2nd International Conference on Good Psychiatric Management (GPM) for Personality Disorders

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# GOOD PSYCHIATRIC MANAGEMENT (GPM) FOR ADHD

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# DISCLOSURE

No conflicts of interest to declare.

CALL TO ACTION

# Bringing ADHD into the fold of Generalist Care

*Beyond specialized care and beyond medication only approaches: a whole-person generalist framework*

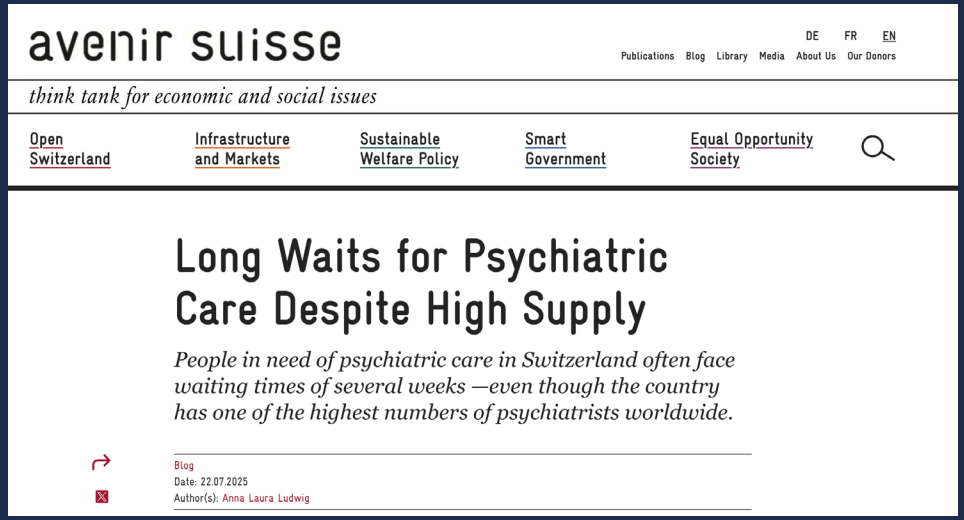
## WHY GENERALIST CARE?

The Swiss reality

| | |
|---|---|
| **41 days** | average wait for adult psychiatric consultation |
| **56 days** | average wait for child/adolescent psychiatry |
| **1,000+** | of 4,750 psychiatrists are aged >65 : retirement wave |

**Specialized ADHD services are scarce.**

**Patients wait months, then often receive medication alone without psychotherapy or relational support.**



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### Long Waits for Psychiatric Care Despite High Supply

*People in need of psychiatric care in Switzerland often face waiting times of several weeks —even though the country has one of the highest numbers of psychiatrists worldwide.*

Blog
Date: 22.07.2025
Author(s): Anna Laura Ludwig

*Avenir Suisse (2024); FSP survey (2024)*

THE PROBLEM

# BPD and ADHD: Why This Topic?

PREVALENCE

## 30–60%

of BPD patients meet criteria for ADHD; 14% of ADHD adolescents receive BPD diagnosis

*Ditrich et al., 2021; Weiner et al., 2019*

DIAGNOSTIC OVERLAP

## High

Emotional dysregulation, impulsivity & identity instability overlap
→ risk of mislabeling

*Matthies & Philipsen, 2014*

WORSE OUTCOMES

More severe impulsivity, aggression, substance use, suicidality when comorbid

*Akça et al., 2020; Weiner et al., 2019*

TREATMENT GAP

## 0

No integrated treatment guideline exists for BPD+ADHD
→ GPM as a candidate framework

# BPD & ADHD: SHARED NEUROBIOLOGY

**×19** ADHD increases odds of BPD

**×2.8** BPD risk in first-degree relatives

**Shared** Heritability in twin studies

## SHARED CANDIDATE GENES

SLC6A3 · DRD4 · 5-HTTLPR · COMT

Dopaminergic → impulse control, reward

Serotonergic → emotional regulation

*Amad et al. (2014); Ditrich et al. (2021)*

EARLY INTERVENTION

# Early Identification & Personality-Targeted Prevention

## EARLIER ADHD DIAGNOSIS → BETTER OUTCOMES

Finnish national birth registry study. N = 15,961 individuals (12,208 males, 3,753 females) born 1990–1999, diagnosed with ADHD between ages 4 and 20.

