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Should “Good enough” healthcare network management be considered as a key element of borderline personality disorder treatment?

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Summary: The onset of generalist treatments for patients with borderline personality disorder (BPD), such as John Gunderson’s "Good Psychiatric Management" (GPM), enabled sharing of simple and accessible therapeutic principles designed for a majority of clinicians and a majority of patients. In addition, BPD is often associated with other comorbidities, both psychiatric and somatic (addictions, psychosomatic presentation, obesity, etc.). This correlation explains why BDP patients tend to be high care consumers or “frequent flyers”. Moreover, BPD greatly affects social and vocational functioning. Indeed, this population of patients has significant difficulties in finding a fulfilling place in society. The impact of BDP on patients’ social life even became a prognosis factor. Over the last two decades, models of integrated care have been implemented in Europe. These developments allowed a clear connection between care coordination and care efficacy to be established. This conclusion proved to be relevant for the medical field in general, as well as for psychiatry. Given the wide impact of BPD on patients’ lives, treaters often find it impossible to address all dimensions of their patients’ problems on their own. Consequently, an adapted and effective treatment often requires the construction of a multidisciplinary network of professionals working in a synergistic manner. This teamwork appears both as a genuine component of the sociotherapy patients need and an invaluable tool for patients’ rehabilitation. This article aims to illustrate how GPM is an effective tool for building and managing a healthcare network for BPD patients. However, these team settings require a significant investment of time and energy from the professionals. They also are expensive. For these reasons, we think that the effectiveness of these team settings justifies proper training to ensure their best use.

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Introduction

Patients with borderline personality disorder (BPD) represent 20% of both outpatient and inpatient populations in psychiatry. The prevalence of this specific personality disorder is 2% in the general population [1]. These patients are well known among clinicians for their stormy clinical presentation. They display intense symptoms in four psychological fields: emotion regulation, relationship handling, impulse control and identity [2]. The complexity of the clinical presentation, characterised by emotional outbursts and impulsive behaviours, has contributed to the notorious reputation and stigmatisation of these patients among healthcare providers [3]. Moreover, BDP is often associated with other mental health syndromes [4] as well as with somatic comorbidities. In addition, BPD frequently affects patients’ social and vocational functioning. This impairment tends to persist over time unlike symptoms intensity [5, 6]. This can easily make patients vulnerable in various ways.

As a result, healthcare providers may need to refer their patients to an extended healthcare network [7]. Thanks to coherent cooperation, the members of a professional team aim to improve the quality and effectiveness of health care. To achieve this, healthcare networks often consider two criteria: (1) defining care according to a diagnosis; (2) defining care according to the patient's needs and resources. This is the common conclusion reached by integrated care models implemented in Europe over the past 30 years [8. 9]. This integrated approach also enables a wider range of patients’ problems to be rapidly addressed [10]. According to the specific situation, this network may include social workers, general practitioners, patients’ legal representatives, lawyers, etc. This stresses the importance of both team building and team leading in a coherent way adapted to the patient’s needs.

Before the emergence around 30 years ago of specific manualised treatment, such as dialectic behavioural therapy (DBT) [11], BPD was considered untreatable. During the following decade, evidence-based manualised psychotherapies (mainly DBT, transference focused psychotherapy and mentalisation-based psychotherapy) became the therapeutic gold standard for the treatment of BPD. However, these treatments required a lot of training and few therapists were available [12]. In order to provide “good enough” care to this patient population and “good enough” training for practitioners, John Gunderson devel-

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oped a generalist treatment based upon his practice: good psychiatric management for BPD patients (GPM). The notion of "good enough" care is a reference to D. Winnicott's work [13]. The "good enough" mother or parent provides the child with what is necessary without letting them either become helpless or overwhelming them. Correspondingly, GPM does not try to be a perfect treatment. It only seeks to be adapted and well-balanced.

It is "good enough" to treat patients and to allow them to feel cared for. On the other hand, it provides treaters with "good enough" tools to face a vast majority of situations. It is not perfect, but allow therapists to feel well equipped. Against expectations, recent studies (2009 and 2018) showed that generalist treatments such as GPM or structured clinical management (SCM) were as effective as gold standard treatment [14, 15].

In Switzerland [16], these generalist approaches are now recommended treatments for patients with BPD. This is also the case in countries such as the USA, Canada and Australia [17]. Nevertheless, J. Gunderson and his successors believe that clinicians must extend the implementation of generalist treatments for BPD patients [18]. The GPM design aims to make it accessible and useful to a majority of clinicians and a majority of patients. It is flexible and looks to build a stepped care treatment. To do so, GPM considers the available resources for treatment and the severity of the clinical presentation [18]. In a collaborative way, therapists help their patients in actively developing useful strategies adapted to their situation and needs via core principles. Interpersonal hypersensitivity [19] is the core concept that binds GPM principles together. It prompts therapists to be active. It expects patients to involve themselves actively in the treatment. It expects patients to focus on their lives outside of treatment. As a result, it supports patients in moving on in their lives and prevents them from identifying themselves merely as sick people [20].

