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GPM-AED

General Psychiatric Management for

Adolescent With BPD and *Eating Disorders*

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MEDICINA USP

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Disclosures

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General Psychiatric Management for Adolescents With Borderline Personality Disorder and Eating Disorders

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Borderline personality disorder and eating disorders frequently co-occur among youths. These disorders emerge in adolescence, during the critical developmental period of building an independent sense of self and the capacity to relate to one's community. Because of core differences in the development and psychopathology of borderline personality disorder and eating disorders, adjustments are required when treating these disorders when they co-occur. Few established treatment approaches can address these disorders simultaneously. Evidence-based psychotherapies for borderline personality disorder, such as dialectical behavior therapy and mentalization-based treatment, have been adapted to accommodate the shared vulnerabilities and features of the two disorders. However, these approaches are specialized, intensive, and lengthy and are therefore poorly suited to implementation in general psychiatric or primary health care, where most frontline mental health care is provided. Generalist approaches can fill this public health gap, guiding nonspecialists in structuring informed clinical management for these impairing and sometimes fatal disorders. In this overview, the authors describe the adjustment of good (or general) psychiatric management (GPM) for adolescents with borderline personality disorder to incorporate the prevailing best practices for eating disorder treatment. The adjusted treatment relies on interventions most clinicians already use (diagnostic disclosure, psychoeducation, focusing on life outside treatment, managing patients' self-destructive behaviors, and conservative psychopharmacology with active management of comorbid conditions). Limitations of the adjusted treatment, as well as guidelines for referring patients to specialized and general medical treatments and for returning them to primary generalist psychiatric care, are discussed.

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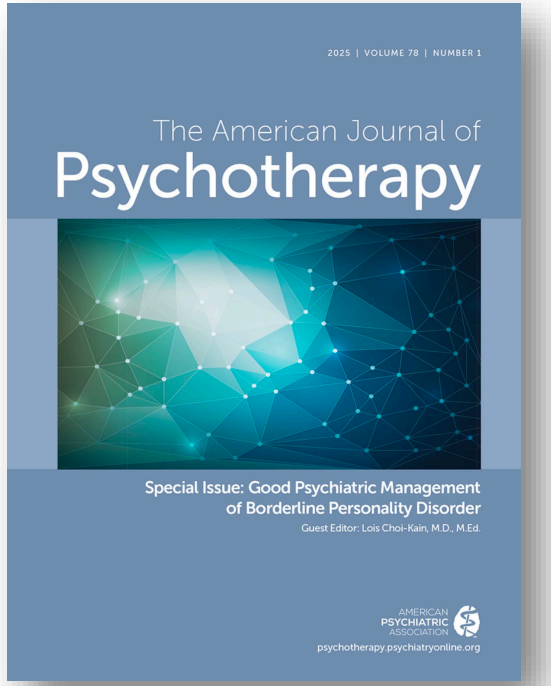


BPD and eating disorders emerge in adolescence

95%

of ED cases onset in

YOUTH

Ward, 2019

The same developmental window:

- Peak age of onset for most mental disorder is mid-adolescence (Solmi, 2022)
- BPD symptoms peak in mid-adolescence (Cohen, 2005)
- Adolescence = acquisition of self-regulation + identity formation
- Strategic window for early detection and intervention

Solmi, 2022 · Ward, 2019 · Cohen, 2005 · Dahl, 2018

Prevalence in adolescents

Co-occurrence is common, not the exception

BPD in adolescents

Prevalence across settings

Community samples	**1.4–3%**
Outpatient clinics	**11%**
Inpatient	**50–53%**

EDs in community (adolescents)

AN	**0.3–0.4%**
BN	**0.3–0.9%**
BED	**0.62–3.6%**
Subthreshold ED	**5–11%**

EDs in BPD

Comorbidity rates

Adults	**17%**
Adolescents	**31–52%**

BPD in ED subtypes

AN (restricting)	**5.5–7.9%**
BN / AN binge-purge	**borderline features**

Restricting type → perfectionistic, avoidant traits
Binge/purge presentations → more BPD features

Clinicians must actively screen teens with BPD for ED.

