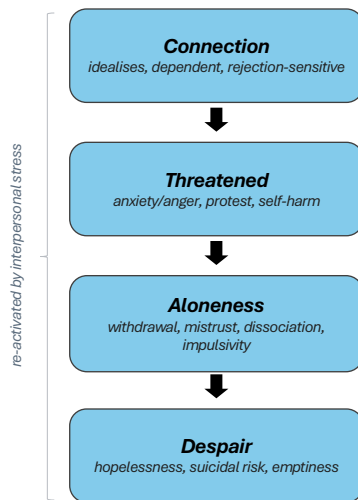


Hypersensitivity not only explains the problems. It also explains why change is hard.



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08 When change activates the hypersensitivity cycle



WHEN A PATIENT TRIES TO CHANGE

Change activates the same cycle

Trying something new activates interpersonal stress and pulls the patient into the cycle.

THE CORE INSIGHT

Resistance reflects the hypersensitivity dynamic

The same pattern is identified in M1, explored in M2, mapped in M3, and activated in M4.

THE PROGRAM LOGIC

One cycle, four modules

The same cycle underlies each module – here seen through the lens of change.



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09 From feasibility to powered evaluation

Testing GPM-I 5.0 as a scalable routine-care intervention

CURRENT IMPLEMENTATION

Delivered in routine care today

- Delivered in routine care by a small clinical team.
- Weekly written feedback is the main care contact.
- Open to national self-referral across Sweden since November.
- **225 self-referrals received in the last 6 months.**

EARLY ROUTINE-CARE SIGNALS

Encouraging early indications

- Early signals suggest higher completion of the revised program.
- Patients report high satisfaction.
- The refined format appears easier to deliver.

NEXT STUDY

Toward a powered evaluation

- Focus on outcomes, engagement, and scalability.
- Test whether the refined version can produce meaningful change at scale.

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Early participant feedback

Illustrative comments from routine-care use, translated from Swedish

Recognising patterns

"I notice when my system is challenged, and can ask whether I want to act from an old pattern."

"I focus more on myself than on others."

Using emotions differently

"I listen more to the information my emotions give me."

"I feel less afraid of going into challenging situations."

Small sustainable changes

"I have started to see that change can be small and sustainable."

"I have started saying no without first building up irritation."

Illustrative feedback, not formal qualitative analysis.

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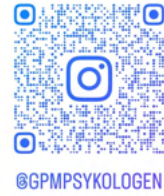


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The Team



Thank you!



@GPMPSYKOLOGEN

Feel free to reach out for questions, collaboration, or any professional exchange

To read more about GPM-I (in Swedish):

internetpsykiatri.se/behandling/personlighetsproblem

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Dan Bengtsson · Linnaeus University





**ADDRESSING SPIRITUAL AND TRANSCENDENT EXPERIENCES
IN BORDERLINE PERSONALITY DISORDER USING GOOD
PSYCHIATRIC MANAGEMENT AND OTHER EVIDENCE-BASED
TREATMENTS**

Brandon Unruh & Sophie I. Liljedahl

GPM Congress 2026

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**ADDRESSING SPIRITUAL
AND RELIGIOUS
EXPERIENCES IN BPD WITH
GOOD PSYCHIATRIC
MANAGEMENT**

Brandon Unruh, M.D.

Medical Director, Gunderson Residence

Founding Director, Mentalization-Based Treatment Clinic

McLean Hospital / Harvard Medical School



Unruh BT. *American Journal of Psychotherapy* 2025. 78(1):63-69.

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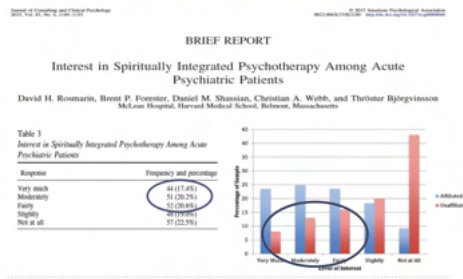
EXPLORING R/S IS WELCOMED BY MOST PSYCHIATRIC PATIENTS...

- R/S appears to be an active part of many psychiatric patients' lives
- Patients in mental health hospital settings welcome discussion of spiritual beliefs & religious practices (Rosmarin et al 2015)

S/R is not Uncommon!

Spirituality/Religion among McLean Hospital patients	
Religious Affiliation	60.5%
"Fairly" or greater belief in God	71%
"Absolutely Certain" belief in God	33.2%
Religion important	45.8%
Pray ≥ 1x/week	81.5%
Religious services ≥ 1x/week	48.2%

Patients want Spiritual Psychotherapy



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BUT PERHAPS LESS WELCOMED BY CLINICIANS?

- Historical clash
 - Freud, *The Future of an Illusion* (1927)
- Real differences between how clinicians and patients value and experience R/S:
 - Mental health clinicians personally place less value upon religion for themselves
 - Only ~25% psychiatrists/psychologists report religious affiliation or belief in God, but a strong majority report clinicians should concern themselves with the religious concerns of pts, and that religion is generally beneficial
 - Neeleman et al 1993, Dein 2010, Delaney et al 2007



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AN UNCOMFORTABLE “LEAP OF FAITH” FOR CLINICIANS

- Good reasons for wariness:
 - Psychiatry/psychology & R/S can be conflictual explanatory systems and authorities
 - Respect for pluralistic coexistence of diverse R/S
 - Potential harmful influence upon patients given authority, power, privilege within patient/therapist dyad
 - Countertransference/transference difficulties in exploring R/S



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WHAT ABOUT PERSONALITY DISORDER TREATMENT?

- Work with PDs is pointedly on the “front lines” of the current “crisis of meaning”
- Our patients come to us feeling helpless, hopeless, meaningless, worthless, purposeless, existentially lost, alone – and unable to change, learn, or grow in any of these domains.
- Living with personality disorder appears to involve an urgent wrestling with needs and desires for meaning/purpose, but greater obstacles to healthy relationships with S/R experiences & resources.

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R/S AS A POTENTIALLY IMPORTANT INGREDIENT IN RECOVERY FROM PERSONALITY DISORDER

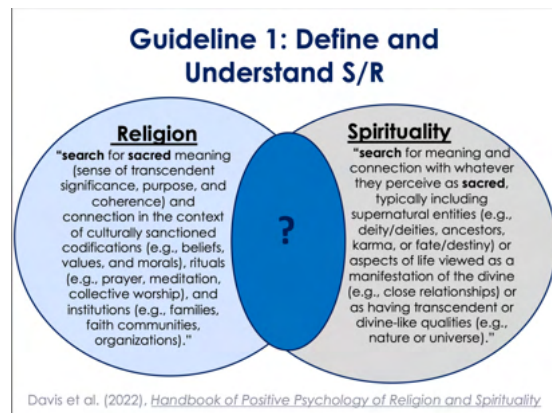


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DEFINITIONS OF RELIGION / SPIRITUALITY (R/S)

- Both **religion (R)** and **spirituality (S)** involve a search for sacred meaning, or sense of transcendent significant, purpose, and coherence - objects of ultimate truth and devotion
- Spirituality is the broader underlying construct, not necessarily associated with measurable behavioral practices, institutional contexts, or communal participation

(Hill and Pargament 2003)



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GENERAL MENTAL HEALTH BENEFITS OF R/S

- At a wide population level, strongly positive relationship between R/S and well-being, health-related behaviors, and mental health outcomes

(Koenig, King, and Carson 2012)



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ANTI-SUICIDE BENEFITS OF RELIGIOUS AFFILIATION & SERVICE ATTENDANCE

- In study of >100,000 US healthcare professionals → **religious service attendance inversely associated with deaths of despair** (suicide, alcohol, drugs) – 68% lower in women, 33% lower in men (Chen et al 2020)
- In Nurses Health Study of 90,000 women, **5-fold lower suicide rate** in those with weekly religious service attendance compared with non-attenders (VanderWeele et al 2016)
- Across broad range of groups +/- psychiatric Sx, religious affiliation and service attendance generally protect against **suicide attempts** [even after controlling for social support] and possibly against **suicide** (Lawrence, Oquendo, and Stanley 2016).
 - Potential mechanisms: access to a supportive community, shaping a person's beliefs, a source of hope, ways to interpret suffering

Health Outcomes of Communal Religiousness

- (+) **Well-being** (Pawlikowski et al. 2019)
- (-) **Problem-gambling** (Multi-Packer et al., 2017)
- (-) **Smoking** (Pawlikowski et al. 2019; Zhang et al., 2021)
- (-) **Drinking** (Pawlikowski et al. 2019; Sartor et al., 2020)
- (-) **Other-directed aggression** (Ghossoub et al., 2022)
- (-) **Depression** (Chen et al., 2020; VanderWeele, 2021)
- (-) **Anxiety** (Chen et al., 2020)
- (-) **Suicide** (Chen et al., 2020; VanerWeele et al., 2016)
- (-) **All-cause mortality** (Chen et al., 2020)

"It may be the confluence of the religious values and practices, reinforced by social ties and norms, that give religious communities their powerful effects on so many aspects of human flourishing"

VanderWeele (2017)