**Males**

**GPA* 7.12 → 6.52**

GPA at age 16 decreased with each advancing age of diagnosis (dx at 4 vs dx at 16)

**Females**

**GPA 7.64 → 6.59**

Similar pattern, with steepest decline between ages 6 and 12 at diagnosis

**Education**

**↑ Upper secondary**

Earlier diagnosis linked to higher rates of upper secondary education and lower school dropout

* Grade Point Average

*Volotinen L et al. (2026), JAMA Psychiatry*

## PERSONALITY-TARGETED PREVENTION (PreVenture)

Co-Venture trial. Cluster RCT, 31 schools, Montreal. N = 1,669 high-risk 7th graders (44% of screened). Two 90-min personality-matched group CBT sessions.

**4 personality risk traits targeted:**

*Impulsivity · Sensation seeking · Anxiety sensitivity · Hopelessness*

**5-year results**

**35%** reduction in annual SUD growth

OR = 0.655 (95% CI: 0.462–0.919)
At year 5: 87% reduced odds of SUD (OR = 0.131)
NNT = 52 to prevent one SUD case

*Conrod PJ et al. (2025), Am J Psychiatry, 182(5):473–482*

**Implication for GPM-ADHD: Early identification of ADHD + personality-targeted interventions may prevent both SUD and BPD development**

PATHWAYS

# Developmental Pathways & Pharmacological Perspectives

## DEVELOPMENTAL PATHWAY: ADHD → BPD

- ADHD in childhood creates a cascade of failures, rejection experiences, and shame that may prime borderline personality development.
- Executive dysfunction disrupts stable identity and relational patterns.

*Philipsen A (2006), Psychother Psychosom Med Psychol*

## COMBINED TREATMENTS: PSYCHO + PHARMA

- A combined approach integrating psychotherapy with pharmacotherapy appears most promising.
- Treatment of the neurodevelopmental layer (ADHD) may be a prerequisite for effective personality-focused psychotherapy.

*Storebø OJ & Simonsen E (2014), Nord J Psychiatry*

## STIMULANT TREATMENT & BPD SYMPTOM REDUCTION

- Treating ADHD pharmacologically may directly reduce BPD symptom severity.
- Stimulant medication improves attentional control (blue network), which may restore partial access to mentalizing capacities (green network) and dampen impulsive emotional reactions (red network).

*Prada P et al. (2015), Atten Defic Hyperact Disord*

**Key finding**

Stimulant treatment of comorbid ADHD was associated with significant reduction in BPD symptoms, including impulsivity and emotional dysregulation

CLINICAL FEATURES

# BPD vs. ADHD vs. OVERLAP

| Feature | ADHD | BPD | Overlap |
|---|---|---|---|
| **Impulsivity** | Trait-based, context-independent | Emotionally & interpersonally driven, diffuse self | Both, triggers differ |
| **Emotional dysreg.** | Rapid, low frustration tolerance | Intense, prolonged, tied to abandonment | Time course differs |
| **Identity** | Inconsistent from failure & shame | Core: inner emptiness | Mechanism differs |
| **Interpersonal** | Inattention, forgetfulness | Abandonment fear, idealization/devaluation | Cognition differs |
| **Onset** | Childhood, pervasive | Late childhood, adolescence | ADHD may prime BPD |