In this paper, we will describe the construction and the function of the healthcare network in the treatment of BPD patients, adapted to the Swiss public health setting. This aspect of the treatment generally lacks description but turns out to be crucial for patients displaying intense symptoms and a complex social situation. We based the content of this paper on our long-term clinical experience in the frame of a specialised programme dedicated to patients with BPD [21, 22] and the latest updates of generalist approaches for BPD.

A summary of the GPM concept and recommendations regarding BDP

Psychopathology – the interpersonal hypersensitivity concept

Interpersonal hypersensitivity is at the core of BPD psychopathology according to GPM:

- It states that Interpersonal stress factors trigger the vast majority clinical manifestations of BPD.
- Consequently, BPD phenomenology shifts drastically in response to patients' interpersonal context.
- Supportive behaviours tend to calm patients.
- Angry reactions or withdrawal tend to activate distressed behaviors and more dangerous reactions from patients.
- The GPM interventions are founded upon the interpersonal hypersensitivity concept.

Therapeutic principles

- Offer psychoeducation about BPD to patients and relatives.
- Be active (responsive and curious), not reactive: it is the most effective way to show support. The patient's life matters, is unique and deserves interest.
- Be thoughtful: cautious, reflective and uncertain. You contain the patient's anxiety and become a role model for "thinking before acting".
- The relationship with the therapist is both real and professional.
- Accountability: change is expected. Expect patients to be active within treatment and to move on in their lives.
- Focus on life situations: vocation and relationships. Maintain focus on life outside treatment.
- Be flexible, pragmatic and eclectic.

Adapted from: Gunderson JG: Borderline Personality disorder, a clinical guide, Washington, DC, American Psychiatric Press; 1984 [1]and Choi Kaïn, et al. Evidence-based treatments for BPD: implementation, integration, and stepped care. Harv Rev Psychiatry. 2016; 24(5 :342–56 [12 p. 352].

Detailed investigation of the situation and psychoeducation to enable the building of the appropriate team

GPM was developed as a "good enough" treatment for the vast majority of patients with BPD [1]. It considers it a priority to disseminate all valid knowledge about BPD, its aetiology, course and treatment to treaters, patients and families in order to define realistic objectives in the face of a well-defined problem [23]. The current situation in Switzerland led us to consider that the dissemination process of GPM is also a priority among the extended healthcare network to increase the coherence, consistency and effectiveness of the treatment. A disorganised or uncoordinated intervention may prolong the treatment or, in the worst case, make it ineffective [23].

Consequently, the GPM approach advocates the thorough assessment of every patient's situation to define the nature of the difficulties at hand as clearly as possible (clinical, social, financial, professional, family, etc.). Mapping the situation enables patients and therapists to agree on a priority order of intervention [24]. After this identification process, according to patients' needs and the quality of their surroundings, treaters ought to gather the right professionals with the necessary skills. It might indeed be difficult to develop strategies adapted to symptoms if social, economic or administrative stress factors have not been addressed in a straightforward and relevant way.

However, in order to allow every protagonist to work in good conditions, it is crucial for them to understand the phenomenology of BPD. GPM helps to find a common language between therapists from different therapeutic approaches [24]. It is our experience that it also helps to develop a common language between different but complementary professions: psychiatrists, psychotherapists,

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general practitioners (GPs), nurses, pharmacists, social workers, educators, legal representative, job coach, etc. The key idea is to share with them not only the knowledge we have about the disorder but also the principles of treatment described in the previous section [12].

Sharing the GPM concepts with other professionals aims to develop a synergy in the care process of the whole situation of the patient. For this purpose, patients and professionals must have a clear view of the network and be able to identify everyone's roles and limits. It will first allow realistic objectives in every dimension of the patient's situation to be set. Secondly, it enables coordination of available skills. Consequently, it is essential that a member of the network assumes the leadership of the group. The leader's tasks are monitoring patients' objectives and their realisation, coordinating everyone's interventions, organising network meetings and ensuring a good level of communication both within the group and between the group of professionals and the patient [23]. Patients must be granted the chance to experience both the plurality and unity of the network. At times a source of frustration, this organisation of the network also induces a noticeable reduction of the symptoms.

The choice of the team leader can seem a tricky job. The psychiatrist or mental health professional of the group is often the most effective and coherent choice. It is not a rule though. Other choices can be relevant if the treater is familiar enough with the GPM model. For instance, a paediatrician with an adolescent patient can be a reasonable choice. Remember that the team leader must be available for group appointments and feel at ease with leading them.