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BENEFITS OF R/S FOR CORE PD PROBLEMS (BUT NOT STUDIED IN SPECIFIC PD CONTEXT)

- R/S can reduce **impulsivity**
 - Religious beliefs and doctrines can serve as a suite of self-regulatory filters or buffers used to slow down and assess whether behavioral urges are in line with higher-order values (McCullough & Willoughby 2006)
- R/S generally promotes **meaning** and **purpose** in socially disconnected individuals:
 - Meaning in Life – Association between social disconnection and lack of meaning in life is decreased with intrinsic religiosity (Reynolds et al 2020)
 - Purpose in Life – Associated with religiosity in socially disconnected individuals (Chan et al 2019)
 - Loneliness – Addressing loneliness through a supportive relationship with Sacred Other (Gallegos & Segrin 2019)
- BUT: While R/S generally beneficial for those with clinical disorders, **interactions with specific mental disorders are less clear** (Lake 2012)
- **Little research on R/S in personality disorders**

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COMMON “SPIRITUAL STRUGGLES” OVERLAP WITH CORE CONCERNS IN PD

- Experiences of tension, strain, conflict about “sacred” matters
(Exline 2014; Pargament & Exline 2022)
 - **Divine Struggle** – Feel as though God [Higher Power] has let me down; Feel angry at God/HP; Feel as though God/HP has abandoned me; Feel as though God/HP is punishing me; Question God’s/HP’s love for me
 - **Moral Struggle** – Feel torn between what I want and what I know is morally right; Feel guilt for not living up to my moral standards
 - **Ultimate Meaning Struggle** – Questioned whether life really matters; Feel as though my life has no deeper meaning; Question whether my life will really make a difference in the world; Have concerns about whether there is ultimate purpose to life
 - **Doubt Struggle** – Struggle to figure out what I really believe
 - **Interpersonal Struggle** – Feel hurt, mistreated, rejected, misunderstood by people who rely on S/R coping; Feel angry at organized religion

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ATTEMPTS TO PROMOTE FLOURISHING IN BPD MAY NATURALLY TURN TOWARD R/S

- 1-year modified MBT group therapy aimed beyond achieving BPD Sx reduction to promoting flourishing (Zanarini & Unruh, unpublished)
- Mentalizing conversations focused on cultivating 3 character virtues naturally turned, for many, toward questions of transcendent meaning and R/S:
 - **Gratitude** – To what, or whom, am I grateful in an ultimate sense?
 - **Humility** – Which broader realities transcend Self? By what greater reality am I most ultimately humbled?
 - **Forgiveness** – By what power can I truly be forgiven, and forgive?
 - Naturally look outside oneself along a “vertical” dimension for anchor points
 - Is it possible to fully develop these qualities as human beings without a spiritual orienting system, or a “leap of faith”?

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REASONS TO ENGAGE R/S IN TREATING BPD - I

- “Work and love,” “Work before love” ☒ Meaning for all BPD pts
 - **Getting a vocational role and relationships may not inherently build toward flourishing and higher meaning**
 - **Some do not achieve academic/vocational goals (~47% on SSDI across 24-yr MSAD f/u) or a close dyadic relationship, but still seek meaning**
- Engagement with spiritual/religious beliefs and communities offers a potentially powerful channel of non-psychiatric, long-term social support and meaning-making



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REASONS TO ENGAGE R/S IN TREATING BPD - II

- Theodicies, scriptural interpretation, theological ideas offer alternative “adversity paradigms”
- Perspectives on meaning-making and coping with chronic suffering mitigate narrative that BPD must be completely overcome through treatment or cure (“a cross to be carried” in community)
- Ability to reframe situations through more benevolent system of meaning (Pargament, Mahoney, and Shafranske 2013)



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WHAT ABOUT BEING “SPIRITUAL BUT NON-RELIGIOUS”?

- Faith in God, independent of religious affiliation or service attendance, is associated with substantially lower suicidality in patients with chronic mood disorders (Rosmarin et al 2022) and with greater improvements in depression, self-harm, and overall well-being in mood disorder patients receiving CBT/DBT at psychiatric day hospital (Rosmarin et al 2013)
 - Effects may be mediated by belief in the credibility of treatment and expectations for treatment gains → Faith in God may facilitate believing that things can improve, even at a low point in life
- Patients do not have to be religious to psychologically benefit from participating in benevolent, values-driven communities (religious or not)
 - Positive mental health benefits still associated with attending non-religious community services (VanderWeele 2022)

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WHAT IS KNOWN EMPIRICALLY ABOUT R/S IN BPD?



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R/S & BPD: EMPIRICAL RELATIONSHIPS BETWEEN BPD & S/R

- Among psychiatric inpatients, **higher severity BPD** correlates with **atheism** (Snyder et al 1985)
- Outpatients treated at an internal medicine clinic with **more severe BPD** [on PDQ-4 & SHI] exhibited **less overall S/R wellbeing** (Sansone et al 2012)
- In BPD+AUD patients, **religious service attendance and higher subjective religiousness** associated with **less addictive behaviors** (Khan et al 2019)
- Iranian Shia Muslim medical students showed **inverse correlation between # of BPD features** [SCID-II] and **religiosity and religious attendance (F>M)**, and **lower religiosity especially associated with anger, mood instability, self-harm** (Hafizi et al 2014)

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R/S & BPD: EMPIRICAL PHENOMENOLOGY & CASE STUDIES

- College students with BPD [on PAI] are **low in religious engagement** [external behavioral markers], but **high in spiritual quest** [internal openness to R/S] (Hosack 2019)
- Case study of 3 women with BPD exploring core object-relations patterns in relation to the figure of God (Gravitt 2011)
 - Turning to an idealized spiritual Other may create **complex, distressing experiences of negative religious coping** and represent a double-bind (“God’s ruthless embrace”)
- In a psychoanalytically-oriented, exploratory spirituality group for nine female borderline patients, patients’ **“images of God” greatly influenced how they thought about themselves** (Goodman & Manierre 2008)
 - An exploratory spiritually informed approach might help patients reevaluate images of self through reexamining their images of God and associated positive and negative past S/R experiences
 - But **only some were able to work imaginatively in the S/R domain** to reevaluate negative appraisals of self at all

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R/S & BPD: EMPIRICAL STUDIES ON LONG-TERM BPD COURSE

- S/R engagement are valued by some patients as a pathway to health over time
- 24-year prospective study of long-term pathways to health showed **significant increase over time in % of patients reporting consistent spiritual or religious participation was helpful** to their functioning and self-concept (Zanarini et al 2023)
- Majority of self-identified **“recovered” patients cited a long-term process of “cultivating wisdom through meaning and perspective”** helped them progress beyond symptom remission to flourishing and a life worth living (Liljedahl et al 2023)
 - What role, if any, do spiritual or religious meaning-making processes play?

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R/S & BPD: CONCLUSIONS FOR PRACTICE

- BPD pts are generally open to spiritual and religious “questing,” and R/S frameworks may be perceived as “speaking to” core longings, BUT...
- Spirituality and religiosity are not a panacea for BPD
- S/R have complex positive and negative impacts depending on poorly understood (understudied) variables
- “God representations” or “Images of God” are complex in BPD and may be highly distressing
- But for some, S/R interact positively with recovery process and become essential ingredients in a life worth living
- Hypothesis: The S/R domain may be important to address in treatment for a subset of patients for whom a spiritual orienting system is already deemed important at the outset, those for whom a current “spiritual struggle” is negatively impacting BPD symptoms, and those who over time may harness S/R engagement as a pathway to recovery and flourishing.

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POTENTIAL BENEFITS OF RELIGIOUS COMMUNITIES FOR BPD

- Reduction of suicidal behavior and possible protection against completed suicide
- Aloneness – Connectedness and being valued by others
- Community cultivation of psychological virtues associated w/ flourishing (forgiveness, gratitude, humility)
- Relationships embedded within wider community more manageable than intimate dyadic relationship
- Accelerated shaping toward adaptive interpersonal behaviors (benevolent communities less inclined to withdraw)
- Purpose/meaning through inhabiting a valued role within a non-professional, less performative community
- Recontextualizing and coping with chronic symptoms & suffering within a wider narrative frame of spiritual struggle and growth

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POTENTIAL HARMS OF RELIGIOUS COMMUNITIES FOR BPD

- Reinforcement of maladaptive BPD behaviors:
 - Self-harm eliciting harmful communal/interpersonal response
 - Prolongation of problematic dependency
- Trauma and abuse (sexual, psychological, spiritual) occur within communities
- Adhering to a minority religious affiliation might intensify isolation
 - Religious beliefs/practices less protective against suicide in societies opposing specific religions or religion-in-general
- If religion leaves a person feeling guilty, distant from God, or abandoned by the religious community, that can increase suicide risk (Lawrence, Oquendo, and Stanley 2016)
- Religious or spiritual practices may be especially difficult to adopt (at least at first) for especially hopeless, depressed, and suicidal individuals

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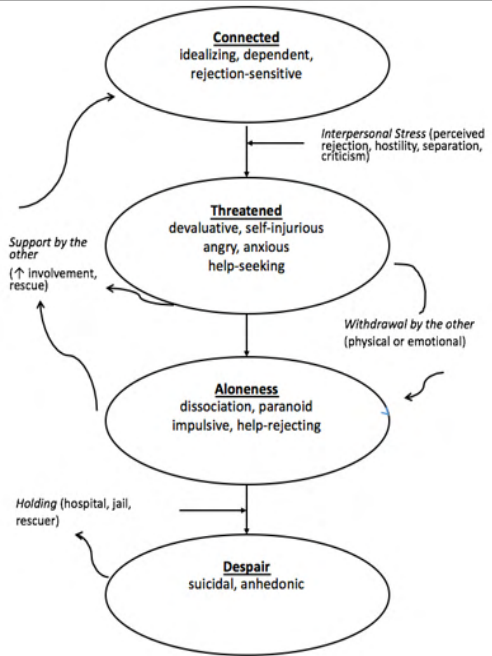
WHAT CAN CLINICIANS
DO WITH ALL OF THIS?