Zanarini 2021 · Kaess 2013 · Jaite 2013 · Cassin 2005 · Lindvall Dahlgren 2017 · Laczkovics 2023 · Lekgabe 2021 · Gaudio 2011

Shared developmental pathways

Not just co-occurrence — bidirectional longitudinal prediction

BPD symptoms at age 11 (late childhood)

predicts

Binge eating and purging by adolescence at age 16

Brown et al., 2019 · 'high-risk' BPD: 2–4× more likely to engage in binge/purge by 16

High disordered eating in early adolescence

predicts

Later BPD features later in adolescence

Lee & Vaillancourt, 2024

Shared risk factors: *insecure attachment, adverse childhood experiences, emotional instability, impulsivity, rejection sensitivity.*

Brown, 2020 · Lee & Vaillancourt, 2024 · De Poli, 2020

Similar presentations — one main critical difference

Why BPD treatment can be suboptimal

SHARED FEATURES

- Emerge in adolescence; disrupted identity formation
- Emotional instability, rejection sensitivity
- Impulsivity and self-destructive behaviors
- Insecure attachment and ACEs as shared risk factors
- Suicidality and elevated premature mortality
- Recurrent, chronic course if untreated

KEY DIFFERENCES IN CORE PSYCHOPATHOLOGY

BPD

Interpersonal hypersensitivity
→ symptoms activate in stressed relational contexts

EDs

Overvaluation of weight, body shape, eating behavior
→ self-worth organized around bodily control

→ Effective generalist treatment must target BOTH.

Treasure, 2020 · De Poli, 2020 · Fairburn, 2008

Why adapt GPM-A for BPD + eating disorders?

A generalist approach when specialists are scarce

ACCESS

Specialists for both disorders are scarce

Comorbidity is common; generalist care must reach both.

EARLY INTERVENTION

Adolescence = best window to start the treatment

Outcomes are better when we treat before chronicity sets in.

SPECIFICITY

BPD treatment alone misses ED psychopathology

We add ED-specific interventions to existing GPM-A.