Take-home messages of the section

- Define patients' problems and prioritise them.
- Select appropriate and coordinated network members and choose a leader.
- Check and update GPM knowledge among network members.

Coordination and communication between network members

Once the network is established, its main therapeutic tool is its capacity to communicate actively and efficiently [8]. It is very important that every protagonist remains up-to-date regarding the global evolution of the patient. The onset of a common mailing list and regular meetings, every 3 months for example, are very useful in achieving this objective. They will ensure the building of the team and the creation of a coherent message to the patient.

The network becomes an entity in itself with its own life, relationships and growth. As such, it must be taken care of to ensure its continuous dedication to the patient's situation. Its members must keep on exchanging and thinking independently of the evolution of the patients and even in their absence. The significant amount of time the professionals dedicate to communication about the patient is an underground work, often ignored, time-consuming and invisible, but crucial. It allows the shaping of an accurate and realistic representation of the patients and of their functioning [23]. The network meetings are also places where treaters can speak about the difficulties they face, their needs and their limits.

This dynamic and plural setting becomes a therapeutic area centred on clinical observation to allow the common elaboration of integrated interventions. It enables quick detection and containment of clinical crises, in-coming stress factors or splitting behaviours [25] from the patients. The pro-active communication of the professionals allows them to refer the patient to the right colleague if they receive misplaced demands from the patient.

As a result, it is fundamental to monitor steadily the evolution of the patient and the care process. A poor course or the signs of treatment failure must trigger reflection and adaptation of the professionals' work and methods [26].

Take-home messages of the section

- The leader manages the mailing list and ensures periodic meetings (e.g., every 3 months).
- Ensure good communication among members and between the patient and the team.
- Professionals must be proactive and share their views of the situation.
- Monitor patient and network evolution.

Importance of social and occupational aspects

BPD is associated with a great impact on social and vocational functioning [27]. Moreover, work is a key aspect of life. It participates in the shaping of an individual's identity and is a core component in the development of the feeling of being useful, dependable and responsible [27]. For these reasons, we can easily see how this aspect of patients' lives is directly related to their prognosis. This is why we believe that this matter must be addressed with patients directly. We aim to assess their ability to work, or at least to remain active through an occupational activity, in order to shake the often-strong idea that reintegration and change is impossible or out of their hands [24]. This kind of belief could prompt patients to remain passive. If this were the case, it would be fundamental to question the disposition of the patient to avoid an active involvement in society. It could be, for example, a clinical expression of avoidance or exploitative tendencies, which should not be ignored.

Swiss social services often have the reputation for being quite demanding of their beneficiaries, whom they do not hesitate to refer to medical professionals, especially GPs and psychiatrists, to investigate a medical or psychological condition that could interfere with the rehabilitation or reintegration process. The discovery of such a condition often results in a more passive stance of the social service.

Because of the clinical, social and vocational odds at stake, the outpatient clinic staff are frequently in contact with social services professionals to help them better understand the situation of their beneficiaries. The goal is to turn social services into an ally, who will also encourage and sustain patients' motivation to reintegration. As Gunderson and Links early stated, the therapeutic modalities that target social impairment and vocational rehabilitation (sociotherapy) should become more central and more available [28]. GPM is an integrated approach. The patient's whole life matters. We think it is unique, interesting and deserves care [28]. In other words, we could say that pro-

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gressively finding a place in society is part of the treatment and not a consequence of a successful treatment.

Take-home messages of the section

- Assess the patient's ability and motivation to work or to be occupied.
- Shake the belief that one has to get better to get a life. Getting a life helps getting better.
- Include social services in the network to find reintegration pathways.

The GPM recommended stance for professionals

Seeking skills outside of the medical field is an embodiment of the "real and professional relationship" GPM prompts therapists to develop with their patients [24]. It is an acknowledgment of the patient's range of issues and, as such, represents a way to be true to them and resolve any confusion regarding the motivation of the therapist to offer assistance. At the same time, this attitude shows that the therapist, and consequently every member of the network, renounces the idea that a "clairvoyant or omnipotent" [29] individual could solve every problem. From this perspective, GPM is consistent with Kernberg's early statement that BPD patients tend to develop relationships based upon extreme idealisation and devaluation [30]. Network members act as "representatives of reality" who can progressively recognise and in parallel question the feasibility and effectiveness of patients' longing for an omniscient and exclusive relationship [12]. This more realistic disposition of the professional network allows the progressive development of a constructive answer to patients' desire for change. This arrangement may also allow patients to feel increasingly connected and cared for in their relationship [19]. Over time, these feelings of connection and security could lead patients to build a new relational referential [31], as Winnicott advocated, which they will be able to use in their day-to-day lives.

The purpose of this approach and teamwork is to enhance social and vocational rehabilitation of patients with BPD. It seems obvious that, for such a task, the key member of the team is the patient. This is why patients' active collaboration is fundamental. They are not responsible for their suffering, but they are the main actor in their changing through their resolution to take action [24].