# REJECTION SENSITIVITY: ADHD VS BPD

| ADHD — Rejection Sensitivity Dysphoria RSD | | BPD — Interpersonal Hypersensitivity IH |
|---|---|---|
| Trigger | Criticism of performance / reliability | Perceived rejection / distance |
| Core fear | "Something is wrong with me" | "No one will stay" |
| Onset | Explosive, seconds to peak | Builds, hypervigilance, scanning |
| Duration | Brief,  minutes to hours | Prolonged, hours to days |
| Self-state | Shame-dominant. Intact self between episodes. | Diffuse self |
| Mechanism | CEN fails → neurobiological event | DMN overwhelms CEN → relational pattern |

CEN:  CENTRAL EXECUTIVE NETWORK

DMN: DEFAULT MODE NETWORK

# WHY GPM FOR ADHD?

1. GENERALIST & PRAGMATIC : learnable by any clinician
2. FUNCTIONALITY-CENTERED : work, school, relationships as anchors
3. PSYCHOEDUCATION-DRIVEN : teaching the condition is central
4. INHERENTLY ADAPTABLE : GPM-A, substance use, now neurodiversity
5. RELATIONSHIP FRAMEWORK :  interpersonal hypersensitivity and stress sensitivity models

BIRCH VALUES **INSPIRATION**

# *Brilliant Ideas:*

(OR BAD POETRY, OR GROCERY LIST...)

# WHO IS CAPTAINING THE SHIP?

## A PROPOSED SELF-AGENCY MODEL

# THE SEESAW THAT GOVERNS SELF-AGENCY
## CEN & DMN

### CEN — CENTRAL EXECUTIVE NETWORK

**WHAT IT DOES**

Goal-directed thinking, problem solving, sustained attention, working memory, response inhibition.
The brain's "task mode."

**STRUCTURES**

Dorsolateral prefrontal cortex (dlPFC)
Posterior parietal cortex
Fronto-striatal circuits

### DMN — DEFAULT MODE NETWORK

**WHAT IT DOES**

Self-referential thinking, mind-wandering, autobiographical memory, social cognition, "who am I?" processing.
The brain's "self mode."

**STRUCTURES**

Medial prefrontal cortex (mPFC)
Posterior cingulate cortex (PCC)
Temporoparietal junction (TPJ)

**THE KEY PRINCIPLE**

CEN and DMN are anti-correlated when one is active, the other quiets down.

*Menon(2023) ; Choi-Kain et al. (2022)*

# WHO IS CAPTAINING THE SHIP?

A PROPOSED SELF-AGENCY MODEL

## THE SEA
**Affective–Interpersonal Field**

### BPD

Stormy.
Diffuse self + interpersonal hypersensitivity.

### ADHD

Calm surface, invisible currents.
Micro-failures accumulate.
Rejection sensitivity dysphoria comes from inside.

## THE CAPTAIN
**Executive Self-Agency (CEN)**

### BPD

Present but overwhelmed.
Abandons helm under stress.
State-dependent.

### ADHD

Intermittently absent.
Leaves helm to chase something shiny.
Agent constitutionally compromised.

## THE COMPASS
**Self-Reflective Capacity (DMN)**

### BPD

Spinning.
DMN hyperactive.
Reads threat everywhere.
Can't be dampened.

### ADHD

Works but unconsulted.
Intact but inconsistent.
Attentional dropout.

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*Ayduk et al. (2009); Choi-Kain et al. (2023) ; Shaw et al. (2014)*

# THE SEESAW THAT GOVERNS SELF-AGENCY
## CEN & DMN

**IN BPD**

DMN won't quiet down.
Self-referential noise stays loud → the captain can't hear, can't steer.
The seesaw is stuck on the "self" side.

**IN ADHD**

CEN is intermittently offline.
The captain leaves the helm even in calm seas.
The seesaw rocks unpredictably: task mode flickers on and off.


*Raichle (2015) ; Menon (2011) ; Choi-Kain et al. (2023)*

STRESS SENSITIVITY MODEL

# GPM Stress Sensitivity Model — ADHD layer


**ADHD at this stage**

Hyperfocus on idealized object. Impulsive attachment, novelty-driven bonding.