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GPM'S INTERPERSONAL COHERENCE... EXTENDED

- Conceptually derived from Gunderson & Lyons-Ruth's developmental model of BPD genetic & phenomenological core as interpersonal hypersensitivity
 - Symptoms oscillate with shifts in levels of IP connectedness
- Useful frame for working with core BPD pathology, but also with a normative human spiritual/existential yearning? (C.S.Lewis 1955)
 - Longing to be aligned with an unconditionally loving other or transcendently orienting system of ideals grounded outside the self ("**spiritual orienting system**")



Gunderson & Lyons-Ruth 2008
Gunderson & Links 2014

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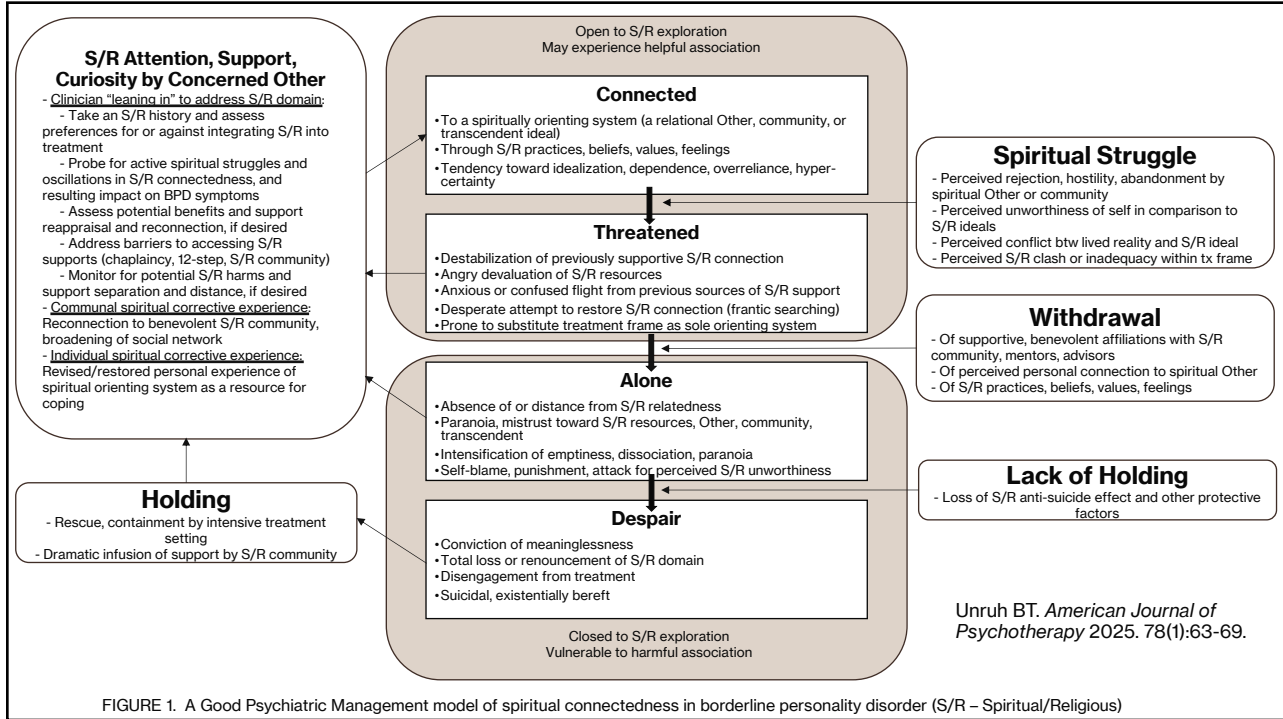


FIGURE 1. A Good Psychiatric Management model of spiritual connectedness in borderline personality disorder (S/R – Spiritual/Religious)

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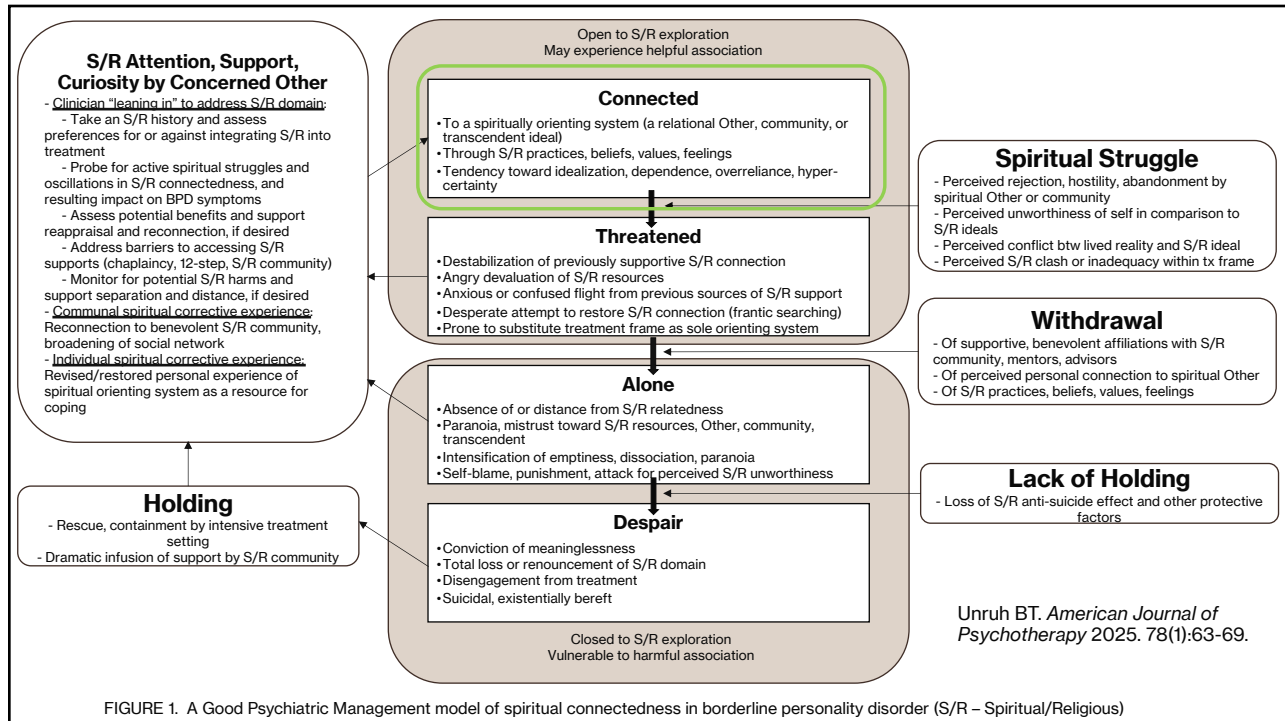


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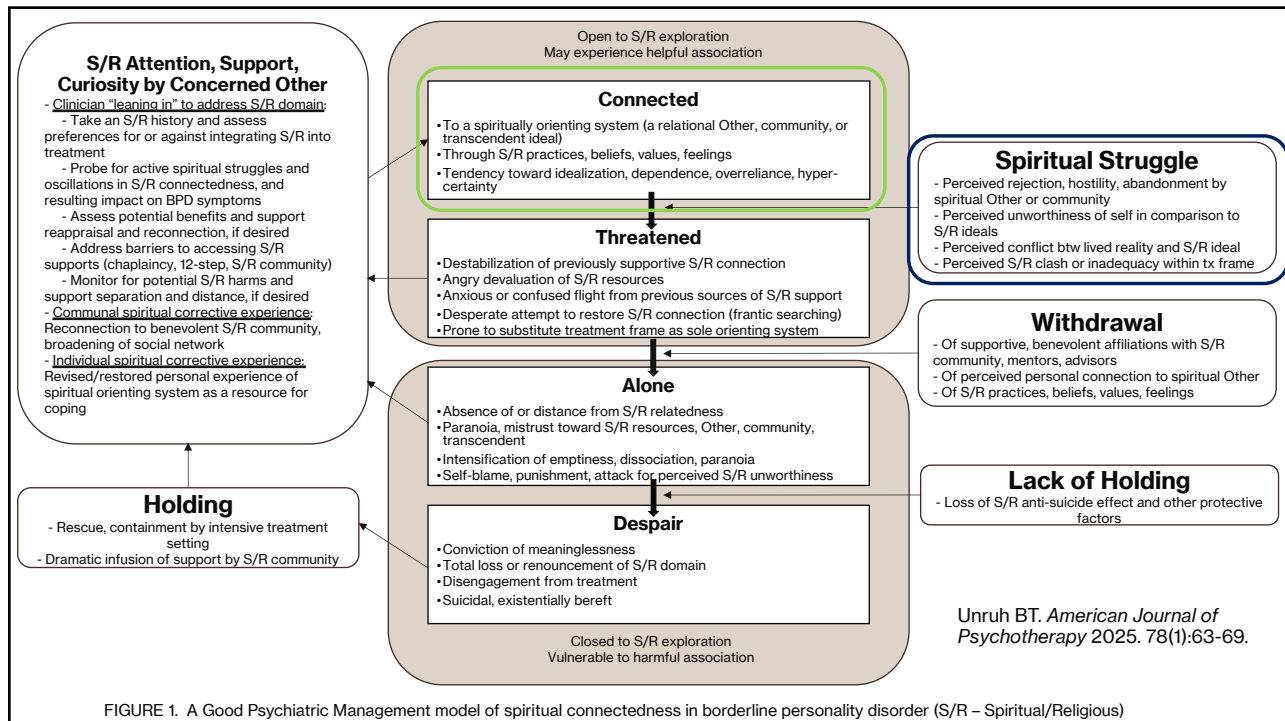