However, this approach can be effective only if every member of the network assumes it. This explains why it is so important to explain the GPM understanding of the disorder among professionals, as we have already stated. It also justifies the amount of time dedicated to communication [8]. Indeed, the effectiveness of the stance relies on coherence between the different interventions of the co-treaters [23]. Unfortunately, professionals may fail to work together. A dysfunctional partnership is harmful to the patient and has to be addressed [23]. If a solution appears impossible to find, the network leader may have to ask the co-treater who does not stay within the framework to leave the team [23]. Keep in mind that this event may put the patient before a choice: "Whom shall I follow and why?"

Take-home messages of the section

- Patients with BPD have a tendency to develop idealised relationships.
- Offer "a real and professional relationship" and expose professionals' main limit: neither "omnipotent" nor "clairvoyant". It will help patients to feel connected and cared for in the end.
- The patient is the main actor in his/her changing and cannot rely exclusively on treaters.
- The network must monitor every intervention to ensure that it is coherent and that no treater is operating alone.

Interacting with a multidisciplinary network: a potentially deep and mixed relational experience for patients

The interactions between patients and the group of professionals appear as a reduced-scale society where patients re-enact their usual relational patterns and mechanisms. Consequently, from the patient point of view, the establishment of an adapted healthcare network often induces mixed feelings and reactions. The GPM core psychopathological concept – *i*nterpersonal hypersensitivity [19] – allows us to understand these reactions. We previously mentioned it in table 1. It states that BPD phenomenology shifts drastically in response to patients' interpersonal context. As such, clinical manifestations should urge therapists to look for interpersonal stress factors in their patients [24].

Patients who understand that professionals try to help them in a global way beyond psychological suffering alone often experience a relief. They feel cared for and hopeful that change is possible. What is more, the coherent message and active stance of the healthcare team bring them a feeling of content, which frequently induces less intense clinical presentations. As a result, it regulates impulsive behaviours which effectively soothe patients psychologically, but which also are harmful and dysfunctional [19]. This clinical evolution brings the possibility for patients to accept some help and opens the door to taking more time to think before acting. According to interpersonal hypersensitivity, this clinical contentment is an illustration that patients feel understood, supported and cared for by their surroundings and treaters. As long as this attitude persists, symptoms shall decrease and remain low [24].

The efforts of the team of professionals to prompt patients to develop an active involvement in the treatment may unveil contradictory attitudes. A common example of this manifestation is a clear desire for help from the patient associated with an actively passive outlook limiting the possibility to receive any assistance. Statements such as "When I'm doing better I shall deal with the issues in my life" or "I can be active again but someone must find me a suitable job or occupation" represent well this attitude. Early in treatment, professionals should question these contradictory expectations and express their doubts and "skepticism" regarding patients' motivation for their passive stance and "level of dependency to the relationship" [12]. The combined efforts of every protagonist in the professional network should help the patient renounce passivity and instead take action progressively . In the optic of "a stepped care" [12] treatment, if the patient shows lasting difficulties in being active in achieving common

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objectives, treaters should suggest redefining more realistic objectives. Less ambitious but accessible is often a more efficient way to move on.

The intervention of a team of specialised medical and social staff may also induce negative reactions from patients who consider the team worthless and even hostile [25] at some point. According to interpersonal hypersensitivity, patients with BPD tend to feel insecure, disconnected and even threatened from a relational point of view when interpersonal stress factors show up [19]. For instance, patients may display devaluation and hostility because they feel abandoned or controlled by some professionals within the team or forced into directions they deem too demanding. Disagreements with treaters may also trigger a symptomatic outburst.

At this point, patients with BPD exposed to interpersonal stress factors tend to classify people into “good” or “bad” people. This is the “splitting” phenomenon developed by Melanie Klein [32]. Under stress, the patient fails to keep an integrated representation of people around them. It means that treaters or relatives do not have qualities and shortcomings any more. They are only “good” or only “bad”. We could also say that patients can only feel that people around are “with them” or “against them”. This classification only represents how patients can perceive themselves, either “good” or “bad”, but not integrated [32]. Interpersonal hypersensitivity allows us to understand that splitting is a defence mechanism that is psychologically efficient but very dysfunctional at the same time [24]. Its purpose is to decrease anxiety. To do so, it seeks to destroy the interpersonal stress factor. This disposition often induces relationships based upon a struggle for domination [30]. In this context, attempts to divide professionals is only a way to seize back control over the situation and the group by discarding members the patient deems “bad” [32]. This manifestation can concern all the professionals or only some of them. Ultimately, it exposes the patient to the risk of ending up alone and isolated if professionals are not able to contain these manifestations [24]. However, this process often impedes the course of the treatment, as if the patient chose in a time of confusion to battle health professionals rather than the symptoms.

