Case presentation

Kim Siscoe, MD
Eating Recovery Center
Denver CO, USA

- **Transitional age patients from an eating disorder facility with inpatient, residential and partial hospital program level of care.**
- **All patients provided consent to have their information shared today.**
- **No disclosures**

Patient: Katie

- 20 year old college student with Anorexia Nervosa, Restricting type, onset in late adolescence.
- Severe self harm by head banging, scratching skin, cutting
- Frequent suicidal ideation
- Excessive pacing on the unit
  - 37km per day.
- Rejects the BPD diagnosis throughout the hospitalization.

Challenges

- Self harm triggers
  - meal completion
  - compliment
  - comments made by peers
- Staff felt punished by her-self harm
  - “you didn’t self harm for my entire shift! Great job!” - this would lead to immediate self harm.
- Conflict in groups, peer frustration
  - Peers triggered by self harm and pacing

GPM interventions and principles

- Chain analysis
  - How staff and peer interactions led to self harm
  - Chain analyses completed before and after meals, to explore how completing or restricting a meal affected her internal states.
- Through chain analyses, we were able to discover her key vulnerabilities that led to self harm and eating disorder behaviors:
  - feeling misunderstood
  - negative self image worsened by praise
  - feeling unworthy or deceitful if other’s compliment her.

Chain Analysis: Pacing

- **Clinician:** Every time I walk down this hallway you seem to be pacing. What's happening?
- **Katie:** I just have to pace. I have to burn calories, I need to move and it's what allows me to eat at least something.
- **Clinician:** So it helps to regulate emotions and helps to feel safe to eat a bit, that must make it so hard to stop. I heard some of your peers made comments about the pacing?
- **Katie:** Yeah, they said it was triggering them.
- **Clinician:** That seems like it would be upsetting. What went through your mind when that was said?
- **Katie:** I felt like they were mad at me, like I was doing something wrong but I'm just honestly trying to get by.
- **Clinician:** What emotions came up? Can you remember?
- **Katie:** I felt criticized and rejected. I felt nervous and hopeless. I got so frustrated and I thought about cutting again and it just made me want to pace more.

Chain Analysis: Pacing

- Clinician: You were trying to cope with a lot of strong feelings, and self harm and more pacing felt like a way to manage that. Let's think together about other ways to cope next time. It might not feel as effective at first but try, and give it time.
  - Taking a walk in a less crowded area on the unit if pacing is a must.
  - Checking in with staff when things feel overwhelming.
  - Can we think of how to respond to upset peers ahead of time?
- Patient: I guess I could try. I don't think people know that sometimes it's either pace or self harm you know? So, I choose to pace.
- Clinician: It's valid to want to cope with intense feelings but, we should make sure that you, and others, are safe and comfortable throughout all this. We're just adding more tools to be able to handle it more safely.

GPM interventions and Principles

- Normalize peer confrontations in the clinical setting.
  - “No one here is at their best right now”
  - They are trying to get by too.
  - Some peers may be speaking up out of concerns for you
  - It may be easier for others to focus on someone else’s behaviors instead of their own.

GPM interventions and Principles

- Collaborative problem solving:
  - Planned for peers to be triggered and what to say to them.
  - What can be done to cope instead of self harming and restricting the meal plan?
  - Pacing tapering schedule
  - Sitting during any phone calls to reduce pacing
  - Going to groups!
  - Team validating moments of success without complimenting.
    - “I know that moment was hard to get through, and whatever you did seemed to be useful”.

GPM interventions and Principles

- Reframe staff compliments/encouraged agency:
  - She was able to tell staff how she wanted her successes to be acknowledged.
    - Normal for staff to want to point out positive changes in behaviors.
- Normalized rest and eating socially
  - Discussed what this could look like for her.
- Explore guilt, shame, perfectionism:
  - Never being allowed to rest is not a life worth living.
  - What does a normal day look like for someone else.

GPM interventions and Principles

- Goal setting:
  - Reduce pacing
  - Increase meal plan
  - Prepare for return to school/meal preparation
  - Tracking self harm/triggers/coping skills

- Staff Psychoeducation:
  - About the effect of compliments on patients with BPD – that it can feel invalidating or minimizing of the hard work they are doing

- Validated distress while encouraging more safe and appropriate coping strategies
- Worked through how to manage confrontation with peers
- Chain analyses assisted in discovering triggers and emotions associated with problematic behaviors
- Able to use GPM principles despite BPD diagnosis being rejected
- Staff education about BPD to support patients
- She was able to complete her meal plan, get to target weight, stop self harming and limit pacing

Patient: Brittany

- 21 year old female with OSFED and severe restriction prior to admission.
- Lives at home with parents
- Has friends but never in a romantic relationship
- Just started a job in the last year as administrative assistant
- Good completion for 10 days
- Stopped eating and needed acute food refusal protocol

Challenges

- Polarizing with staff, peers expressing frustration
  - “Attention seeking”
  - Takes up a lot of staff time for seeking reassurance.
  - Very interpersonally hypersensitive, feeling that ”everyone hates me”.
  - Bullying as a child and as an adult, including at work.
  - Severe self harm episodes
    - Severe scratching, infected wounds

Challenges

- Wheelchair dependence, without medical justification after a syncopal episode.
  - Nurse provided her a wheelchair.
  - She refused to get out of the chair afterwards even when her meal plan completion improved.
- Feels disbelieved by all, staff and peers alike
  - "People think I am faking everything, but I use the wheelchair because I am scared to fall".
- Avoiding group therapy due to fear of criticism from peers

GPM interventions and principles

- Diagnostic disclosure
  - Depersonalization of symptoms
- Psychoeducation about BPD
- Encouraged autonomy and doing what she could to promote better outcomes for herself.
  - Completing meal plan, drinking fluids, adequate sleep.