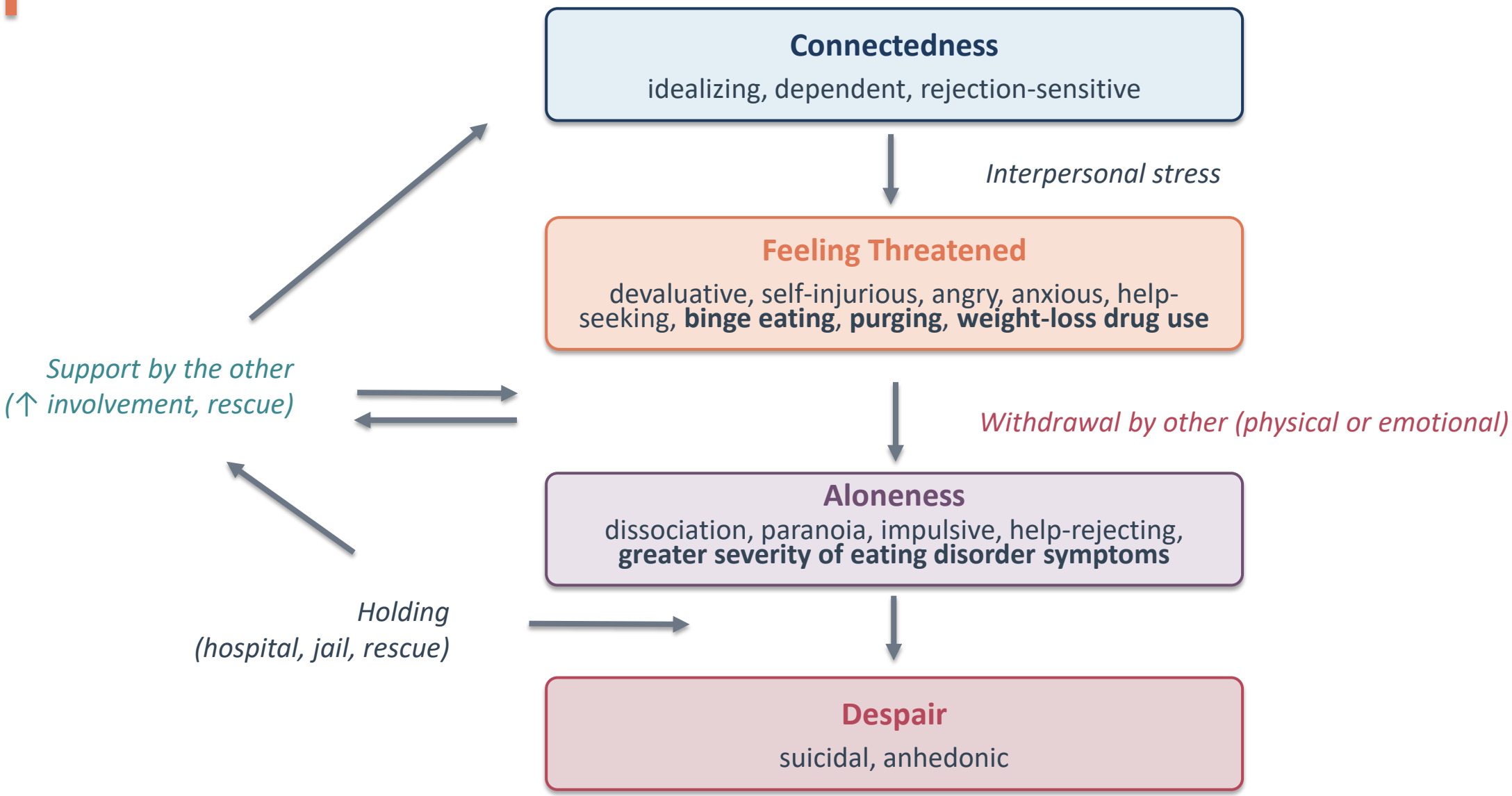
STEPPED-CARE

Specialized care for non-responders

Step up for severe or treatment-resistant cases.

Generalist-first, specialist-when-needed — same logic as GPM-A.

*Inter*personal Hypersensitivity Model — with ED symptoms



Adapted from Gunderson & Links, 2014

*Intra*personal Hypersensitivity — the ED-specific process

Triggers: interpersonal (social evaluation) • intrapersonal (internal cues, perfectionism) • guilt/shame from eating behaviors

VULNERABLE SELF
Sensitive to social evaluation specific to eating, body shape, or weight; vague discomfort

SELF-DISTURBANCE
Feeling fat and other negative self-evaluations; poor self-regulation; impulsivity

WITHDRAWAL
Dissociation; social isolation; self-absorption; severe eating control strategies

DESPAIR
Suicidality; extreme control strategies; malnutrition

Habits

Compensatory behaviors in eating disorders (e.g., restricting, purging)

Interpersonal (social evaluation) or intrapersonal (internal cues, perfectionism) stressors or guilt or shame caused by eating disorders

This loop can be triggered WITHOUT an interpersonal stressor — by hunger, a broken food rule, or emotional distress.

Self-standards; perfectionism

GPM-A principles and structure — adapted for eating disorders

GPM-A principle	ED adaptation
Interpersonal hypersensitivity model	Integrate with eating-disorder model
Psychoeducation	Add ED knowledge — for patient AND family
Active, non-reactive stance	Actively search for ED behaviors and triggers
Pragmatic and flexible formulation	Include ED symptoms in the case formulation
Getting a life	Life > body over-evaluation
Safety management	Add evaluation of ED physical-health risks
Eclectic interventions	Include ED-specific adaptations
Coordinated split-treatment	Dietitian, FBT, ED specialist when needed

Eight add-on interventions

INTERVENTION	DESCRIPTION
Eating regularly	Sit down for meals and snacks at regular intervals (e.g., 3 meals + 2–3 snacks/day)
Psychoeducation on EDs	Weight fluctuation, limited control overweight (strong genetic influence), medical complications
Eating styles	Reduce anxiety around weighing oneself too frequently or avoiding the body; optional when patient is not underweight
“Feeling fat” / “Feeling full”	Work with the patient toward accepting emotions, the body, and physical sensations
Family interventions	Psychoeducation on the ED, structured regular eating, avoiding unhelpful comments
Collaborative weighing	Reduce anxiety around weighing; optional when patient is not underweight
Body checking & avoidance	Identify and monitor ED behaviors; engage patient in critical appraisal to promote change
Safety management	Evaluate suicidality and physical complications of EDs

Table 1, Croci, Brañas et al., Am J Psychother 2025

Dual Focus: Assessment and Safety Management

Two parallel tracks: psychiatric and physical

INITIAL ASSESSMENT · OUTCOMES

Actively investigate eating behaviors
weight cycles, excessive exercising, compensatory behaviors, dietary rules, body checking — ask early and routinely.

SCOFF *— quick 5-question screen (≥2 "yes" = suspect ED)*
Sick · **C**ontrol · **O**ne stone · **F**at · **F**ood

EDE-Q
Eating Disorder Examination Questionnaire — use at baseline and follow-up as a shared outcome measure.