Therapists should seize the opportunity to lean in and understand patients’ manifestations of hostility or aggression towards both themselves and others. This clinical feature is a core dimension in severe personality disorder and must be addressed to bring change. The GPM model of interpersonal hypersensitivity [19] is an efficient tool for talking about these aspects and showing patients that their reaction is likely due to a feeling of threat and disconnection instead of a sense of confidence and a feeling of support from the network. Coming back to the coherent and common message of the professionals and the objectives agreed on with the patient can help to overcome this kind of crisis and bring him or her back to a connected state [19].

Take-home messages of the section

- Assess patients’ reactions to the interactions with the team: relief, contradictory attitudes, threat, aggressivity, etc.
- Address these reactions and help patients consider their consequences.
- Rely on the interpersonal hypersensitivity model to help patients explore and regulate these reactions.
- “Splitting” is a common clinical manifestation among patients with BPD. It effectively soothes patients from a psychological point of view. However, it is very dysfunctional at the same time.

The healthcare network: an evolving therapeutic tool with a beginning and an end

A professional healthcare network evolves along with the patient’s situation. In many situations, our experience is that the network becomes silent at some point. This occurs when every member knows what to do and how to do it. Simultaneously, it reflects the fact that the patient is able to rely actively and appropriately on this extended offer of care. The result is often decreased clinical intensity and the achievement of objective life changes (picking up an activity, training or a job, finding a suitable living place, less conflict in relationship, less isolation, etc.).

As a component of sociotherapy, the network should always question how relevant its presence or range is. Indeed, professionals should steadily monitor how useful their combined efforts are and whether they are adapted to the patient’s situation. For a time, patients need to depend on others’ skills to move on. However, at some point, we wish them to acquire some of these skills to move on in their lives in a more autonomous way [33].

There is no predefined course for a professional network. Patients only know from the beginning that the treatment is not meant to last forever [24]. Members may join and leave the team depending on the situation, patients’ needs and professionals’ point of view. The evolution of the professional network becomes an illustration of the possible evolution of a social group in the real life.

Being able to define with the patient when members of the team have achieved their purpose or that the network should be dismissed is also part of the treatment. This aspect is essential for BPD patients because of their difficulties in facing interpersonal stress factors and espacially separation. The evolution of the network allows patients to test the evolution of their relational skills in a secure setting. It also enables them to develop resilience in a secure environment, a skill indispensable in reaching recovery and rehabilitation [36]. Indeed, resilience is fundamental to building vocational competence and to deal with hard-to-handle features of temperament.

Take-home messages of the section

- The network illustrates the evolution of a real social group in real life.
- Interacting with the network and its evolution helps the patient develop resilience and social skills.
- Patients are expected to draw on the professionals’ skills to develop skills of their own.
- At some point, the professional network shall be dismissed.

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A clinical situation

We would like now to share with the reader a clinical situation in order to illustrate our point. It shall be found in the appendix: *"Start low, go slow, but steadily"*.

Conclusion

Our experience with BPD patients led us to consider that the establishment of an individualised and adapted professional network is essential to addressing the wide range of issues this specific population faces. Beyond clinical content, the most significant impact of a specialised team of multi-disciplinary professionals is the capacity to alter and if possible treat the impact of BPD on patients' vocational and social functioning. The involvement of social workers, for example, may enable patients to access specific reintegration pathways that therapists alone might never have been able to open.

Because of the effect of social and vocational factors on BDP patients' prognosis, we consider that the deployment of an adapted multi-disciplinary professional network is a necessity worth the cost [27]. What is more, intervention late along the patient's trajectory only increases the level of challenge they will have to face alongside their therapists. Thus, we consider that an adapted, early and extensive intervention for BPD patients is a "good enough" investment from a public health point of view.

Creating an appropriate setting of sociotherapy for patients with BPD through the building of an adapted and dynamic multidisciplinary network is a therapeutic field that requires more investigation in order to validate the clinical results we observed. It would be valuable to assess more accurately its impact on patients' trajectories and would allow the definition of recommendations based on the clinical and social features of the patients. From this perspective, it would be interesting to take into consideration the unique position of patients' relatives. At the crossroads between healthcare beneficiaries and those who provide assistance, their capacity to get involved in a beneficial and well thought-out manner, their limits, their needs and their specific interactions with both patients and professional teams should be integrated into further investigation.

Take-home messages

The reader shall find below all the key messages that emerged chronologically throughout the article, section after section. They should help build and then manage a healthcare network for patients with BPD. It is most useful to navigate back and forth from one section to another during therapy to check that nothing important has been overlooked. The case vignette in the appendix of the article uses these take-home messages as milestones to illustrate the therapeutic process.