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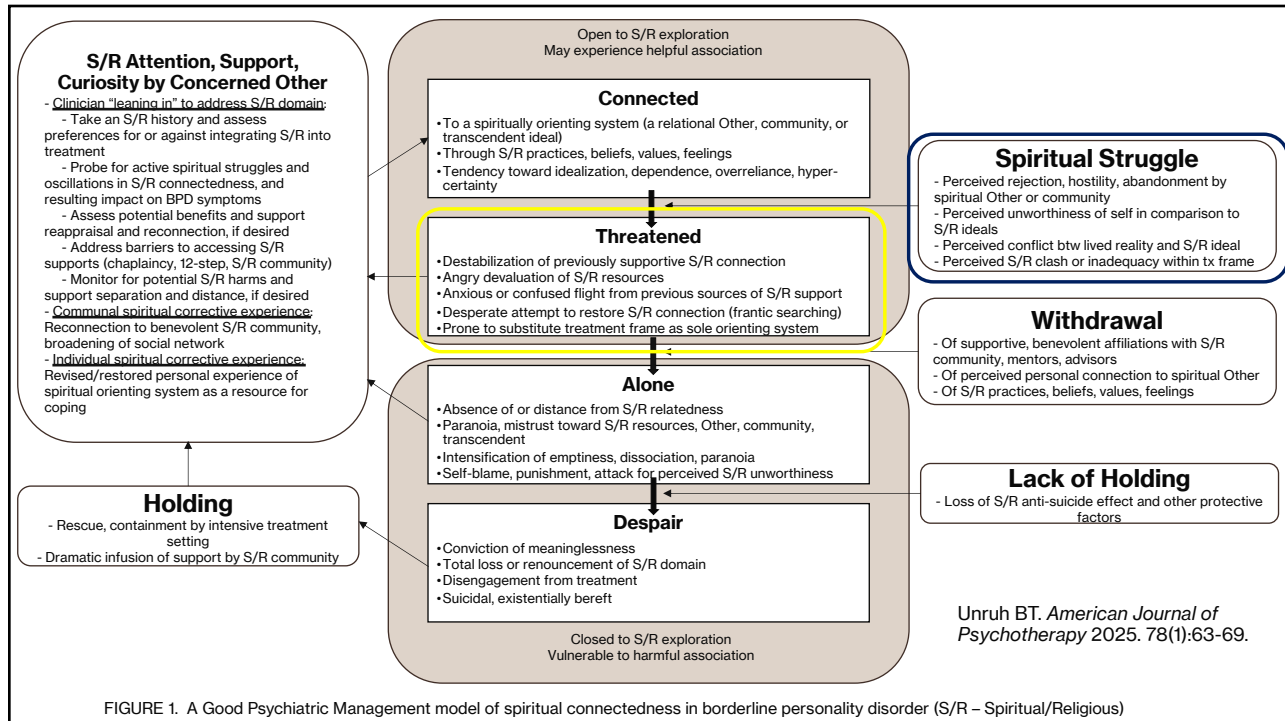


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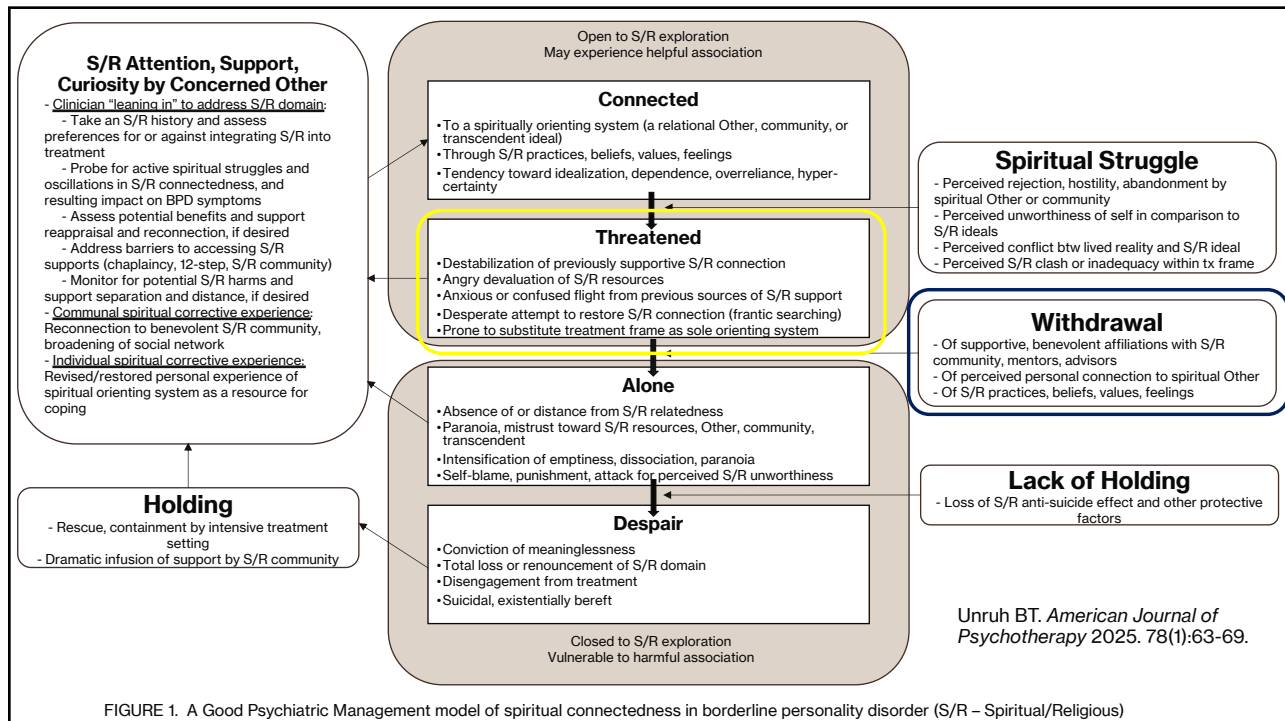


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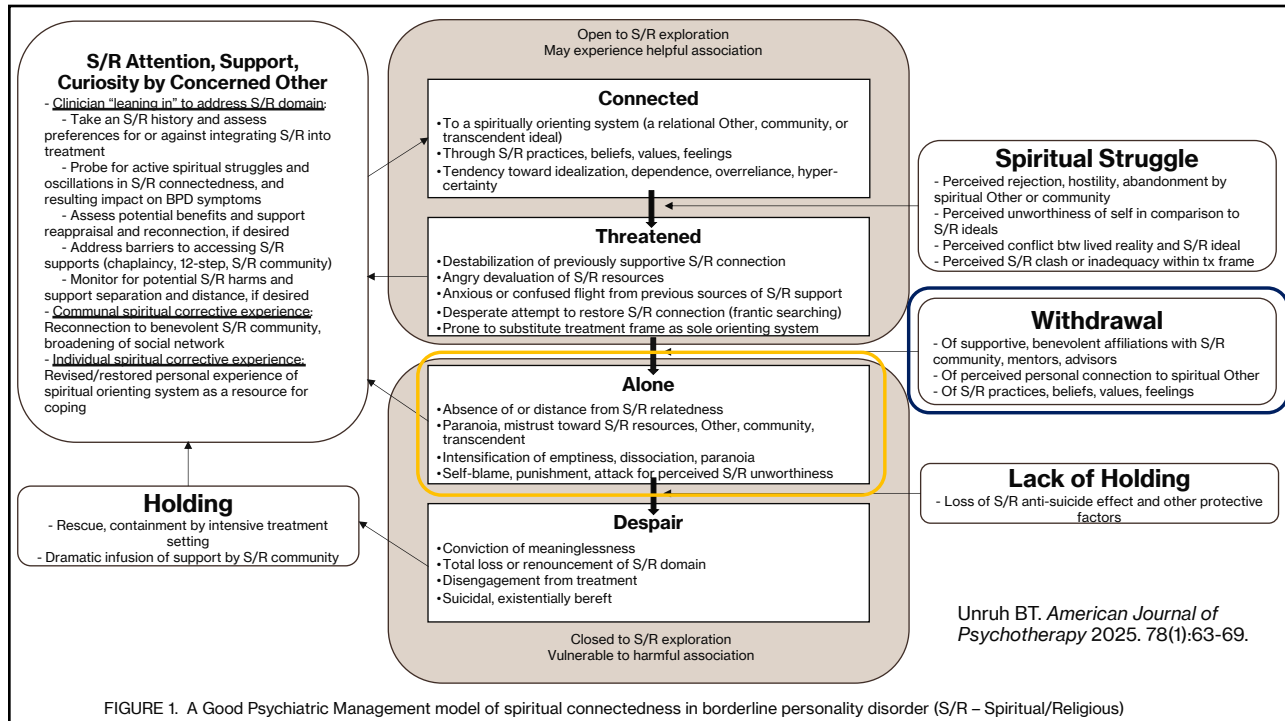