SAFETY MANAGEMENT

When
at initial evaluation · signs of malnourishment/weight loss · binge / purge behaviors

What
physical exam · weight & height · vitals · labs · EKG

Red flags
underweight or rapid weight loss · purging with medication misuse · vital signs· delayed pubertal development · obesity or rapid weight gain

Severe cases → ***refer to specialist***

Engagement and Interventions for Initial Sessions

Four components of the opening phase — motivation is where the work is

1

Rapport Building

Support and validation. A non-judgmental stance toward eating and bodily shame.

2

Building Motivation

Motivational-interview style questions that elicit the patient's own reasons to change.

3

Psychoeducation

Explain ED + BPD in plain language. Use a 'no blame' etiology frame — for patient and family.

4

Case Formulation

Preliminary, collaborative map of triggers, emotions, and behaviors — built in session with the patient.

Motivational questions · *examples*

01 What does binging do for you?

Open the patient's own account of function — regulation, escape, comfort.

02 How does it affect your relationships?

Link eating behavior to interpersonal life — the shared terrain of BPD + ED.

03 What role do emotions play around binging?

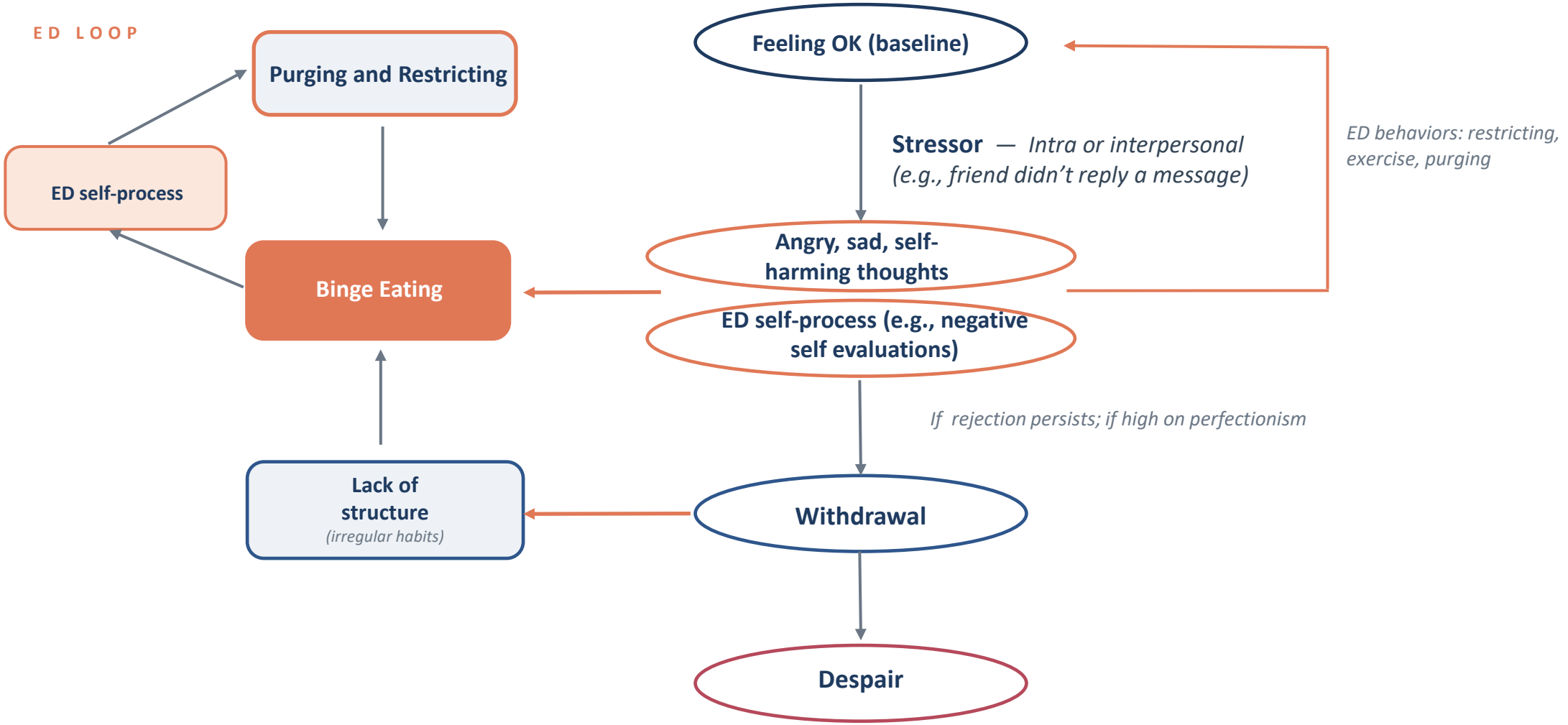
Frame eating as a way of not-feeling — opens space for affective work.

