Borderline Personality Disorder Collaborative

GPM Complex

Laura Cooke-O’connor | Advanced Clinician Coordinator

Cathy McLeod Everitt | Service Development Manager

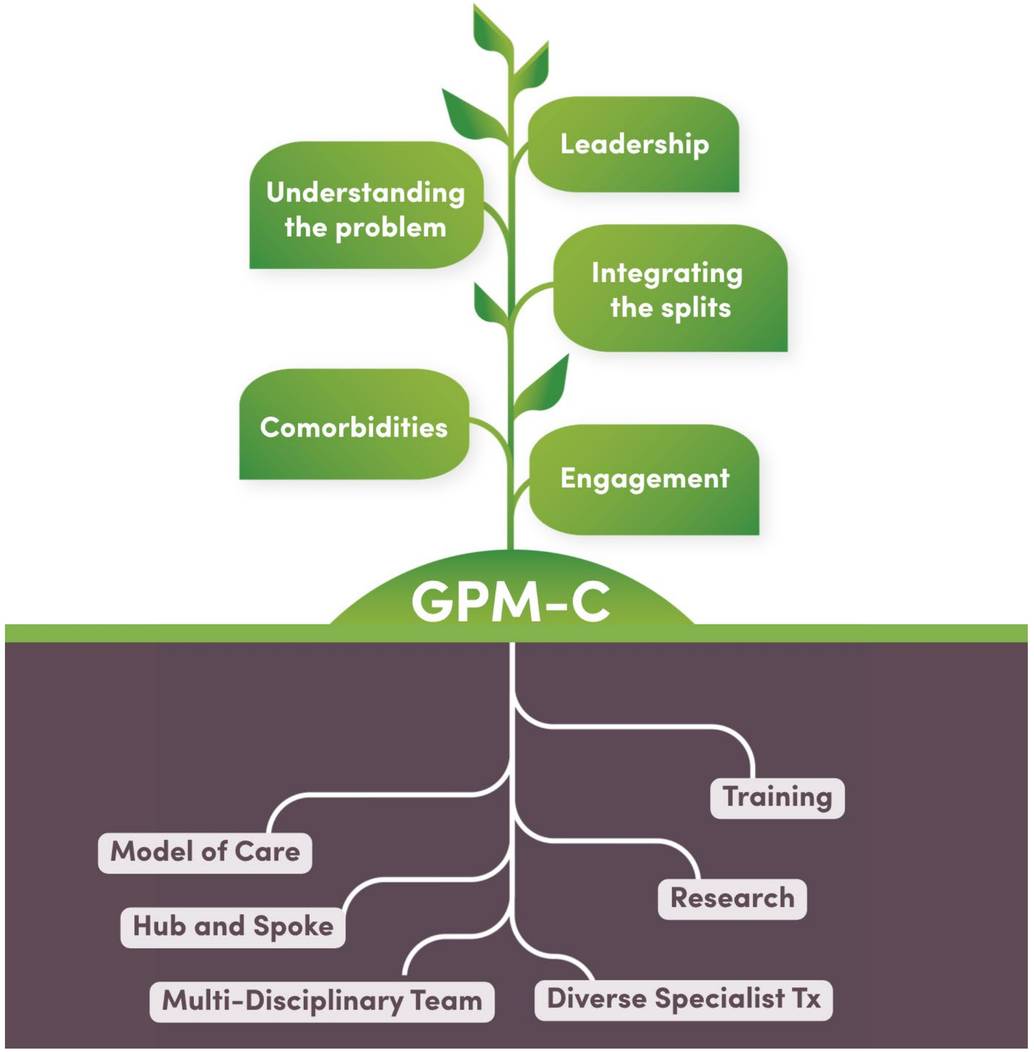
South Australia

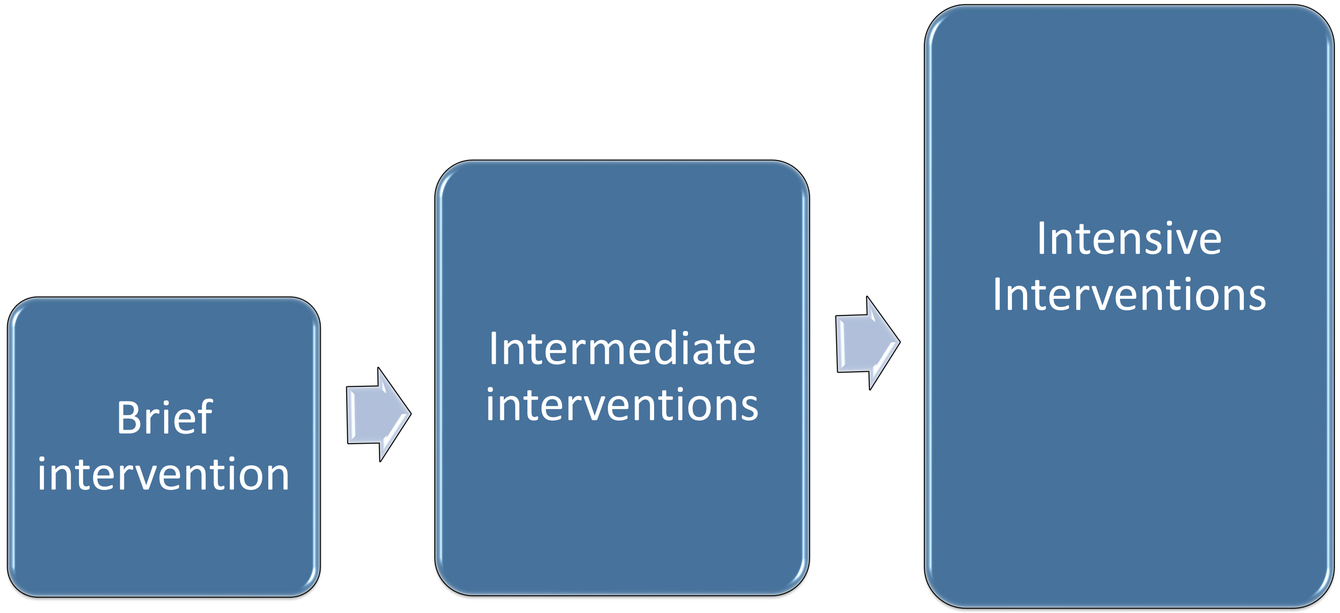
Population: 2m
Area 983, 482km²

BPD pop est:
17,700 – 70,800

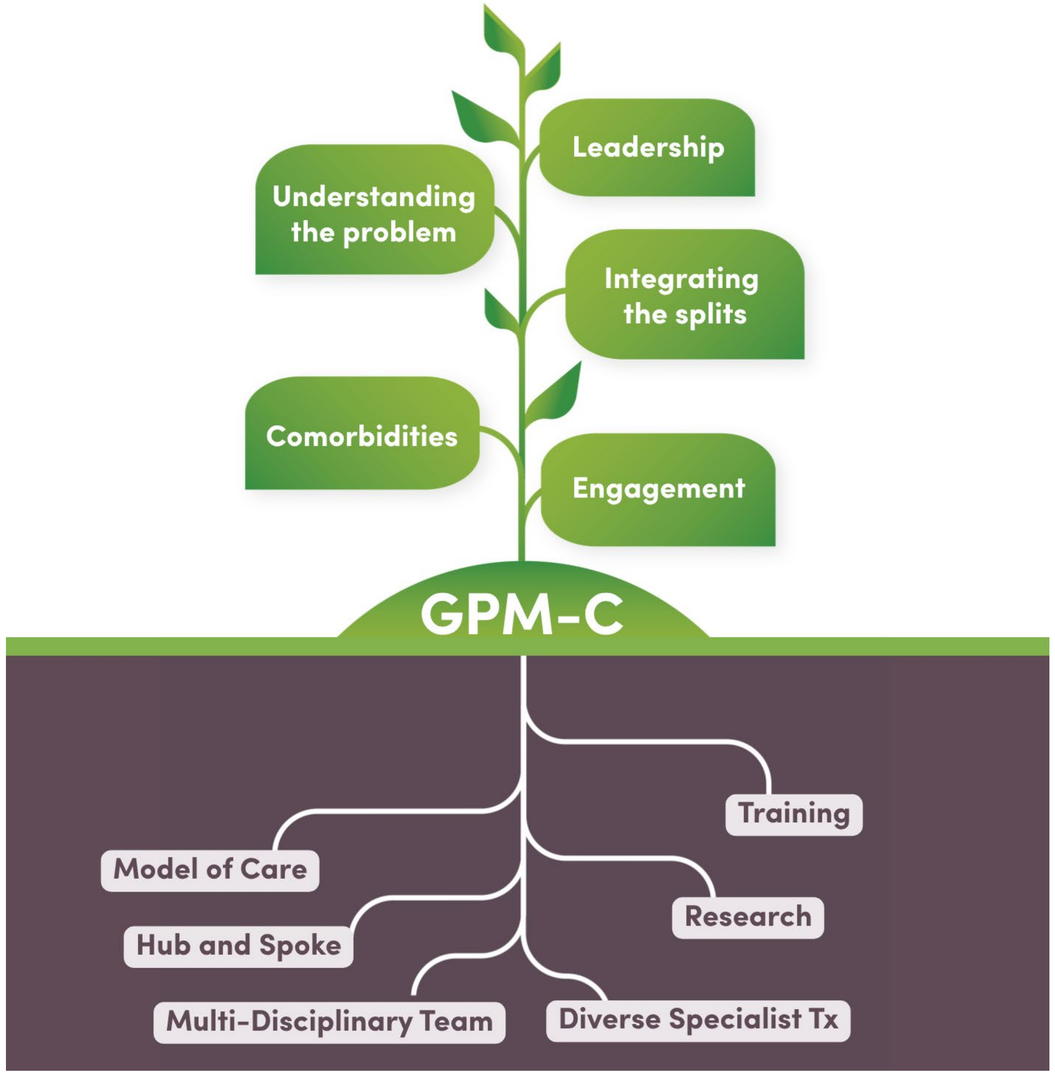
BPD Co: 12.5
Clinical FTE

Stepped Care Model

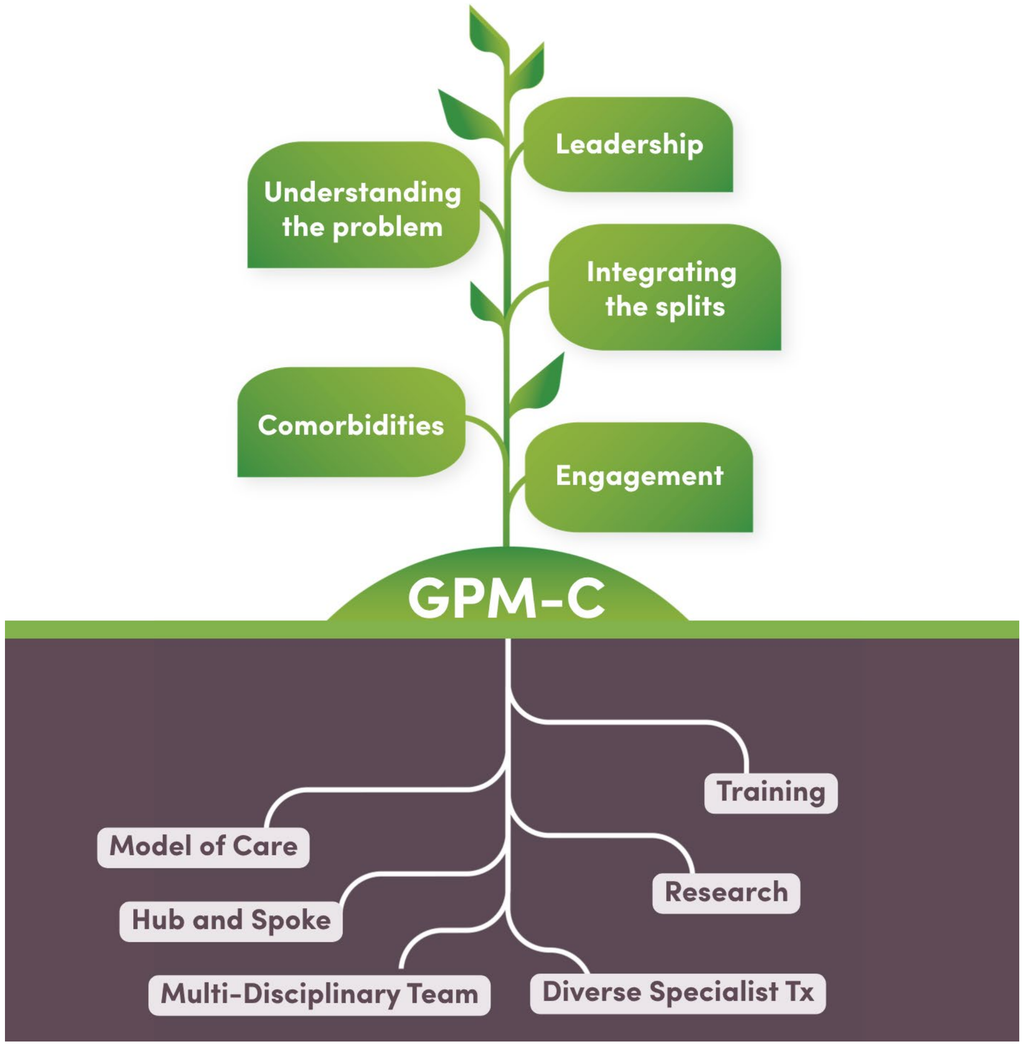




Hub and Spoke



Implementation Process



GOOD PSYCHIATRIC MANAGEMENT

OVERALL PRINCIPLES

SIX PRINCIPLES OF GPM

1

BE ACTIVE (responsive, curious), not reactive

- Seek to understand, develop treatment plans and procedures around key problems
- Challenge passivity, avoidance, silences, diversions in pt & team
- You are the “container” (cautious, thoughtful, “hold” projections)

SIX PRINCIPLES OF GPM

1 - BE ACTIVE

2 **SUPPORT** via listening, interest, selective validation

SUPPORT: VALIDATION

- Seeing the everyone's description as legitimate and understandable
- NOT the same as agreeing — requires "not knowing" or being right or wrong
- Orients team and patient to collaboratively "make sense" as a first step of good general care

SIX PRINCIPLES OF GPM

1 - BE ACTIVE

2 - SUPPORT

3 **FOCUS ON LIFE SITUATIONS,** relationships and vocation

WORK BEFORE THERAPY!