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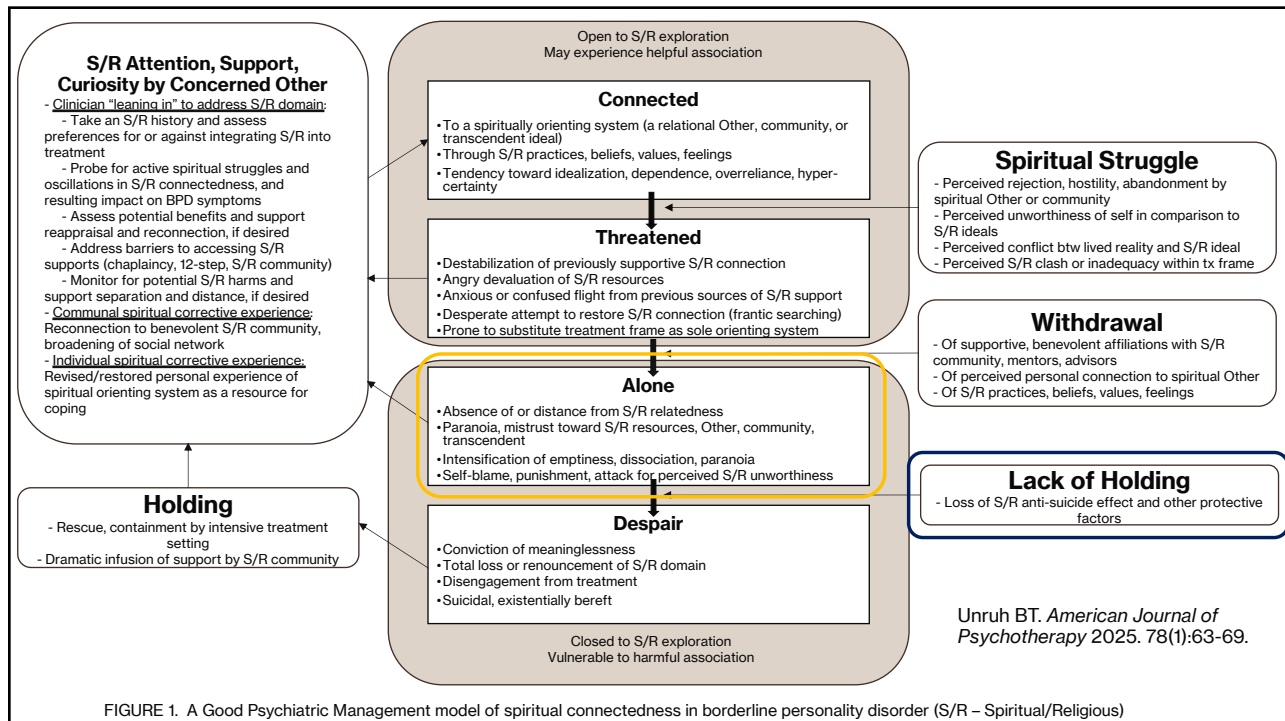


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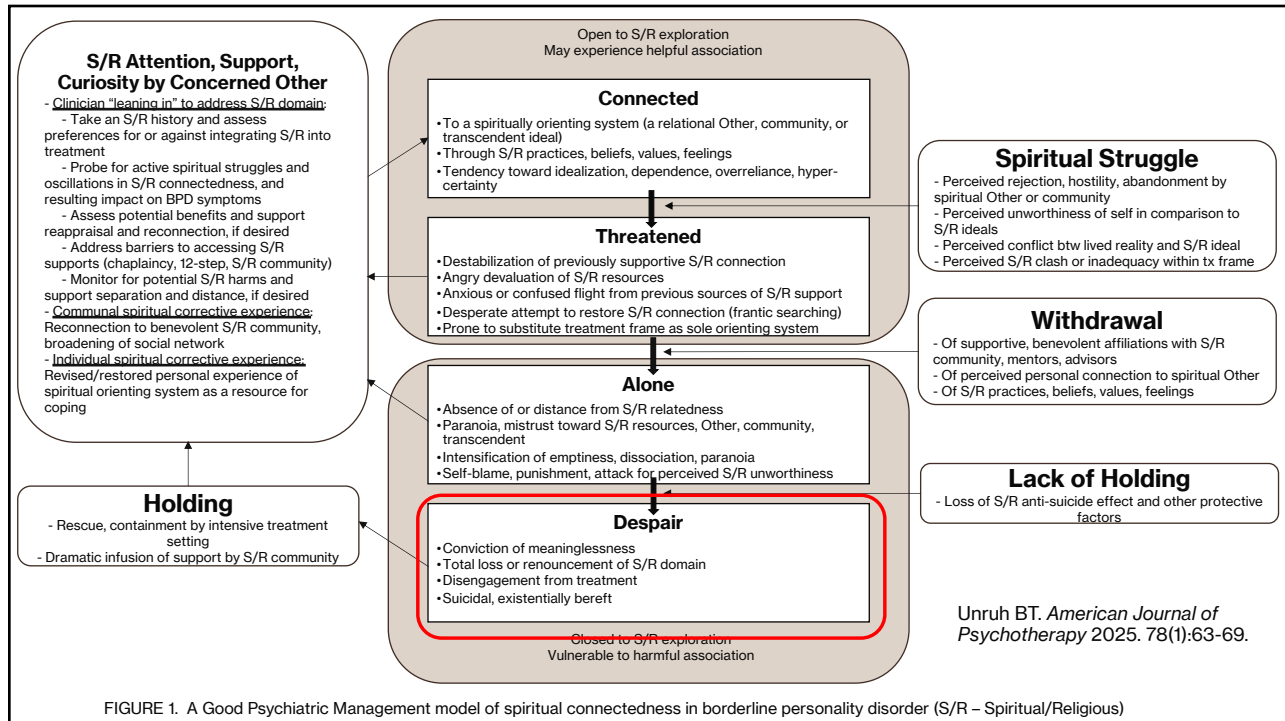


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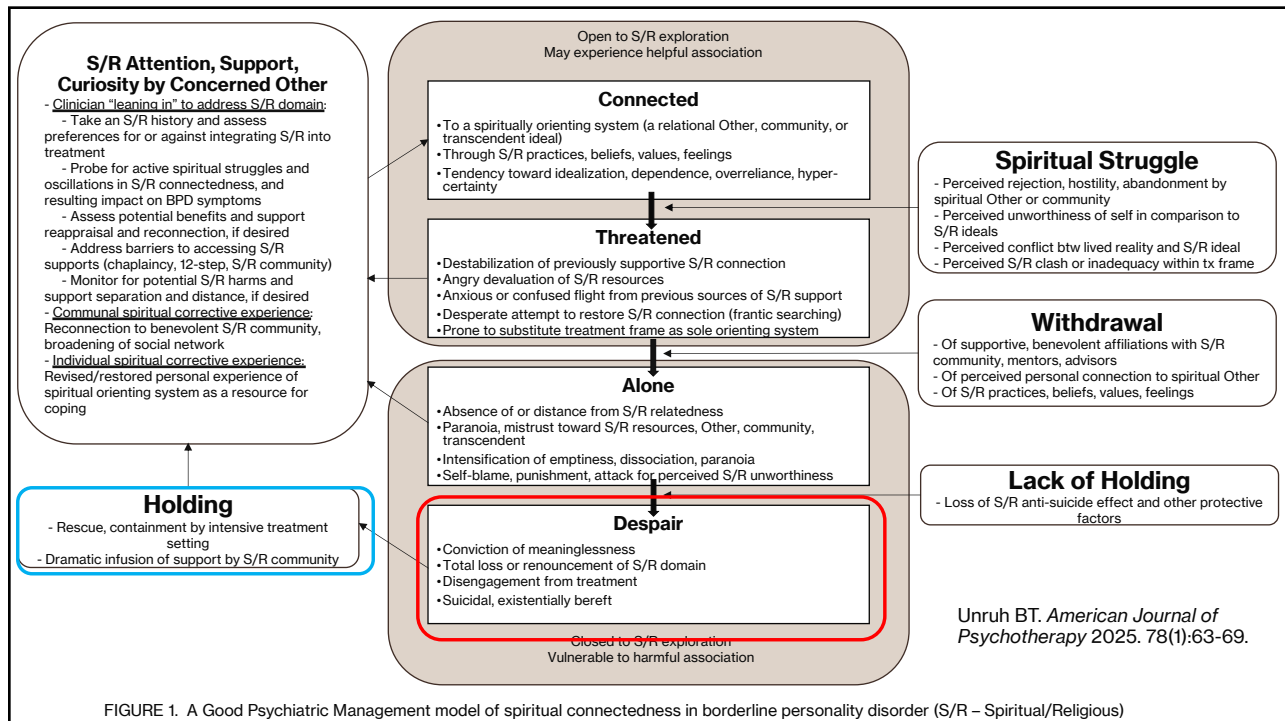