04 What kind of life do you want — and how does binging fit into that?

Bridges to 'getting a life' — the GPM core that anchors long-term change.

Preliminary Collaborative Formulation

Maria, 13 years old



In session: regular eating and coping with binge/purge

The most impactful intervention + what to do when it breaks down

REGULAR EATING — most impactful

3 meals + 2–3 snacks / day

planned intervals · seated at a table

- Patient owns their eating habits when possible
- Parental support when severity requires it
- Avoid grazing, multitasking, fast eating, between-meal eating
- Expose to varied foods and settings
- Dietitian support when available

Dalle Grave & Calugi, 2020

COPING WITH BINGE / PURGE

Binge analysis (chain analysis)

Map triggers: what happened before? feelings? thoughts? relational context?

Skills for mood lability

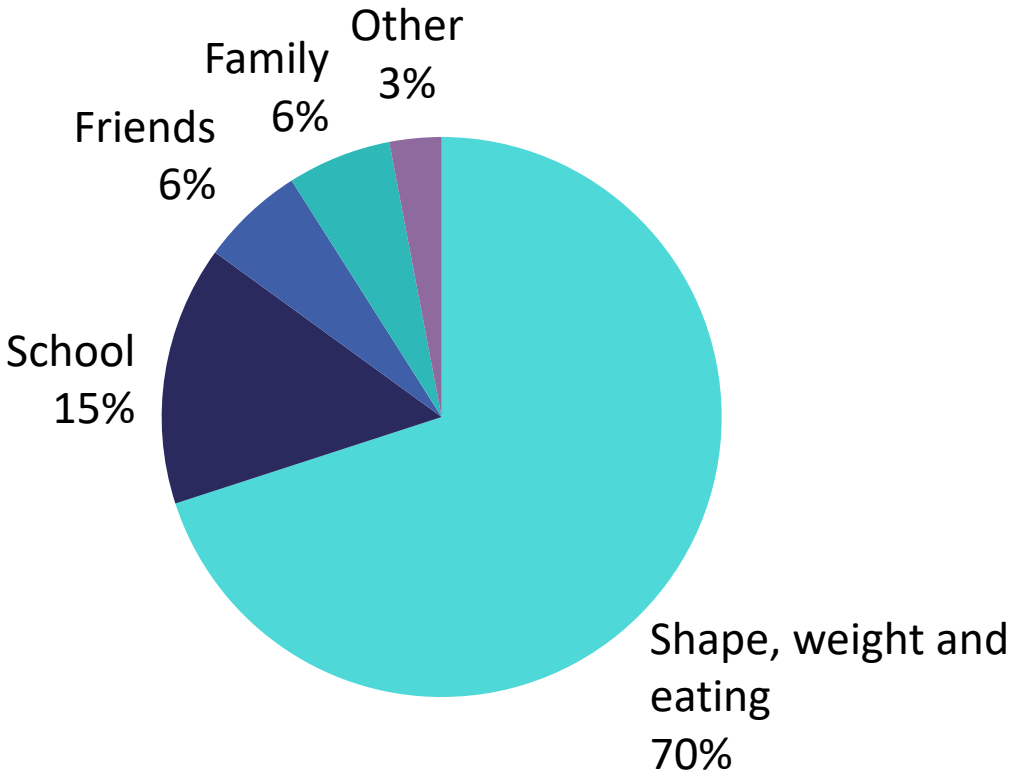
Counting breaths, grounding, calling a friend, short walk — emotions are temporary.

Environmental structure

Post-meal plans, avoid the bathroom after meals, eat with family when possible.

