

GPM-A

General Psychiatric Management for

Adolescents With BPD — *Brazilian Implementation*

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Disclosures

Financial conflicts of interest

Marcos S. Croci, MD

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Marcelo Brañas, MD, PhD

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Why?

The scale of the problem in Brazil

A population-level demand that specialist care cannot meet

Demand

- **6.8% any PD** in São Paulo (*Santana et al., 2018*)
- **1.8% BPD** in São Paulo and Porto Alegre (*BHRC**)
- **20–30%** of outpatient mental-health attendees ·
35–40% in *CAPS* (specialized community mental health centers)
- **17.4% adolescent NSSI rate** (*Angelo, Pan, Miguel, Brañas & Croci, 2026, in submission*)

Supply

- **6.39 psychiatrists per 100,000** — OECD average
17.83 (*Scheffer et al., 2025*)
- **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.*

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

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

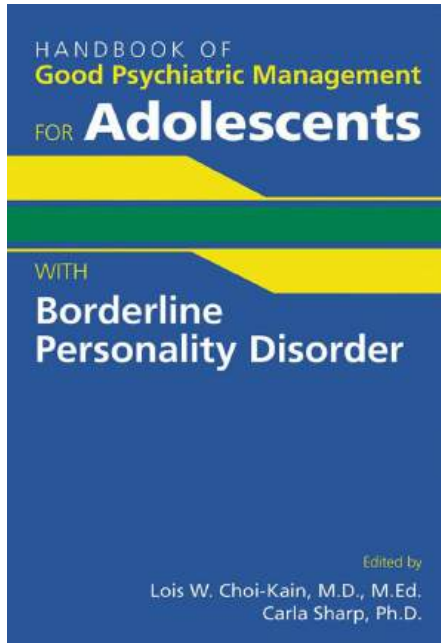
Institutional myths

- ✗ *“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.

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.)

Lois W. Choi-Kain
Carla Sharp
(Eds.)

**Manual do bom
manejo clínico para
adolescentes (GPM-A)
com transtorno de
personalidade
borderline**

 hogrefe

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

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



The ADRE program

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

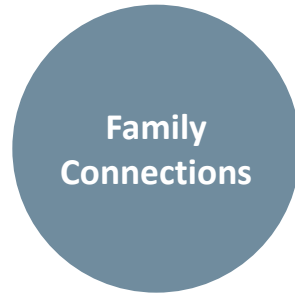
ADRE — Dual mission

Clinical care for moderate/severe cases + residency training for the next generation



Interventions and structure

Core program + stepped-care add-ons when needed



group
12 sessions



weekly
6–12 months



group · psychoeducation
adjunctive

+ if needed, stepped-care model · Choi-Kain et al., 2016



if needed
6 months



if needed
as indicated

ADRE pathway — referral, screening, treatment

Adolescents 13–17 y/o enter through a structured 6–12 month program

1 By Referral

- Secondary public psychiatric services in São Paulo
- Other clinics at the Psychiatry Institute at USP
- Children's & Adolescents' Institute at USP

2 Initial Screening

- Psychiatric Interview and Zanarini's Childhood Interview for BPD (CI-BPD)
- Inclusion / exclusion criteria
 - inclusion: ≥ 5 BPD criteria, or ≥ 3 + self-harm
 - exclusion examples: severe ED, severe SUD

3 Treatment

- Weekly GPM-A sessions
- 6–12 months duration
- Stepped-care add-ons when indicated

Zanarini et al., 2003 — Childhood Interview for DSM-IV Borderline Personality Disorder

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)

Teaching the GPM model

Spreading the model across clinicians, residents, and trainees

Introductory lectures

- **All PGY-1 and PGY-2 residents** attend
- **Foundations** of personality disorders
- Introduction to the **GPM approach**

Annual workshop

- **Held annually** in Portuguese
- **Mandatory** for clinicians joining ADRE
- Open to **Brazilian clinicians and residents**

ADRE supervision

- **Weekly supervision** at ADRE
- **Hands-on application** of GPM in real cases
- **Continuous calibration** with the multidisciplinary team

Weekly supervision

How the team stays calibrated and residents stay supported

Case discussion

- **Weekly supervision**
- **GPM fidelity** — drift from GPM-A principles flagged and corrected early.