- Therapeutic protocols that require a robust alliance and reflective process requires a frame to be safe and effective
- Understand what is working or not and why
- Constructive collaboration is required as a basic first step

SIX PRINCIPLES OF GPM

1 - BE ACTIVE

2 - SUPPORT

3 - FOCUS ON LIFE SITUATIONS

4 **THERAPY RELATIONSHIP IS REAL (DYADIC) AND PROFESSIONAL**

- Selective disclosure - e.g., “you scared me,” “that would make me angry”
- Stay in your lane (i.e, roles and goals) competence build confidence and trust

SIX PRINCIPLES OF GPM

1 - BE ACTIVE

2 - SUPPORT

3 - FOCUS ON LIFE SITUATIONS

4 - REAL, DYADIC, PROFESSIONAL

5 **CHANGE IS EXPECTED**

- A lack of improvement is indicative of treatment failure
- Re-evaluate whether or not team is reaching goals

SIX PRINCIPLES OF GPM

1 - BE ACTIVE

2 - SUPPORT

3 - FOCUS ON LIFE SITUATIONS

4 - REAL, DYADIC, PROFESSIONAL

5 - CHANGE IS EXPECTED

6 **ACCOUNTABILITY -** pts as active collaborators in treatment, in assuming control of their life

- "You are the primary agent of change"

STEPPED CARE MODEL

	Severity	Definition	Potential Interventions
5 Chronic persistent	Unremitting & unresponsive disorder	Unresponsive to interventions from previous stages	Low frequency Supportive therapy Case management (e.g. state/public services)
4 Severe	Remitting & relapsing	+ severe self-harm + potentially fatal suicide attempts	Higher level of care Buffer from life stressors Integration of EBTs OR Change EBT (rarely available) Family Skills & Intervention
3 Sustained moderate	Sustained threshold level symptoms	Unresponsive to basic treatment + self-harm + suicidality	OUTPATIENT GPM (plus medication management) Single model EBT Family skills & intervention
2 Early-mild	1st episode of threshold BPD	+ self-harm - suicidality	GPM (psychoeducation) Case management Skills group, support groups Family skills & intervention
1 Preclinical	Subthreshold	Interpersonal hypersensitivity Emotional dysregulation	Psychoeducation & health literacy Problem solving Supportive counseling addressing interpersonal hypersensitivity Family psychoeducation

Adapted for Applications of GPM for BPD: A Practical Guide (APPI 2019) by Gabrielle Ilagan and Lois Choi-Kain from Choi-Kain LW, Albert EB, Gunderson JG: Evidence-based treatments for borderline personality disorder: implementation, integration, and stepped care. Harvard Review of Psychiatry 24(5):342-56, 2016.

GPM – COMPLEX CARE

Build a strong structure/home in which to provide good enough care

Understand the problem

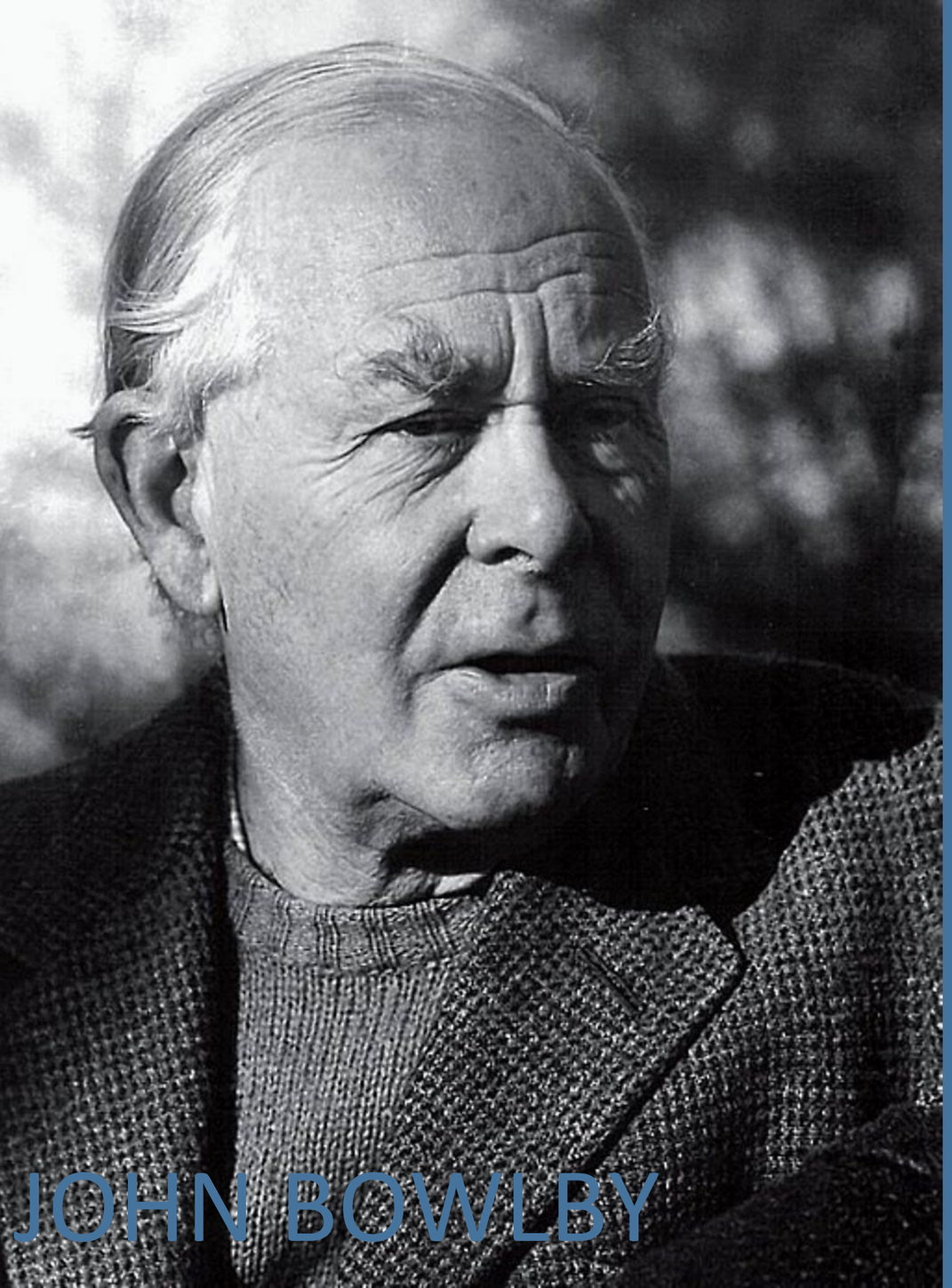
Integrate splits: There is no magic bullet

Manage co-morbidities and co-occurring problems

Enlist patients' involvement – especially in treatment decisions

CORE FORMULATION

INTERPERSONAL HYPERSENSITIVITY



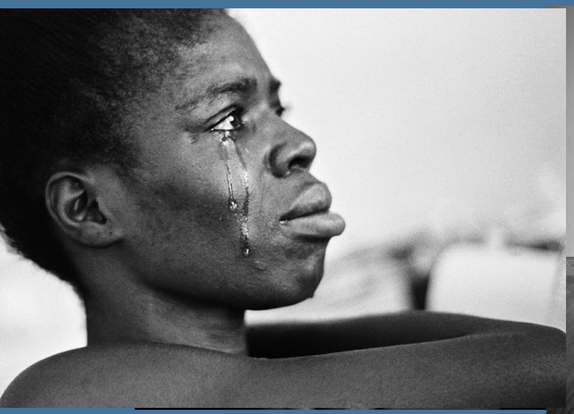
Childhood attachment determines

later capacity to make affectional bonds as well as a whole range of adult dysfunctions… [including] personality disorders.