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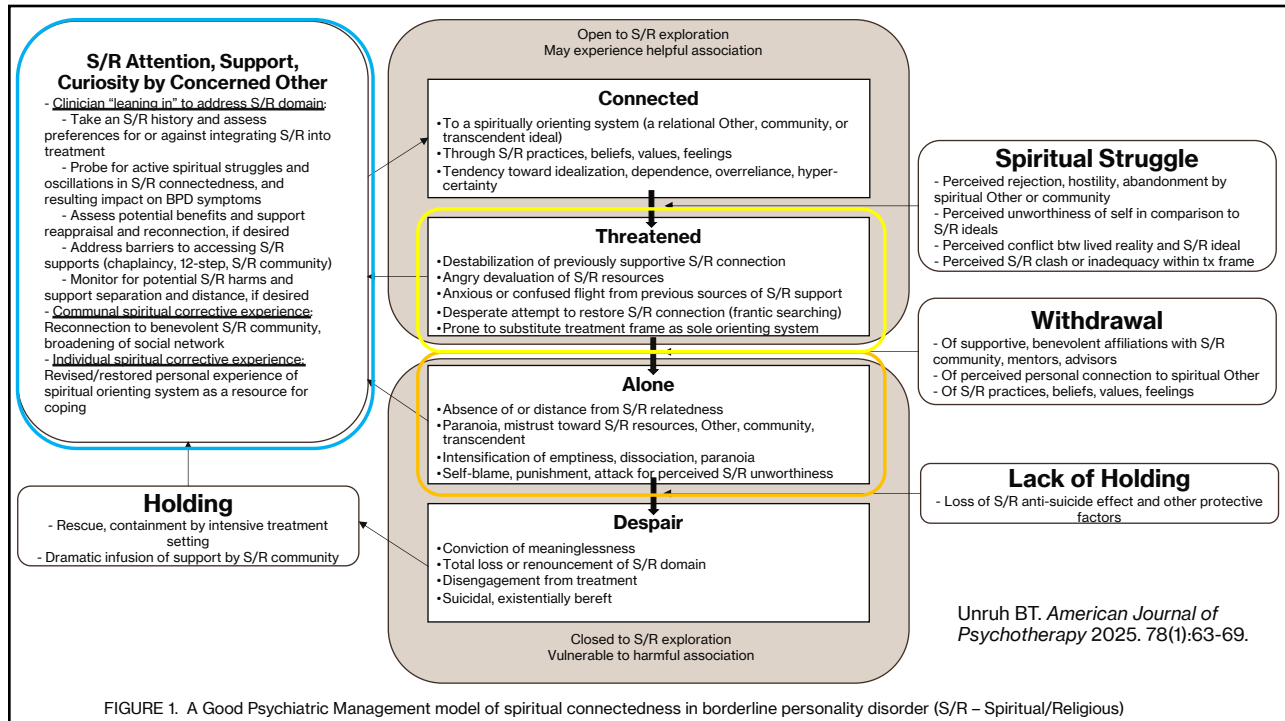


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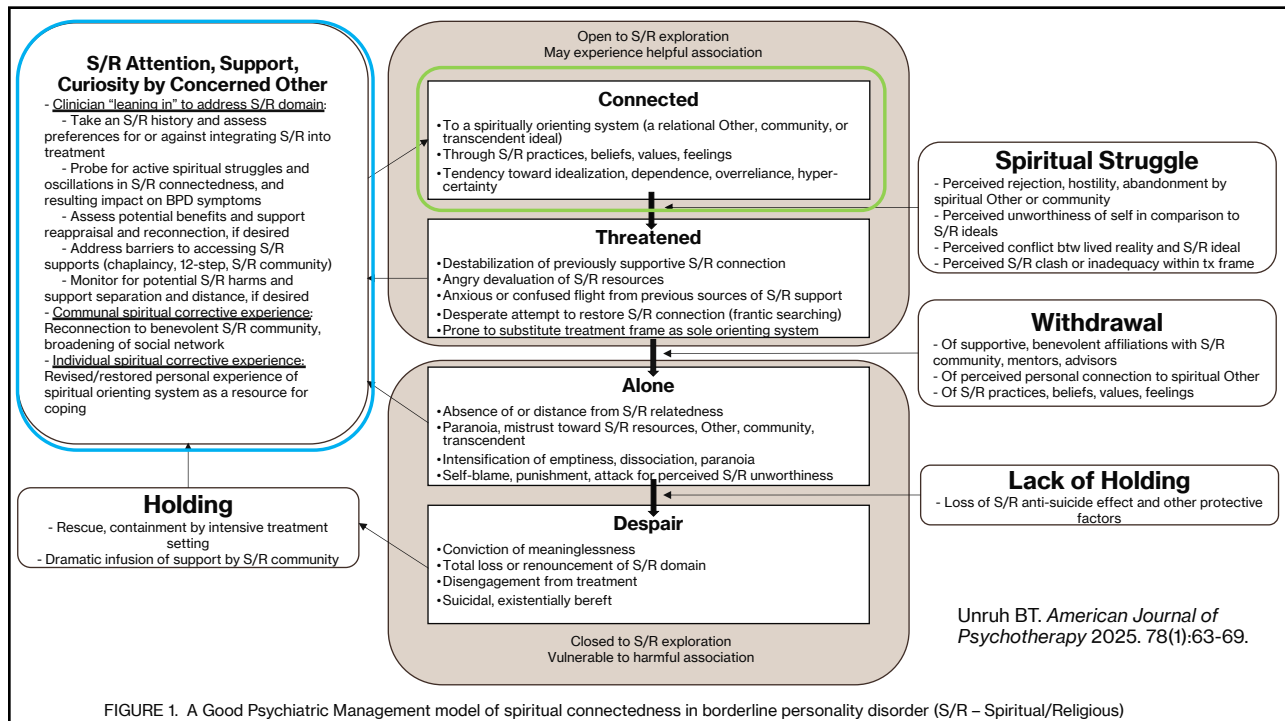


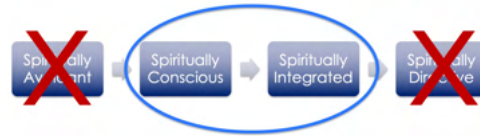
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RECOMMENDATIONS: OVERALL CLINICAL STANCE

- Overall approach to patient's spiritual experiences:
 - Not spiritually **avoidant** or **directive**
 - Spiritually **conscious** and **informed**
 - Of the importance of spiritual experiences, practices, beliefs, and communities (spiritual orienting systems) for the patient, their influence on the presenting problems, and their potential to help or hinder recovery
 - Perhaps also spiritually **integrative**
 - Harness the patient's relationship to spiritual orienting system(s) to improve distress, symptoms, and functioning

Continuum of Spiritually Competent Mental Health Care



Saunders, Miller, & Bright (2010)

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RECOMMENDATIONS: INITIAL ASSESSMENT & INTERVENTIONS

For all patients:

- **Take a basic spiritual history** to assess historical, current, and potential benefits and harms of R/S experiences:
 - 1) Do you view yourself as a religious or spiritual person?
 - 2) Are you connected with a religious or spiritual community?
 - 3) Has your religious faith or spirituality contributed to your problems?
 - 4) Has your religious faith or spirituality been a source of strength in your life?
 - 5) Would you like to explore ways of including your faith or spirituality in your treatment?