Reducing resident anxiety

- **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.

Supervisor sees the patient

- **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

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.

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.*

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.

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.

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

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

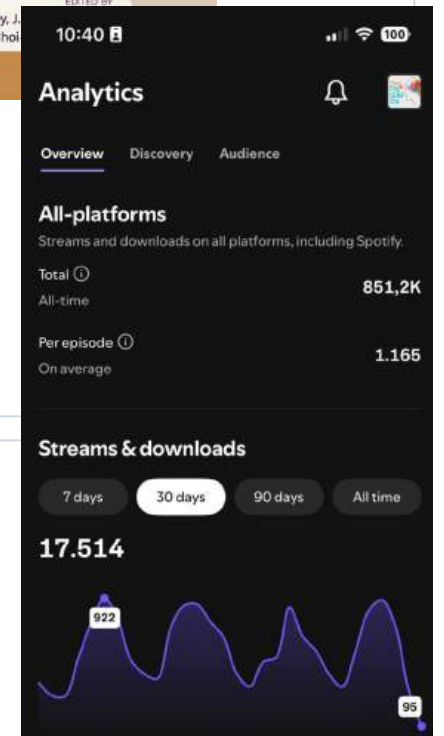
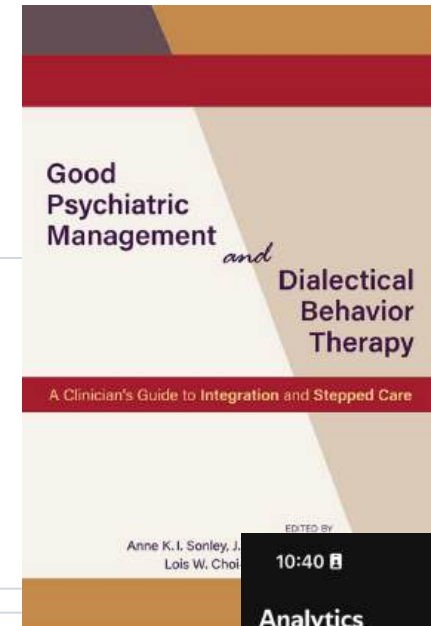
- **GPM and GPM-A Manuals** translated to Portuguese
- **Harvard Medical School** online course
- **GPM+DBT** book translation in final stages

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

Belém, Brazil



**Yasmin
Nascimento, MD**



Silvana Costa, MD

FAMERP → GPM

São José do Rio Preto, Brazil



Larissa Fares, MD



Bruno Soleman, MD

Périgueux → GPM-A

Centre Hospitalier Périgueux, France



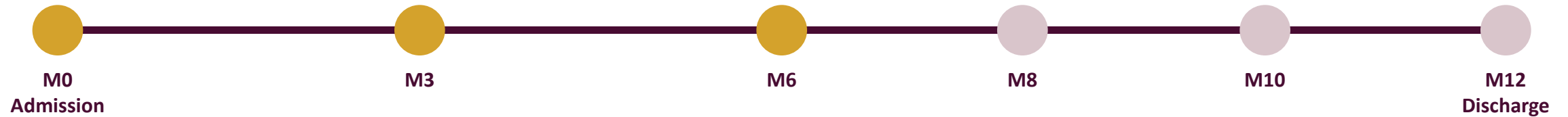
Vinicius Freitas, MD

Next frontier: leadership-level work — hospital directors, residency coordinators, and the health ministry.

BPD Awareness Day: ongoing project in the Brazilian Senate.

Research protocol — assessment timeline

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



Weekly · Monthly (M1–M9) · Quarterly checkpoints (M3, M6, M8) · Full battery at M0 & M10

Diagnoses and personality functioning

CI-BPD · LPFS-BF 2.0

Repeated assessment

BSL-23 Main & Supplement (monthly) · BPFS-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

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.

Tack!

Thank you!

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*GPM for Latin America
paper*

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