GPM interventions and principles

- Chain analyses
  - Discovered how dizziness and excessive use of wheelchair are linked to fears of being invalidated, unwelcome, not belonging. (Paradoxically this is why peers rejected her)
- Explored staff/peer perspectives
  - “How might staff perceive my actions".

GPM interventions and principles

- Gradually lessening use of wheelchair
- Slowly improving oral intake
- Focus on life outside of treatment
  - Taking care of leave paperwork
  - Applying for other jobs
  - Reaching out to old church group she stopped attending.
- Progress led to improved peer relationships, increased agency, more self confidence.
  - More attendance to groups and group participation.

Chain analysis example: Wheelchair

- Brittany: Everyone hates me. They think I am faking it because I am using a wheelchair. I’m just scared to fall because I feel dizzy all the time.
- Clinician: Why do you think they are so frustrated with all of this?
- Brittany: I don’t know! They are just mean!
- Clinician: So, someone actually said this to you? That you are faking it?
- Brittany: Someone in group said there are too many people using wheelchairs and overly relying on them. It’s me and one other person in a wheelchair so it’s obviously an attack towards me.
- Clinician: What was it like to hear that? It obviously affected you.

Chain analysis example

- Brittany: It’s happened to me my whole life, no one ever believes me about anything I am going through.
- Clinician: That’s so tough to feel like you are never believed! I wonder why this happens or why the wheelchair upsets them so much?
- Brittany: I mean, I guess everyone here is dizzy, everyone feels poorly physically. The last time I had a fall was kind of a long time ago. I guess everyone is trying hard and the wheelchair makes it look like I am not.
- Clinician: I know you feel scared to fall again, which makes this more difficult, but it would be great to rely less on the wheelchair and more on yourself. Any ideas of what we could work on together to help this? It doesn’t seem practical to stay in the wheelchair long term.

Chain analysis example

- Brittany: I can't really go back to work in the chair. I guess I can try to drink more water, like everyone keeps telling me to do. It might help to feel less dizzy and more confident out of the chair.
- Clinician: Water is a great start. Let's increase the goals for your meal plan completion too. I know it's scary, but nutrition can't hurt here.

Summary and Takeaways

- Validated symptoms without reinforcing the disabled identity
- Reframing symptoms and patterns of behavior as BPD symptoms helped to depersonalize these experiences
- Chain analyses – it became a coping skill for this patient, and she was able to do this on her own by journaling
- Focus on agency
- Focused on life outside of treatment – new job, friends.

When eating disorder meets personality disorder:

The Highlights

- This population has problems related to Interpersonal hypersensitivity, AND incoherent sense of self
  - Threat to feeling acceptable socially and physically.
  - Self identity is concretely organized by way of weight/shape overvaluation.
    - "I can only be loved, happy, valued if I am thin"
    - Dysfunctional attempt to regulate the self by way of eating disorder behaviors.
- Eating disorder behaviors are triggered by things other than interpersonal stressors, like breaking a food rule and what that means about them.

When eating disorder meets personality disorder:

The Highlights

- For both:
  - Still use diagnostic disclosure
  - Psychoeducation for BPD and eating disorder
  - Multimodal treatment – dietician!
  - Chain analyses
  - Case management
  - Sharing case formulation with the patient
  - Convey that change is expected
  - Focus on life outside of treatment and life outside of eating disorder.

When eating disorder meets personality disorder:

The Highlights

- Family may need additional psychoeducation about eating disorders.
  - Avoid diet culture topics
  - Encouraging eating regularly and variety.
- Some add on interventions for eating disorders:
  - Collaborative weighing
  - Addressing body checking
  - Talking about ED behaviors and the purpose they serve
  - Normalizing things like weight fluctuation, bloating, other body sensations.

When eating disorder meets personality disorder:

The Highlights

- Malnourishment affects neurocognitive function rendering therapy and medications ineffective.
  - Medical intervention needed first. GPM later!

- GPM-AED is a flexible approach that addresses both disorders and their interaction while focusing on safety, promoting functionality and agency.

References

- Croci, M. S., Brañas, M. J. A. A., & Javaras, K. N. (2025). General psychiatric management for adolescents with borderline personality disorder and eating disorders. *American Journal of Psychotherapy, 78*(1). https://doi.org/10.1176/appi.psychotherapy.20230045
- Gunderson, J. G., Stout, R. L., McGlashan, T. H., Shea, M. T., Morey, L. C., Grilo, C. M., Zanarini, M. C., Yen, S., Markowitz, J. C., Sanislow, C., Ansell, E., Pinto, A., & Skodol, A. E. (2011). Ten-year course of borderline personality disorder: Psychopathology and function from the Collaborative Longitudinal Personality Disorders study. *JAMA Psychiatry, 68*(8), 827–837. https://doi.org/10.1001/archgenpsychiatry.2011.37
- McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., & Streiner, D. L. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166*(12), 1365–1374. https://doi.org/10.1176/appi.ajp.2009.09010039
- Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2010). Time to attainment of recovery from borderline personality disorder and stability of recovery: A 10-year prospective follow-up study. *American Journal of Psychiatry, 167*(6), 663–667. https://doi.org/10.1176/appi.ajp.2009.09081130
- Gunderson, J. G., & Links, P. S. (Eds.). (2024). *Handbook of good psychiatric management for borderline personality disorder*. American Psychiatric Association Publishing. https://doi.org/10.1176/appi.books.9781615378432

Thank you!