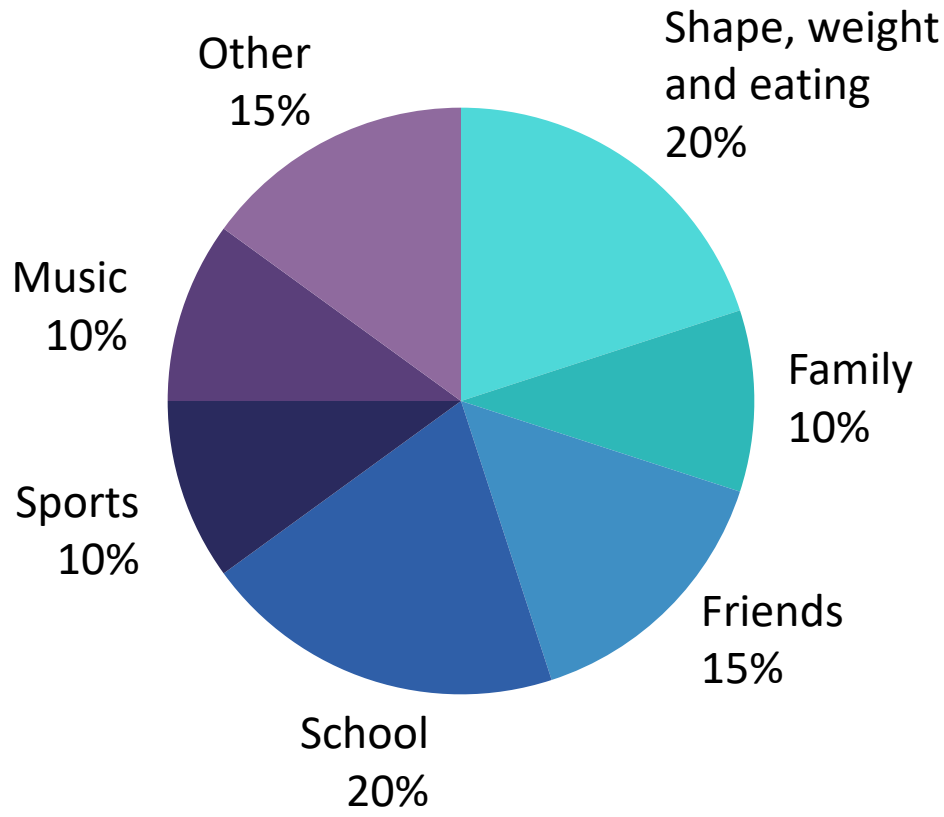
Safer et al., 2017 · Robinson et al., 2019

Getting a Life: Addressing Weight Over-Evaluation



Patient with eating disorder

Short-term goals
Case management
Foster identity separate from ED



Patient after treatment

Adapted from Fairburn, 2008 · Dalle Grave & Calugi, 2020

Involving the family

Allies — not therapists, not adversaries

PSYCHOEDUCATION	SUPPORT STRUCTURED EATING	ADDRESS BARRIERS
Etiology is complex — 'no blame'	**Help, don't battle**	**Evaluate what's blocking recovery**
Family response influences improvement. The ED causes the symptoms — not bad parenting.	Structure meal times, focus on problems pragmatically, avoid power struggles around food.	Comments on eating/body ('fat talk'), parents' own eating habits, expressed emotion/criticism.

The clinician guides the structure. Families carry out day-to-day support.

Comorbidity and conservative psychopharmacology

Medication is adjunctive, not primary

PRIORITY ASSESSMENT

Does the comorbidity block engagement in GPM?

If yes: severe SUD, mania, complex PTSD, severe ADHD — manage first.
If no: proceed with GPM-AED; many depression/anxiety symptoms improve after ED treatment.

RULE OF THUMB

Borderline symptoms predict persistence of depression, but the converse is not true — treat BPD to help depression.

BE CAREFUL WITH

Stimulants	Appetite suppression → worsens restriction
Bupropion	Seizure risk in EDs → avoid
Atypical APs	Weight gain → discuss openly if needed
SSRIs	Ineffective in malnourished patients; helpful for persistent depression/anxiety/OCD

Take-home

01	**Adolescent window**	BPD and EDs both emerge in adolescence — the critical period for self and identity.
02	**Different cores**	Interpersonal hypersensitivity (BPD) vs. weight/shape over-evaluation (ED). Treat BOTH.
03	**GPM-AED**	A generalist framework for mild–moderate ED + BPD — usable when specialists aren't.
04	**Safety first**	Low BMI, rapid weight loss, purging + medication misuse, delayed puberty, severe malnutrition → refer early.
05	**Stepped care**	Specialized treatment reserved for non-responders and severe cases — clear referral pathways.

Tack!

Thank you!

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