Organizing strategies of disorganized attachment

- Disorganized attachment functions to organize unpredictable caregivers

Dissociation



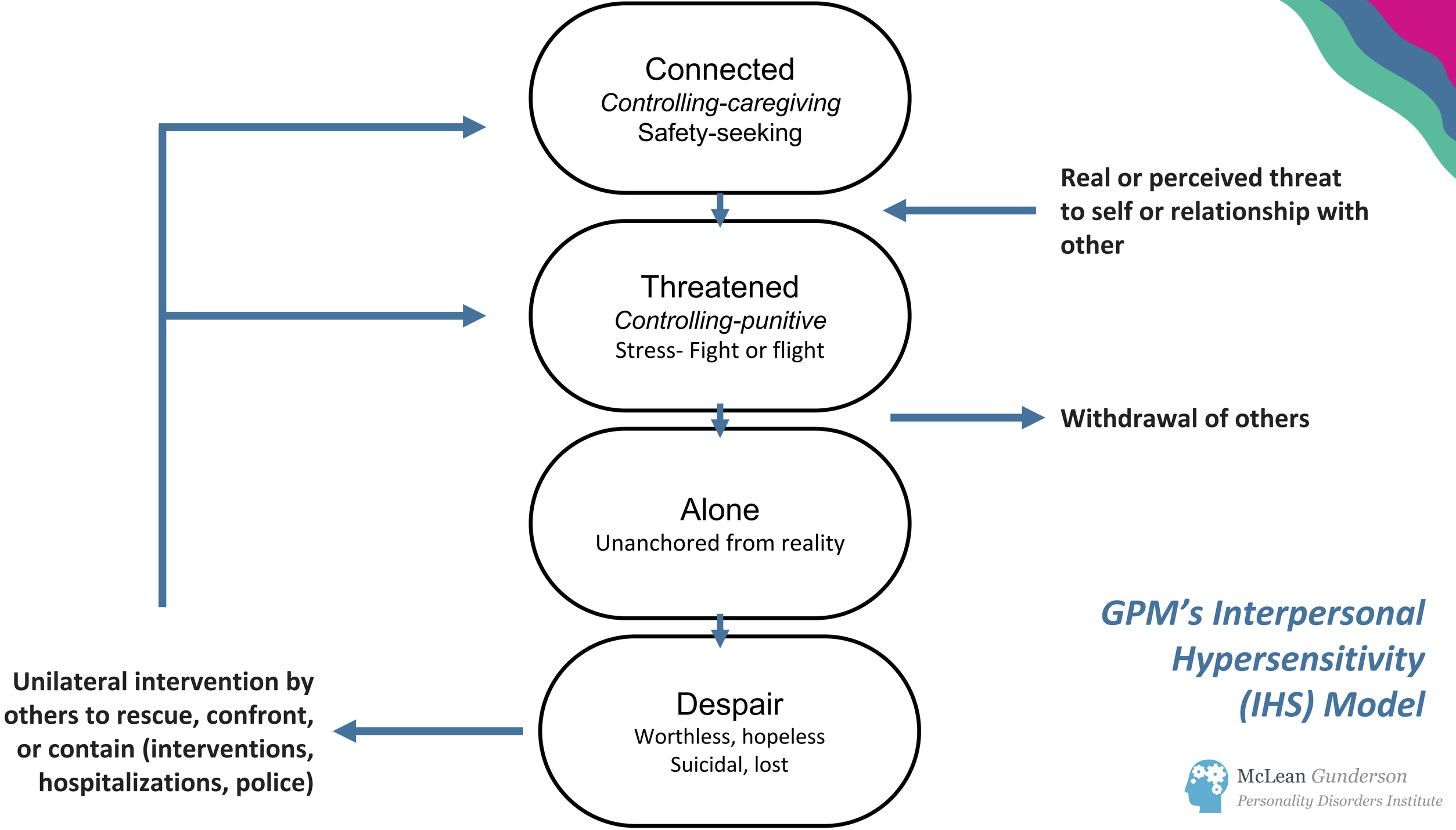
Controlling

Entertaining

Caregiving

Hostility

- Aim to improve bids and quality of support, more relating, less reacting

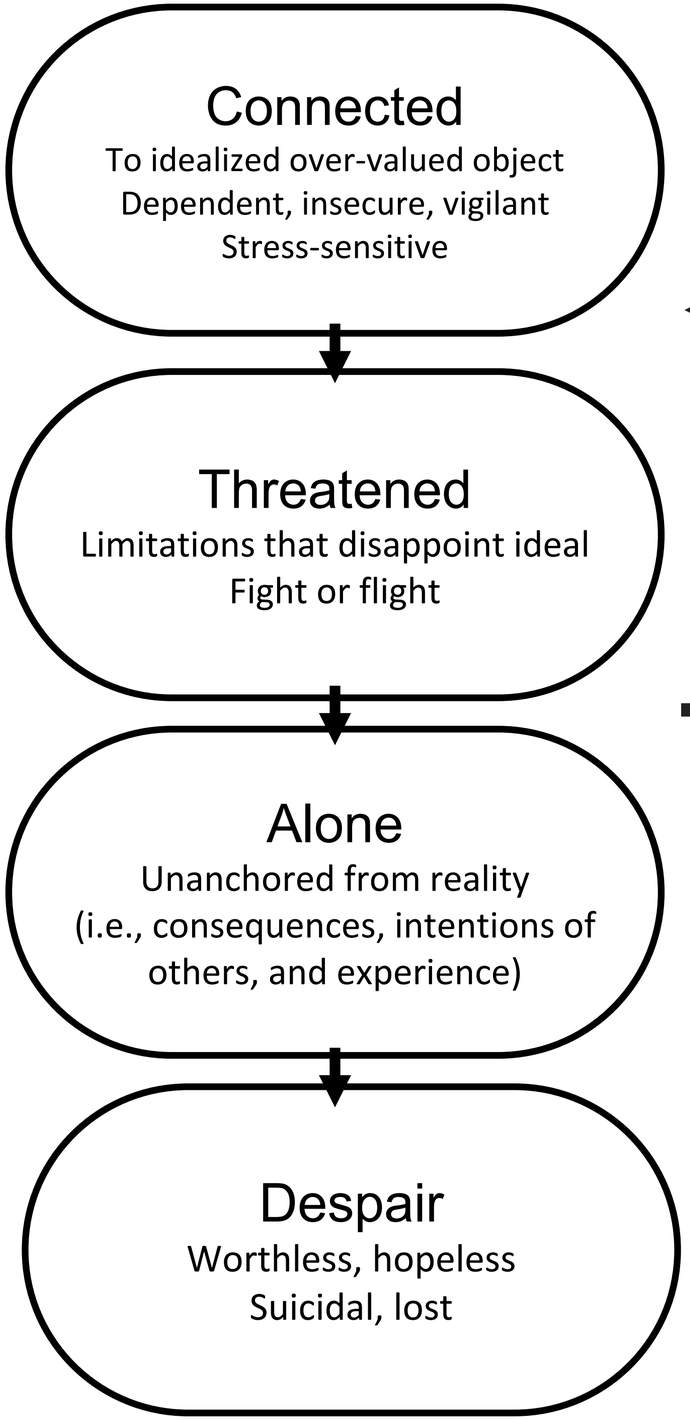


GPM's Interpersonal Hypersensitivity (IHS) Model

McLean *Gunderson*
Personality Disorders Institute

Damaging effects of stress is mediated by 5 domains:

1. Interpretation
2. Predictability
3. Outlets for frustration
4. Social support
5. Control



Interpretation
Predictability
Active Coping
Prosocial behavior

Control
Outlets for Frustration

GPM's Stress Sensitivity Model

McLean *Gunderson*
Personality Disorders Institute

GPM: THERAPEUTIC APPROACH

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

COMORBIDITY

ADDRESS COMORBIDITY

	CONSIDERATION	EXAMPLES
PRIORITIZE COMORBIDITY WHEN	COMORBIDITY PRECLUDES INVOLVEMENT OR ACTIVE LEARNING	MANIA, ADHD, ASD COGNITIVE LIMITATION, ANOREXIA
PRIORITIZE BPD WHEN	COMORBIDITY IS UNLIKELY TO REMIT OR LIKELIER TO RECUR UNLESS BPD IS IN REMISSION	DEPRESSION, ANXIETY, SOCIAL PHOBIA, REMITTED BIPOLAR DISORDER, SUBSTANCE USE, BULIMIA
STABILIZE BPD BEFORE ADDRESSING COMORBIDITY TO	INCREASE PATIENT'S ABILITY TO TOLERATE EXPOSURE THERAPY	PANIC DISORDER, PTSD, OCD

ADAPTED FROM MERCER & LINKS, 2019

Case Study

Background

Name: Karen

Details: 45 female

Background: mother of two children, unable to manage parenting responsibilities, not living in the family home at time of referral.

Frequent presentations to hospital and dysregulated behaviour including aggression, absconding, threats of suicide and threats of violence to mental health and front line staff. In the year of referral over 200 days in bedded services

Family expressing high levels of dissatisfaction of mental health services, including complaints to the minister.

The Community Mental Health Team were struggling to know how to manage the degree of dysregulation and acting out behaviours. The team were experiencing high levels of burn out and hostile counter transference.

Referred to BPD Co for diagnostic clarification and recommendations of support for staff.

Leadership:

- Review of existing service plan
- Support services to define roles and responsibilities

Understand/Define the problem:

- 10-session GPM Assessment
- Predominant Dependent Personality Disorder (DPD), as well as BPD with avoidant features

Integrate Splits:

- Explore team's counter-transference
- Tension between short-term containment and safety interventions and reinforcement of ongoing dependency and avoidance

Address Comorbidities:

- Adapted ICM for DPD (overvalued reliance on external supports)

Engagement:

- Strong resonance with ICM
- Engagement in working toward simple, practical goals
- System-level engagement with therapeutic formulation, with development of management plan to facilitate consistency of response across services
- Engagement of family: family meetings, psychoeducation, supporting recalibration of expectations and readjustment of responses

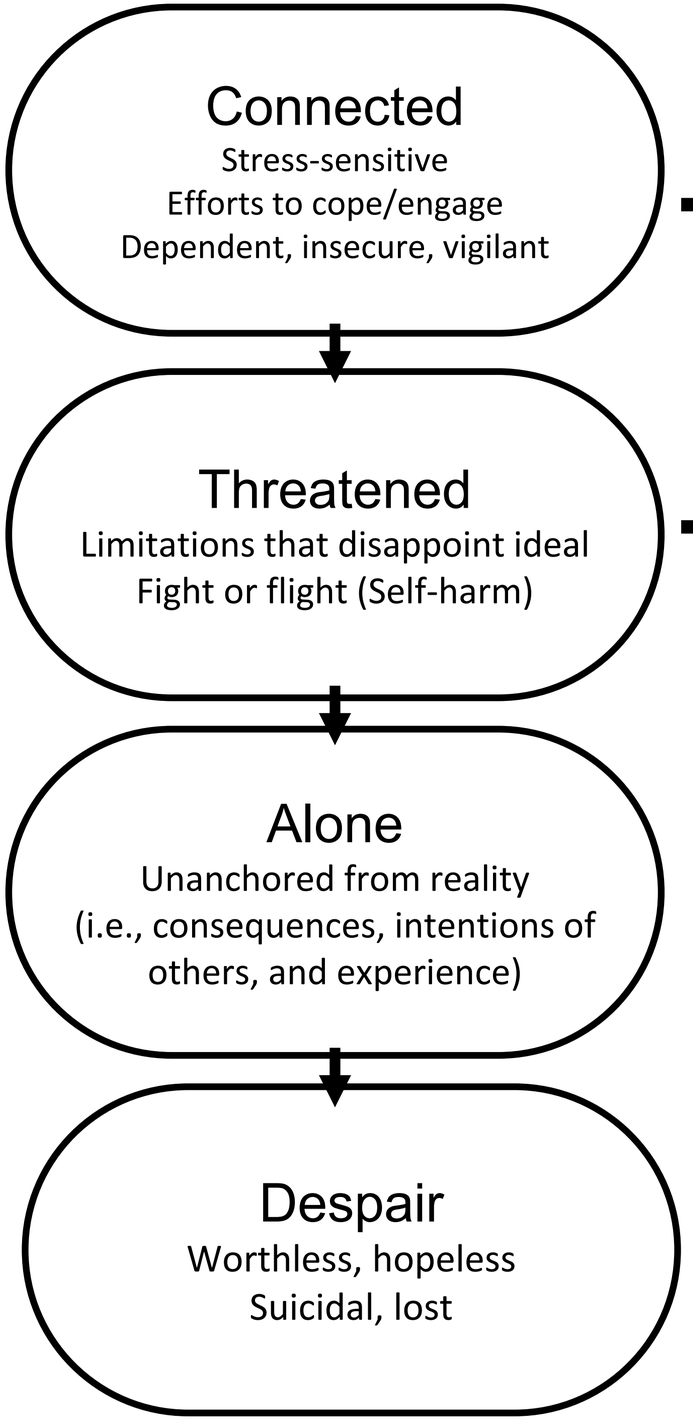
Progress:

- Karen has returned to living in the family home and is increasing her participation in family and parenting activities and responsibilities
- Significant reduction in hospital days over the past year (172 → 7)
- Increased capacity to tolerate direct conversations about the core problem and impacts of reassurance-seeking and containment-seeking behaviours

GPM TEAMWORK

RULES FOR PARTNERSHIP IN SPLIT TREATMENT

ESTABLISH CLEAR ROLES	ESPECIALLY FOR MANAGING CRISES (SAFETY), TAKING PHONE CALLS FROM FAMILY MEMBERS
TALK TO EACH OTHER	INSIST ON THE NEED AND RIGHT TO TALK TO EACH OTHER, EXCEPT FOR PERSONALLY SENSITIVE DISCLOSURES THAT DON'T INVOLVE SAFETY OR THAT JEOPARDIZE THE TREATMENT
DON'T ACCEPT THE OTHER TREATER'S VILIFICATION	EXAMINE, DON'T PROTECT OR AGREE WITH THE OTHER TREATER'S VILIFICATION
ENCOURAGE VOICING COMPLAINTS DIRECTLY TO TREATER	URGE THAT COMPLAINTS BE VOICED TO THE OTHER TREATER (THIS IS A CORRECTIVE EXPERIENCE!)