Investigation

– Define patients' problems and hierarchize them.
– Select adapted and coherent network members and choose a leader.
– Check and update GPM knowledge among network members.

Coordination and communication

– The leader manages the mailing list and ensures periodic meetings (e.g. every 3 months).
– Ensure a good communication among members and between the patient and the team.
– Professionals must be pro-active and share comprehension of the situation.
– Monitor patient and network evolution.

Social and occupational aspects

– Assess patient's ability and motivation to work or to be occupied.
– Shake the belief that one has to get better to get a life. Getting a life helps getting better.
– Include social services in the network to find reinsertion pathways.

The GPM recommended stance

– Patients with BPD have a tendency to develop idealized relationships.
– Offer "a real and professional relationship" and expose professionals' main limit: neither "omnipotent" nor "clairvoyant". It will help patients feel connected and cared for in the end.
– The patient is the main actor of his/her changing and cannot rely exclusively on treaters.
– The network must monitor that every intervention is coherent and that no treater is riding alone.

Clinical reactions

– Assess patients' reactions to the interactions with the team: relief, contradictory dispositions, threat, agressivity, etc.
– Address these reactions and help patients consider their consequences.
– Rely on the *interpersonal hypersensitivity* model to help patients explore and regulate these reactions.
– "Splitting" is a common clinical manifestation among patients with BPD. It is effective to soothe patients from a psychological point of view. However, it is very dysfunctional at the same time.

An adapting tool

– The network illustrates the evolution of real social group in real life.
– Interacting with the network and its evolution helps the patient develop resilience and social skills.
– Patients are expected to draw on the professionals' skills to develop skills of their own.
– At some point, the professional network shall be dismissed.

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Appendix: A clinical illustration

"Start low, go slow, but steadily."

Tom is a 25-year-old patient. He entered the mental health system when he was about 11-year old and has ever been followed since. The patient and his previous therapists described a very demanding and painful life course. Early, his parents got divorced and he experienced neglecting from both of them. Additionally, he suffered of physical violence from his father. Later, difficulties arose at school around the age of 10, both in terms of results and in terms of relational skills with other pupils. Consequently, he was oriented to adapted classes, which enabled him to achieve mandatory school around the age of 17. The accumulation of issues in his life and the growing difficulties of the parents to attend to him led the health professionals to recommend that Tom enter an adapted social and psychiatric home when he was 16 year-old. With time, Tom mobilized more and more professionals until his health care network became unusually wide. He was simultaneously followed by a psychiatrist, a psychotherapist, a psychologist in the context of an association dedicated to teenager facing social difficulties, a legal representative, a few educators, a social assistant, a pediatrician and a GP.

Through time, the team retained the following diagnoses: BPD, social phobia with agoraphobia, PTSD, recurrent major depressive disorder and eating disorder (bulimia nervosa). From a somatic point of view, Tom also presented morbid obesity and chronic obstructive pulmonary disease. The list of diagnoses came along an equally long list of medication made of a combination of neuroleptics, mood stabilizer, antidepressant, anxiolytics and hypnotics. The number of professionals and the lack of assumed leadership made it hard to organize common meetings to define adapted objectives and a clear course of action to assist Tom in this severe situation. As a result, everyone's intervention was scattered. What's more, the professional team frequently had to deal with Tom's suicidal thoughts and self-harm, which led him many times to hospital. Finally, the social homes where Tom was hosted could only accommodate him for a given amount of time. Consequently, a feeling of emergency regarding housing often disturbed the professional team.

In the middle of all this complexity, the patient's situation presented a poor evolution and Tom began to marginalize himself progressively renouncing social life, training and activity opportunities. At the age of 22, during a short hospitalization, it was suggested that Tom should move to our town in order to benefit from a more stable and lasting housing solution. Tom's entry in a new home implied to build a whole new system away from previous treaters and family.

Although it represented a massive change and a crisis for the patient, it seemed to be a perfect therapeutic opportunity.

This is how we met Tom. During our first interview, Tom described himself in a very knowledgeable manner, but kept identifying and limiting himself to diagnoses that had been stated along his treatment. According to him, he was not suffering from any illness. He was an embodiment of illness. The situation appeared quite desperate and we were wondering what could be achieved with so little hope left in this young man.

Investigation

- The patient's issues seem quite obvious: symptoms, housing, social isolation, lack of occupation. However, they have not been hierarchized.
- The professional network is wide but clearly lacks a leader.
- Why so many professionals without clear respective roles?
- There is apparently no attempt to find or use a common way to understand and handle the situation.

Coordination and communication

- The coordination is modest and the network seldom meets because it is too vast.
- The modest level of communication tends to let every treater ride alone.
- There is no common goal to achieve with the patient.
- The patient chooses whom he meets among professionals. Nobody questions these changes.

Social and occupational aspects : There are none.