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RECOMMENDATIONS: INITIAL ASSESSMENT & INTERVENTIONS

- Explore the relational context of any changes in beliefs or practice over time
- Get specific
 - "... consider not only **how much** religion is involved in coping, but also **how** religion is involved in coping; specifically, the **who** (e.g., clergy, congregation members, God), the **what** (e.g., prayer, Bible reading, ritual), the **when** (e.g., acute stressors, chronic stressors), the **where** (e.g., congregation, privately), and the **why** (e.g., to find meaning, to gain control) of coping." (Pargament et al 2014)
- Assess for dynamic interplay between suicide risk and specific religious characteristics (e.g. feeling loved or by God; rejected or accepted by religious authority/community)
 - "In the moment when you were acutely suicidal, what was your experience of God?"
- Ask if patient wants R/S beliefs and practices to be included or excluded from Tx
- Predict how clinician's own R/S commitments may interact with therapeutic process

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RECOMMENDATIONS: INITIAL ASSESSMENT & INTERVENTIONS

For patients uninterested in incorporating R/S into treatment:

- Attend not just to consciously/verbally articulated worldview (sense of self, others, value, meaning, purpose) but conscious/unconscious relationships to the *concept* of God (actual or potential; existing or non-existing; broadly and inclusively defined to include concepts of Higher Power or transcendent truth)
 - Rizzuto's "Image of God"
 - Van der Velde (2026, personal communication)
- Identify and incorporate current "spiritual struggles" into discussion of treatment goals, treatment plan, and therapeutic stance

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RECOMMENDATIONS: INITIAL ASSESSMENT & INTERVENTIONS

For patients interested in incorporating R/S into treatment:

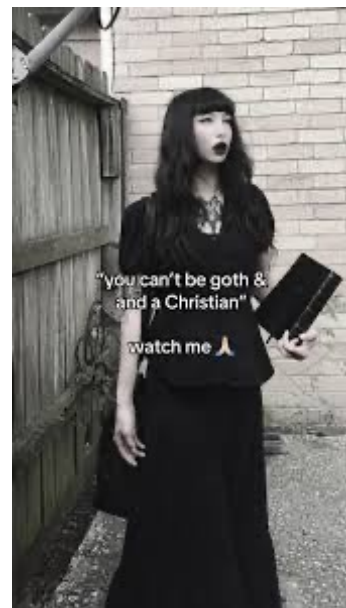
- Help the patient identify and consider reapproaching R/S resources within their tradition which may previously have been minimized, distorted, or limiting on account of PD Sx
 - Identify R/S beliefs, texts, stories, practices which have been or may be helpful for managing specific Sx or wider meaning-making
 - Consider potential benefits of retrying communal R/S participation

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CASE EXAMPLE 1: “GOTH/PUNK CATHOLIC CHRISTIAN”

- 30 year-old F with BPD/NPD, PTSD, opera singer/student until a violent sexual assault devastated her aspirational self → anorexia, many ER visits for extensive self-harm, hospitalizations/residentials, many treatments
- R/S background: Raised Catholic, ritualistic/stoic Mass attendance for many years, then after trauma dropped church but maintained personal belief in (cold, distant) God
- Therapeutic modalities: Multiple EBTs for BPD, Bohus' DBT-PTSD, CPT for PTSD
- Therapeutic stance toward R/S: Take spiritual history, establish and collaborate around her wish to integrate preexisting Catholic Christian R/S beliefs, practices, community into therapeutic dialogue to work on symptoms, functioning, meaning-making



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CASE EXAMPLE (CONT.)

- Therapeutic R/S self-disclosure: *indirect*, through comments and questions demonstrating my familiarity with Christian Scriptures and tradition
- GPM-informed approach to addressing past spiritual experiences and current spiritual orientation prompted new perspective-taking, meaning-making, and self-regulation through reconsideration of Christian stories, themes, practices, community:
 - God created a good world, but human freedom (The Fall) led to evil (trauma)
 - God's heart is with those who suffer and God has plans to use them (Elijah, Job)
 - Christ as empathic mirror, near to her suffering, co-regulator of her emotions
 - Hopelessness – in the garden of Gethsemane (“My soul is very sorrowful, even to death”)
 - Aloneness – the Son's separation from the Father on the cross (“Why have you forsaken me?”)
 - Rage/anger – driving out money changers in the temple (“fashioned a whip”)
 - Christ as transformer/redeemer of her suffering
 - Scarred and risen Christ appearing to Thomas (“Take your hand, put it in my side”)

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CASE EXAMPLE (CONT.)

- Actively explored risks/benefits of reengagement with religious community
 - Corrective experience through forming secure attachment to priest
 - Volunteering within religious community
 - Came to see herself as the sort of person who could reapproach risks and surmount fears
 - Transformative re-attachment to a close and loving Image of God (as stable, worthy object of transcendent desire for connectedness)
 - “I attended a Holy Day service at my Church this week and it felt so wonderful to be back in God's arms, to receive Communion, to speak to my Father again and ask him to help me through this month. I thought about His undying love for me, to the point of death. I intend to keep going to see Him.”

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CASE EXAMPLE 2: “NO SPIRITUALITY, NO RELIGION (BUT MAYBE...)”

- 23 year-old F survivor of incest
- Spiritual history-taking → “complete and lifelong” certainty that “there is no spiritual world, there is no God.”
- “How could a good God allow what happened to me?” Acute experiences of perceived abandonment by God in context of overwhelming trauma served as clear evidence of God’s badness or nonexistence
- “No spirituality, definitely no religion”; no conscious identification with any spiritual orienting system or wish to incorporate into treatment.
- However, *nascent* spiritual orienting systems were present:
 - A powerful sense of connection to animals, nature, and children
 - A wish to become more anchored within herself and (eventually) helpful to others in a deep (transcendent, spiritual) way.



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CASE EXAMPLE (CONT.)

- Intensive focus around symptom reduction (self-harm, dissociation, PTSD Sx, risky sex) and remaining outside of the hospital, followed by intensive focus on returning to educational and professional trajectories
 - But the pattern of frequent hospitalization and self-harm continued through finishing college.
- Began attending graduate school in one of the helping professions. In the course of learning practical skills and building confidence that she could do good things for others in need, began to perceive a “helping spirit” within herself and “around” her while inhabiting her new role. Clinician actively explored and encouraged this development as a potential spiritual orienting system that could bring meaning and transcendence “without spirituality or religion.”
- Became more connected to an “ethic of helping” and to the notion that she had a transcendental purpose to be a “helping spirit” for others.
- Despite ongoing fluctuations in the level of connectedness she would feel to this transcendent personal vision of who she “was made to be” at any one time, this became an abiding spiritual orienting system associated with a significant reduction in chronic hopelessness and emptiness.

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Artwork by Liane Collot d'Herbois



(NOT) THE END...

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“WILD GEESE” BY MARY OLIVER

YouTube https://www.youtube.com/shorts/9TOLAMei_w4

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BACKGROUND

- There is a growing literature of qualitative studies dedicated to understanding recovery from BPD from the perspective of individuals with lived experience
 - For ex: Ng et al., (2019); Grenyer et al., (2022); Larivière et al., (2015)
- However, understanding how people with lived experience define Life Experienced as worth living (LWL) and its place in the pathway to becoming well, including *flourishing* is still emerging (Liljedahl et al., 2023).
- We also do not know how some individuals with lived experience manage to attain stable and enduring periods of wellness and flourishing without falling back into symptoms during times of difficulty.
- Nor do we understand whether and how meaning-making, transcendence, and spirituality may fit into the process of becoming well

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AIMS

- This presentation is dedicated to understanding and communicating:
 1. **Transcendent experiences** that were described by individuals with lived experience of both BPD and recovery from BPD.
 2. Whether and how these experiences are related to LWL, recovery, wellness and flourishing.
 3. How these experiences might move people forward in relation to goal-setting, identity affirmation and recovery in GPM

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COLLABORATION STUDY

- A three-site collaboration study was conducted in Gothenburg, Sweden with the overall aim of defining LWL, recovery and flourishing by those with lived experience.
 - To ensure representation across the illness-to-wellness spectrum, we recruited participants from three different settings.
 - Site 1. A cohort recruited from a national self-harm inpatient unit (commencing intensive DBT)
 - Site 2. A cohort commencing outpatient (Standard DBT)
 - Site 3. Self-Harm and Eating Disorder Organization (SHEDO) - Recovered cohort

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RECRUITMENT

S1: INPATIENT SUBSAMPLE, S2: OUTPATIENT SUBSAMPLE, S3: RECOVERED SUBSAMPLE



For S1 participants: The study was introduced at the first meeting with prospective participants once eligibility for admission was established ($n = 8$).



For S2 participants: Individuals committed to beginning outpatient DBT were invited to participate at the first commitment session ($n = 9$).



For S3 recovered participants: Those who identified as recovered, having been treated for BPD with DBT were invited to participate through information about our study being shared via SHEDO ($n = 9$).

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INCLUSION CRITERIA FOR PARTICIPANTS COMMENCING DBT (S1 & S2)

Severe and repetitive self-harming and life-threatening behaviour alongside:

i. Three or more diagnostic criteria of Borderline Personality Disorder: BPD

ii. Co-occurring PTSD may be present, but not necessary for inclusion

iii. Age between 18-65.

iv. Ability to give consent.

v. Ability to read and write in Swedish.

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INCLUSION CRITERIA FOR RECOVERED INDIVIDUALS (S3)

- History of severe and repetitive self-harming and life-threatening behaviour
- **Historic diagnosis** of BPD or BPD+PTSD
- Treatment with DBT
- **Self-identified as recovered for a minimum of two years**
- Age between 18-65
- Ability to give consent
- Ability to speak Swedish or English.