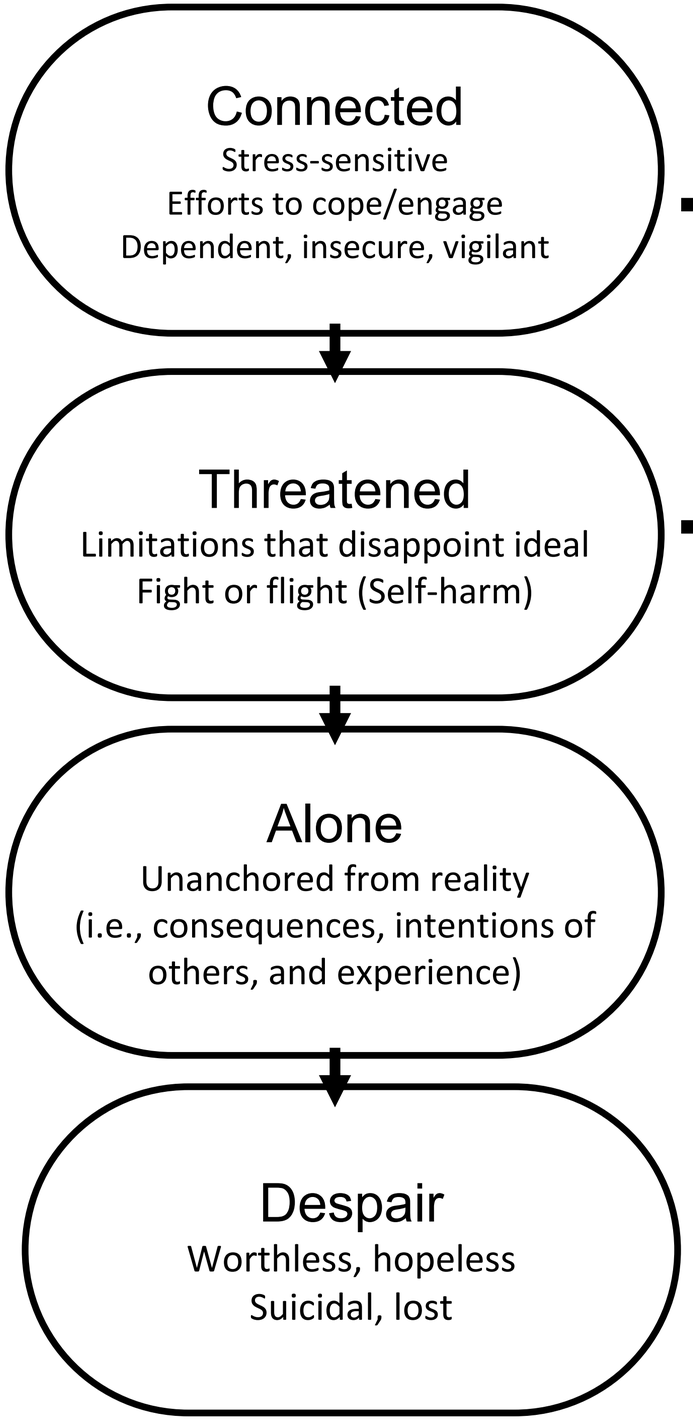


Protective, concerned, preoccupied, anxious. Overinvolved, inadequate boundaries, adherence to plan

Criticized, blamed, unappreciated, angry Rejecting, punitive, rigid adherence to plan.

Relational dynamics COUNTERTRANSFERENCE

McLean *Gunderson*
Personality Disorders Institute

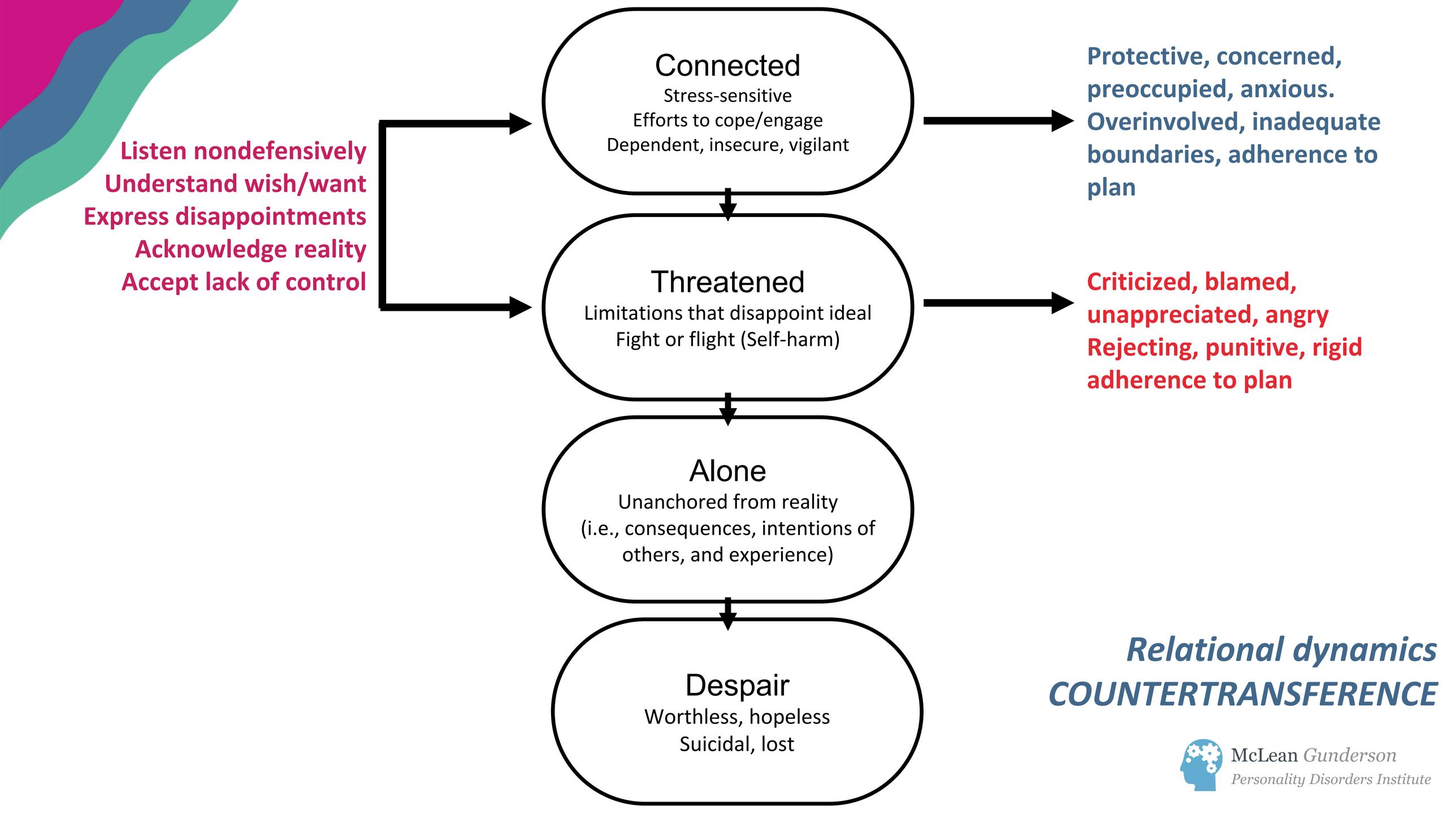


Foster self-reliance, self-assertion, expressing need for help prosocially. Accept uncertainty and lack of control.