The GPM recommended stance: Not relevant at this point.

Clinical reactions

- Since there is no clear direction and little coordination, the network mainly deals with emergencies. Somehow, the clinical manifestations are controlling the situation. As a result, the situation seems stuck.

An adapting tool

Because of what was previously noted, the network adaptation process is very modest.

It is as if patient and professionals were dealing with some kind of passivity. People are reacting to emergencies, but neither anticipating nor building.

Given the record of the patient, we quickly felt the need to clarify some aspects. For this reason, we offered Tom a new time of investigation in 10 interviews. We wanted to have a current clinical assessment as a starting point. In addition, we got into contact with all the previous professionals to benefit from their points of view and to understand how they worked as a team. In the meantime, we decided to opt initially for a small-sized network of professionals: the case manager from the psychiatric home, the psychiatrist from our outpatient clinic, the legal representative and the GP. We wanted to set the focus again on the patient and his needs. To do so, we thought that a small group with roles that the patient could identify easily and quickly would be a valuable change. In the past, Tom had indeed learnt how to call upon members of the network in a hectic way. As a result, the professionals often answered in a scattered way. They could not find the time to keep up and think together to a coherent strategy. Tom's behavior had allowed him to maintain a blur around his situation, which impeded his treaters. Somehow, Tom's ability to deal with the lack of communication of professionals and to keep them isolated had strengthened a form of immobili-

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ty by rending most of the interventions unconstructive. This disposition led us to make the hypothesis that Tom could be in a way satisfied by the situation. Even though it was not what he had hoped for he could enjoy the secondary gain of being the one controlling the situation for once. But why?

Our investigation allowed us to confirm the diagnoses of BPD and eating disorder. However, we could not find anymore the necessary criteria for the other past diagnoses. We made the hypothesis that some of them, the social phobia and depression for instance, were in fact clinical manifestations of BPD. The clinical presentation was characterized by interpersonal difficulties with a significant fear of abandonment. We also observed difficulties in emotions regulation with a tendency to aggression (toward himself and others) followed by times of isolation. There were also impulse regulation difficulties mainly made of frequent scarifications, massive pill intakes and massive food intakes at night. He remained asleep most of the day and spent his nights watching series and playing videogames.

Tom felt "totally stuck" and had lost hope that things could change, a feeling that came along a great deal of sadness and anger, which could hardly be expressed. As a result, having a social life seemed odd and useless to him. Logically, he had no vocational perspectives either.

As the reader can see, the first therapeutic step is clarification.

Investigation

- The patient's arrival in a new town solved the housing problem. It used to be a major stress factor. Solving this issue was a fundamental step.
- We understood that the patient felt helpless and desperate despite the seeming control he exerted over the previous network.
- We insisted to know what Tom expected from us. At first, nothing.
- We designed a much smaller network with professionals who agreed to use the GPM model as a common working tool.

Coordination and communication

- We elected the psychiatrist of our outpatient clinic as network leader.
- We established a common mailing list.
- We agreed on weekly appointments with the psychiatric home case manager and twice a month appointment with the psychiatrist. There would also be common meetings with all the network members every two months.
- We informed the patient that we would use the mailing list to share important information even though it remained his responsibility to inform every professionals of his important whereabouts.
- We started sharing hypotheses to explain Tom's situation. Though incomplete, they helped us build a therapeutic strategy.

Social and occupational aspects: Not relevant at this point.

The GPM recommended stance

- We proceeded to a diagnostic clarification and shared our comprehension of the disorder with the patient and the professionals.
- We offered to do the same with the patient's relatives but he initially declined. We respected that considering the little implication of the family in the patient's life at this point. We clearly stated the efforts that were expected from the patient: attend appointments, respect the psychiatric home community rules.
- We gave the patient a glimpse of the stepped care treatment. Soon we would talk about medication, occupation, etc.

Clinical reactions: Not relevant at this point.

An adapting tool

We suggested a six months trail period to define together (patient and professionals) how to best answer his expectations for change and build an adapted network to do so.

Our next therapeutic action was to bring back to life the idea that change was still possible. We decided with the other members of the network that our first task should be to enable Tom to doubt that he was definitely "stuck". To do so, we initially set modest but realistic objectives. In parallel to psychoeducation on BPD and the possible ways of treatment, we questioned the necessity of so many pills and offered Tom to think together about their actual effects. On top of being of little help, we also had in mind that this medication was slowing Tom down from a physical and psychological point of view. It was also most likely increasing the weight and respiratory issues. At the same time, with the assistance of his case manager at the psychiatric home, we suggested the possibility of a basic schedule with a given wake-up time to allow the development of a more suitable sleep/wake cycle. Tom initially shared no expectation regarding the treatment and our suggestions were greeted by a firm "no" and threats of self-harm should we try anything he would not agree with. Rather than looking for who was right, we underlined the fact that without his involvement in the treatment, it would be hard to achieve anything, which would make us