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DEMOGRAPHIC CHARACTERISTICS: S1, S2, S3

S1 & S2: Participants identified as women who ranged in age from 21-46*

- Median age 29 years old
- 14 identified as women, 1 as transgender 1 as genderqueer
- There was some diversity in sexual orientation:
 - 9 identified as heterosexual; 1 as lesbian
 - 3 as pansexual,
 - 3 as bisexual

*The first few minutes of one participants' audio recording was damaged and so some demographic characteristics are missing for n=1 (estimates calculated on n=8)

S3: Participants identified as women who ranged in age from 21-41

- Median age 32 years old
- All identified as women, 6 as bisexual, 2 as gay, 1 as heterosexual

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METHODS: MEASURES



A background questionnaire was created to understand demographic characteristics, treatment and diagnostic history, and prescribed medication.



Qualitative interviews followed a semi-structured and open-ended interview protocol designed for this study

Interview evaluated by SHEDO (lived experience organization) and piloted with peer support team members

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THEMATIC ANALYSIS (TA) CONDUCTED BY SEPARATE CODERS



Data were analysed by two coders, whereby the entire datasets were coded and analysed twice

Nvivo 14 software was used to for analyses
Concordance between coders was strong



Analysis and interpretation of the data was conducted at the semantic level.

We followed what participants said exactly rather than interpreting their interviews during the analysis of interview data

TA (Braun and Clarke, 2022) was conducted separately by two independent coders

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PRELIMINARY FINDINGS

- One main and three sub-themes related to:
- *Transcendence as a gateway, path or spark* to feeling life was worth living, feeling well and flourishing



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TRANSCENDENT MAIN THEME (S1, S2, S3)

Main Theme:

Experiences of LWL, wellness and flourishing are cultivated through freedom, presence in nature, and being connected to loved ones

- Subtheme 1: Noticing small details of nature revealing itself
- Subtheme 2: The body as a vehicle for freedom through movement
- Subtheme 3: Joy and safety in loving relationships

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Subtheme 1: Noticing small details of nature revealing itself



- *“... When we were out on one of those staff-assisted walks and we were walking there, and it started to snow, that was the day it snowed. And so I was walking there, and when I... the sun was shining and it was snowing at the same time, and it was like that... it was snowing in my face.*
- *And, it kind of, I didn't stop because I didn't want to disturb the others, but, but I kind of let it do that. It's hard to describe what it was like - how it felt - but it was like I was ... living in it. To... to have this sense that the snow is cold and it's wet and it's falling on my face.*
- *It was as if, for a few minutes, I wasn't there, didn't have what I normally have, all the things I normally carry. But it was like... it was as if these blocks and all that were gone. Just like very briefly, but it was like... I felt free. For those three minutes or whatever it was, I felt free. It hasn't happened that many times otherwise. If I hadn't had this, I would have found it very difficult to think of anything. But... I was like... happy for the rest of the day, so... it was so special.” (S1: P9)*

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**SUBTHEME 2:
THE BODY AS A
VEHICLE FOR
MOVEMENT**



"When I learned to ride a bike.

Then I was all like, shit what a freedom.

I loved cycling even back then. It was very - I remember when I - when, when I rode a bike for the first time, and I fell like this several times but then I could do it!

I was so damn happy and this bike, it was so good. I loved that bike... I felt alive... butterflies in the stomach, and a little like this warm and cuddly in the stomach.

And tension in my face because I smiled so much.

I smiled so much." (S1, p. 7).

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**SUBTHEME 3:
JOY AND SAFETY IN
LOVING RELATIONSHIPS**



"... [I] dare to be with my loved ones fully... to have the ability to thus maintain good and close relationships. That, it gives me such, like, a rush of happiness, when I am with people and feel that, that I can be in this nice and glorious [place in my life] and I am not afraid that it will end, and I will experience it again..." (S3 P5).

"...and I think that my life is beautiful or that life is beautiful, so. That is, that I stop in nature or that when I pet an animal.... Or when I am with my child and such and we have as an expression - my child can say like this:

"Now you have tears like this again of joy".

"And it has been my life, that I can really think that, that, that it is fantastically nice and beautiful, what I get to be a part of...." (S3 P3)

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CONCLUSIONS

- Main themes and subthemes related to experiences of expansion, transcendence and awe were described when:
 - Noticing something new and astonishing/breath-taking;
 - Something perfect in its newness like a kitten or the snow.
 - Noticing and re-encountering the newness and perfection of small children and animals were also described in relation to caregiving and nurturing relationships
- Experiencing the body as a vehicle for freedom was described as transcendent,
 - Through activities like horseback-riding, running, biking, and riding a motorcycle.
- Although these experiences were sometimes fleeting or momentary, they were highly valued.

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IMPLICATIONS AND EXTENSIONS

- Most participants defined a life worth living as one filled with meaningful engagement and fun
 - *Participants described how moments of awe and expansion made LWL, recovery and flourishing feel closer*
- Some participants who declined having ever felt life was worth living nevertheless expressed transcendent experiences when exploring the concept over the course of the interview
 - Possible that they had not focused on or explored these moments and their value
 - This suggests exploring transcendence, awe and experiential freedom might be clinically useful and personally valuable at the commencement and throughout therapy.
 - Understanding one's ability to access transcendent experiences may support an entry to more positive identity and of life itself as well as others from a new point of view.

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EXTENDING THIS WORK IN A GPM MATCHED REGISTER CONTROL STUDY

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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



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ONGOING GPM STUDY (2025-2027)
QUALITATIVE DATA COLLECTED ON TRANSCENDENT EXPERIENCES AND THEIR PLACE IN RECOVERY



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

On a spectrum from symptom remission to flourishing

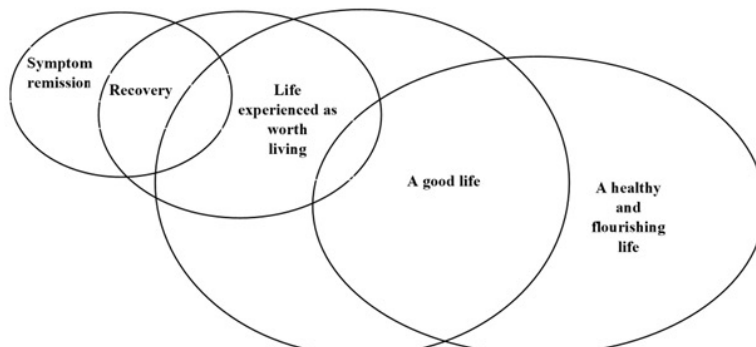


Constructs queried by qualitative interview have to do with functional recovery such as engagement with the workforce, relationships and sense of self



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

SESSION 8: THE PROCESS OF BECOMING WELL, INCLUDING FLOURISHING



Adapted from:
Lijjedahl, S.I., Mossberg, A., Grenner, H. *et al.* Life experienced as worth living and beyond: a qualitative study of the pathways to recovery and flourishing amongst individuals treated for borderline personality disorder. *BMC Psychiatry* 23, 838 (2023). <https://doi.org/10.1186/s12888-023-05357-9>

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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GPM PARTICIPANTS' GPM FEEDBACK

- The process of becoming well including flourishing (Session 8). One participant said she had given up on having dreams since she could not meet her goals. She realized that her dreams are available if she focuses on moments now rather than an idealized future life.
- Another participant pointed to the first two circles in the recovery model and said he had never in his life moved beyond symptom remission and recovery
 - back-and-forth; history of addiction.
 - Part of his self-identified problem was not knowing what a pathway to wellness might look like or involve
- Following w. 8 another participant described noticing things in her environment - such as early spring flowers while out walking – that she had not attended to since childhood because she thought them unimportant (singular focus on achievement/perfectionism)
- In sum: Experiential engagement a possible resource and method for self-discovery

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Stay tuned...

Questions?
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LOIS CHOI-KAIN, SHEDO, ERIK YDREFELT, DAN BENGTTSSON, PEDER BJÖRLING
& MY WONDERFUL TEAM
LINA NORDSTRÖM, HANNE CARLSEN, STEINN STEINGRIMSSON, SARA BÖRJESSON & AHMAD MAHDAWI, HANNA GRENNER & KRISTINA SUNNERDAHL

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REFERENCES

- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage.
- Grenyer, B. F. S., Townsend, M. L., Lewis, K., & Day, N. (2022). To love and work: A longitudinal study of everyday life factors in recovery from borderline personality disorder. *Personality and Mental Health*, 16(2), 138–154. <https://doi.org/10.1002/pmh.1547>
- Larivière, N., Couture, É., Blackburn, C. *et al.* Recovery, as Experienced by Women with Borderline Personality Disorder. *Psychiatr Q* 86, 555–568 (2015). <https://doi.org/10.1007/s11126-015-9350-x>
- Liljedahl SI, Mossberg A, Grenner H, Waern M. Life experienced as worth living and beyond: a qualitative study of the pathways to recovery and flourishing amongst individuals treated for borderline personality disorder. *BMC Psychiatry*. 2023 Nov 14;23(1):838. doi: 10.1186/s12888-023-05357-9.
- Linehan MM. *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press; 1993.
- Linehan MM. *DBT Skills Training Manual*. 2nd Ed. New York, NY: Guilford Press; 2015.
- Ng, F.Y.Y., Townsend, M.L., Miller, C.E. *et al.* The lived experience of recovery in borderline personality disorder: a qualitative study. *border personal disord emot dysregul* 6, 10 (2019). <https://doi.org/10.1186/s40479-019-0107-2>

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