Foster effective disagreement and expression of anger. Understand reasons for self-harm and what is wanted.

Relational dynamics COUNTERTRANSFERENCE

McLean *Gunderson*
Personality Disorders Institute



Relational dynamics
COUNTERTRANSFERENCE

McLean *Gunderson*
Personality Disorders Institute

TEAM PROVIDES INTERPERSONAL COHERENCE

LISTEN TO ALL VIEWS	UNDERSTAND ALL THE TEAM MEMBER'S DILEMMAS AND FORMULATION OF PROBLEMS
TALK TO EACH OTHER	INSIST ON THE NEED AND RIGHT TO TALK TO EACH OTHER
EDUCATE & SUPPORT	VALIDATE DIFFICULTY OF STAFF INVOLVED, FOSTER COMPASSION FOR EACH OTHER, DECREASE BLAME
ENCOURAGE VOICING COMPLAINTS DIRECTLY TO TREATER	URGE THAT COMPLAINTS BE VOICED TO THE OTHER TREATER (THIS IS A CORRECTIVE EXPERIENCE!)

Case Study

Background

Name: Lenora

Details: 16 yo female

Background: Complex developmental trauma, disrupted attachment. Removed from parents as a child, placed in care with extended family, returned to live with mother as an adolescent. Removed from mother's care by Child Protection Services, placed in residential care with multiple placement changes and breakdowns.

Maladaptive care seeking behaviour, frequent presentations to Hospital following self harm and presenting with physical issues to elicit admissions.

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

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

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

BPD Co receive referral from DCP for Psychiatry review current management of patient due to high risk and systems overload

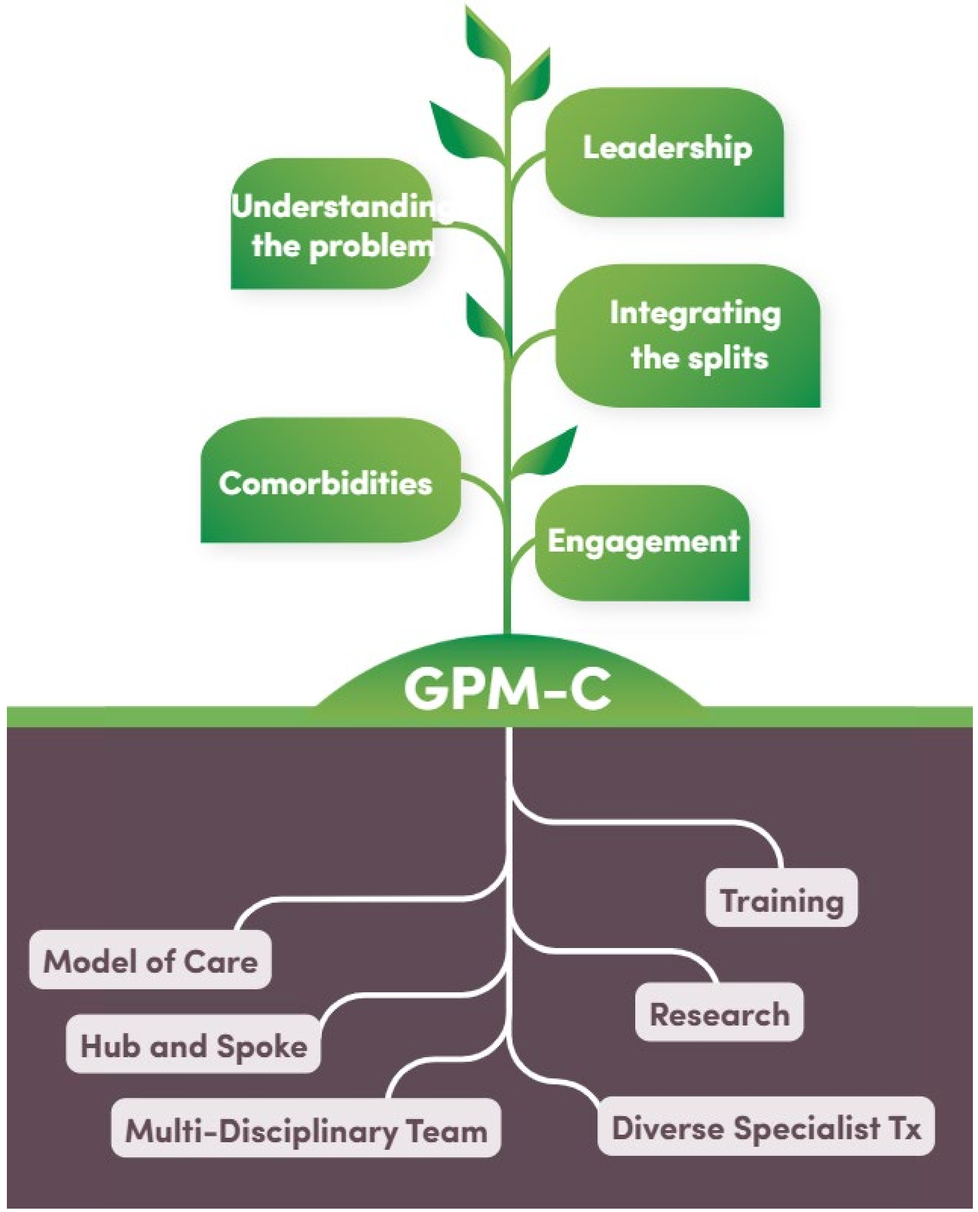
Initial meeting with DCP Executive and CAMHS Psychiatrist followed by meeting with Residential Care and staff management

Meeting with Minister for Child Protection and Chief Executive of Child Protection.

Meeting with Director of Residential Care to understand problems staff are facing.

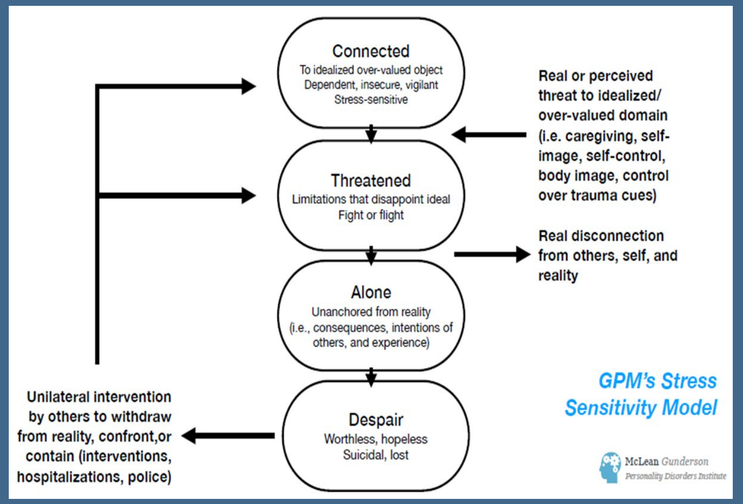
Development of training to be provided to DCP staff and residential care incorporating GPM-A framework /family Guidelines.