useless to him. As a cure, we suggested to simply "give it a try" for a few days. In order for Tom to feel responsible and involved, we insisted that he should be the one to decide the date at which the experiment would begin. He agreed. It worked. The few-day experiment became weeks. Slowly we increased the level of expectation believing that Tom could achieve much more. With time, he succeeded in waking up regularly at a reasonable hour, which allowed him to take part to occupational activities and workshops within the home where he lived. He also developed a social life with other residents and found a steadier way to be in touch with his family. We seized this opportunity to inform the family about the possibility to attend a group dedicated to patients' relatives. Even though they declined, feeling included in the treatment help them set limits with Tom to preserve the quality of the time they had together.

Slowly, Tom was able to claim more and more autonomy showing less anxiety and being able to do more things on his own. For example, he started doing his errands on his

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own whereas in the past he required constant company for such a task. The stepped decrease of the medication also helped restore a part of the patient's dynamism and self-esteem. Moreover, he appeared more and more involved during the interviews. It allowed the professionals to discover the emotional world of the patient. Tom cared for his treaters and was concerned that we might abandon him should he show how well he could be. At his own rhythm, Tom was unveiling the reasons to resist changing. The real secondary gain of his immobility was to secure lasting relationships with his caregivers even if it meant renouncing to his own social and professional insertion.

The network backstage discussion allowed us to observe Tom's evolution from different points of view and conclude that it was coherent. We also learnt to anticipate stress factors with the patient and to defuse his attempts to isolate some treaters or to keep them in the dark.

During the last network meeting, Tom could say: "When I said that I would feel terrible without my medication, I realize now that I was wrong. Maybe you could be of some help after all". Hastily, he added: "It does not mean you can ask me anything". We succeeded in sewing doubt into Tom's immobility. After six months of treatment he could start representing himself the idea of a coconstruction with his healthcare network in his interest. Most likely, the coherent and realistic approach we chose allowed the patient to feel understood and cared for.

Once we agreed with the patients on basic objectives and a way to work together, we could start talking about change. These first steps are very important because they allow the patient to gain some self-confidence, which will then fuel the motivation for more ambitious steps.

Investigation: Not relevant at this point.

Coordination and communication

- The common meetings were maintained as planned.
- They allowed the patient to understand that we were working together to achieve a common goal.
- Tom also experienced that despite their differences the team members stand united and could overcome disagreement to find a common solution to a given problem.

Social and occupational aspects

- We proceeded progressively so as not to discourage Tom. We first expected an implication in the community activities of the psychiatric home.
- We then agreed to define task outside of the psychiatric home.
- Befriending other residents, allowed Tom to slowly escape his loneliness and become less dependent on caregivers.

The GPM recommended stance

- We kept being active, always offering Tom the possibility to think together about the next step: "You are doing good even when you thought it was impossible. Should we push further?
- We insisted on Tom's accountability for change. "We are here to help you achieve your goals, not to do it for you".
- We developed the idea of integrated care. Medication will not solve everything alone. "You may need medication, but also clinical interviews, strategies to deal with some symptoms, occupations, and a social life". It is a whole.

Clinical reactions

- At first, Tom displayed reaction of threat and hostility in front of our attempts to bring change.
- The interpersonal hypersensitivity allowed us to show Tom that interpersonal stress factors induced most of the clinical reactions. E.g. threat of self-harm in reaction to the feeling of losing control over the situation and the fear of being controlled in turn by caregivers.
- We offered Tom a new eyesight on his emotional reactions. He was used to calm down when he obtained what he wanted. Instead, we helped him develop some insight. It allowed him to calm down by understanding what was happening inside him.
- At first, Tom expected nothing and let all the responsibility rely on the network.Progressively, he could consider the team as a partner.

An adapting tool

- Now that Tom presents a more stable clinical state and is less subject to clinical outburst what shall we do next?
- It was clear that the network had to look for professionals wo could help Tom get involved in more demanding responsibilities outside the psychiatric home.
- Who could be relevant: an ergotherapist, the invalidity insurance, etc.?

This situation illustrates the building of a network and of the therapeutic alliance with a patient with severe symptoms. The realistic objectives made change possible again. The next step is to discuss with Tom the direction of the treatment. We aim now to enable him to use everything he has learnt so far to take part to activities outside of the psychiatric home he lives in. In the end, we would like to offer him the possibility to think about the vocational aspect of his life and see if we could help switch progressively from occupational activities to rehabilitation thanks to a specific training program. We shall have to handle the question of time with care. Indeed, we ought to push the patient forward to open perspectives he would not have foreseen or thought about and prevent as much as possible any relapse in immobility. However, simultaneously, we must be careful to respect his pace and needs.

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