**ADHD accelerates the drop**

Inconsistent availability ("I forgot to call") misread as lack of caring.
Attention deficits → misreading social cues, faster perception of threat

**ADHD deepens the aloneness**

Working memory deficits → can't reconstruct what happened. Narrative collapse: "I don't even know why I'm upset." Executive dysfunction blocks organized repair strategies.

**ADHD compounds the despair**

Chronic shame from lifetime of failures. Identity confusion amplified by inconsistent performance. Self-blame spirals reinforced by repeated inability to "just do better."

*Adapted from Lois Choi-Kain's work on Stress sensitivity model (2026) - McLean Gunderson Personality Disorders Institute*

Stress Sensitivity Model

# Stress Sensitivity Model — ADHD layer

## Connected

Idealized hopes

**ADHD:** Hyperfocus on idealized objects.

## Engagement with Reality

Disappointment · Realistic Management

*= Therapeutic target: "Leaning In"*

**ADHD:** This is the hardest zone.

## Alone → Despair

Unanchored · Worthless · Suicidal

**ADHD:** Narrative collapse, can't reconstruct events. Chronic shame compounds despair.

### AVOIDANCE = FLIGHT

1. Withdrawal / Detachment
2. Blame of self
3. Self-harm
4. Falling apart / Helplessness

**ADHD:** Distraction as escape. Shame spirals. Executive dysfunction blocks repair.

### RIGHTING WRONGS = FIGHT

1. Antagonism
2. Blame of others
3. Externalization
4. Lashing out / Hostility

**ADHD:** Verbal impulsivity. Rapid escalation. Can't inhibit anger. Acts before thinking.

*Adapted from Lois Choi-Kain's work on Stress Sensitivity Model (2025) - Gunderson Personality Disorders Institute*

# "LEANING IN"

LEARNING TO COPE WITH DISAPPOINTMENT AND LIMITS

## WHY ADHD MAKES IT HARDER

**CEN** — Can't sustain effortful control on discomfort (Ayduk, 2008)

**DMN** — Can't regulate self-referential noise, blocks perspective-taking

**Affect** — Flooding arrives faster : RSD → loss of agency

**Exec** — Agent in the self is compromised: knows what to do, can't access it

## ADAPTED STRATEGIES

### Slow the session down

"Let's stay here for a moment."

### Name the escape

"Your brain is pulling you out of the discomfort."

### Externalize it

Write it down together. Concrete anchors.

### Micro-doses of reality

seconds of sitting with disappointment = a win.

### Validate the difficulty

"Your brain makes this harder , not a character flaw."

# MULTIMODAL — NOT JUST MEDICATION

A GPM-INFORMED FRAMEWORK FOR ADHD

| | | |
|---|---|---|
| 1 | **Psychoeducation** | First-line. Name the disorder, neurobiology, impact on relationships. |
| 2 | **Pharmacotherapy** | Medication within relational context. Monitor, adjust, discuss. |
| 3 | **Interpersonal focus** | Stress sensitivity model applied to ADHD. Adress RSD and shame cycles. |
| 4 | **Functional goals** | Work/school/relationships as anchors. Systems, not willpower. |
| 5 | **Coaching & scaffolding** | External supports. ADHD brains need outside-the-head help. |
| 6 | **Comorbidity screening** | Screening for BPD, SUD, mood/anxiety. Integrated formulation. |

# TAKE-HOME

1. ADHD IS OFTEN THE UPSTREAM DRIVER → TREAT IT FIRST, REASSESS BPD
2. THE CAPTAIN OF THE SHIP MODEL: SEA, CAPTAIN, COMPASS
3. STRESS SENSITIVITY GUIDES INTERVENTION
4. "LEANING IN" IS THE THERAPEUTIC TARGET → HARDEST FOR ADHD BRAINS
5. EXTERNALIZE, DON'T INTERPRET. CELEBRATE SYSTEMS, NOT WILLPOWER
6. PHARMACOTHERAPY STRENGTHEN THE CAPTAIN ; BORDERLINE FEATURES  MAY ATTENUATE