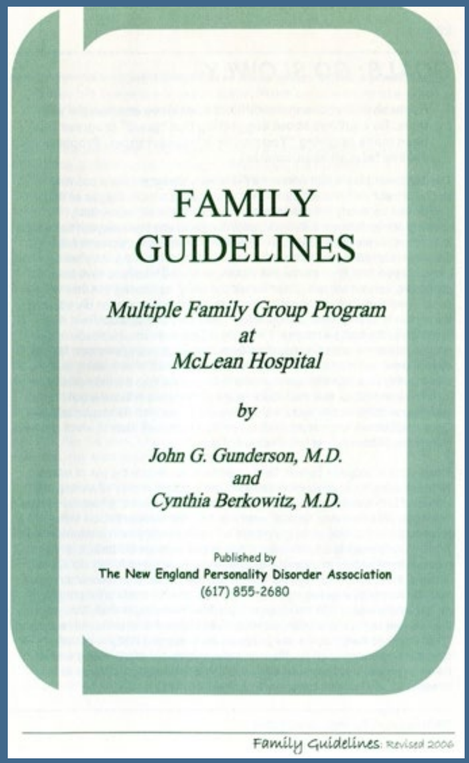
Delivery of training and reflective practice sessions post training to DCP/Residential care staff.



Training the residential care team

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

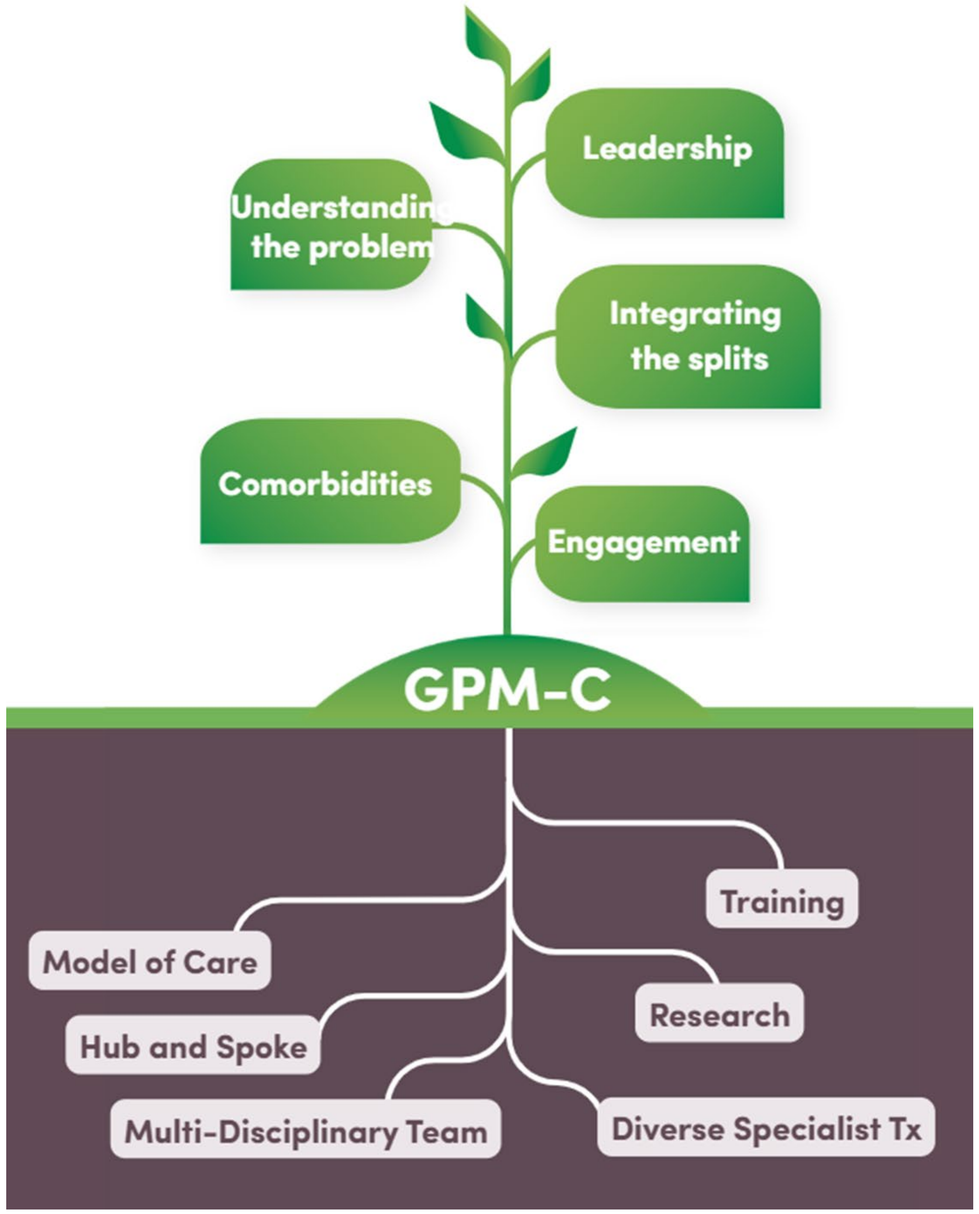




You meet with the CAMHS clinician to provide GPM-A coaching until they can attend training and supervision:

- They let you know the GPM-A approach is helping them manage their own anxiety from the daily emails coming in from multiple services, which cause them to step out of their lane.

- They are focusing on their job of maintaining a therapeutic alliance with Lenora and instilling hope and encouraging agency



Meet with CAMHS Exec promote value of GPM -A. Approval for clinicians to attend training and GPM-A supervision

Build relationships with clinicians working in metro/regional youth mental health services

Promotion of GPM-A Handbook and Training.

Delivery of GPM-A training to CAMHS clinicians.

Delivery of supervision/coaching sessions post training.

Adolescent clinicians working in metro/regional MHS attend GPM-A Complex Workshop with Lois Choi-Kain 2024.

Development of GPM-A Network, meets monthly.GPM-A Supervision with Lois Choi Kain 2025 with clinicians working with diversity of presentations.

BPD Co receive referral from DCP for Clinical Lead to review current management of patient due to high risk and systems overload

Initial meeting with DCP Executive and CAMHS Psychiatrist followed by meeting with Residential Care and staff management

Meet with CAMHS Exec promote value of GPM -A. Approval for clinicians to attend training and GPM-A supervision

Build relationships with clinicians working in metro/regional youth mental health services

Promotion of GPM-A Handbook and Training.

Delivery of GPM-A training to CAMHS clinicians.

Delivery of supervision/coaching sessions post training.

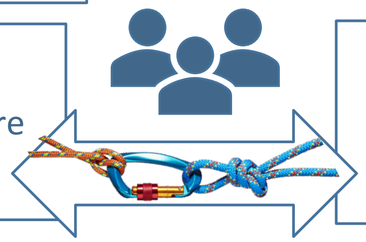
Adolescent clinicians working in metro/regional MHS attend GPM-A Complex Workshop with Lois Choi-Kain 2024.

Meeting with Minister for Child Protection and Chief Executive of Child Protection.

Meeting with Director of Residential Care to understand problems staff are facing.

Development of training to be provided to DCP staff and residential care incorporating GPM-A framework /family Guidelines.

Delivery of training and reflective practice sessions post training to DCP/Residential care staff.



Development of GPM-A Network, meets monthly.

GPM-A Supervision with Lois Choi Kain 2025 with clinicians working with diversity of presentations.

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

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

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

GPM framework for BPD Co Team

Organising framework

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

THANK YOU

BPD CO

HEALTH.BPDSERVICE@SA.GOV.AU

McLean *Gunderson*
Personality Disorders Institute

GUNDERSONPDI@PARTNERS.ORG