

## GPM for Adolescents and Young People



### Morning May 5<sup>th</sup>

9:00 A.M. Personality Disorder and autism (UK)

9:30 A.M. GPM-eating disorders

10:00 A.M. GPM for complex eating disorder

11:00 A.M. GPM for ADHD

11:15 A.M. Adapting GPM-A for conduct disorder

11:30 A.M. Panel

# Borderline personality disorder and autism

  
Cambridgeshire and  
Peterborough  
NHS Foundation Trust



**Dr Robert B. Dudas, MD, PhD (Cantab), FRCPsych, PGCert Med Ed**

Consultant Psychiatrist, OPMHS, Cambridgeshire and Peterborough NHS Foundation Trust

Affiliated Assistant Professor, Department of Psychiatry, University of Cambridge

Training Programme Director for Psychiatry, NHS England, East of England

Academic Secretary, Eastern Division, Royal College of Psychiatrists, UK

**International Conference on Good Psychiatric Management for  
Personality Disorders, Stockholm, Sweden**

**5<sup>th</sup> May 2026**

1

## AGENDA

- Co-occurrence of autism and BPD
- Challenges in diagnosis
- Good Psychiatric Management
- Future directions

2

## Co-occurrence of Autism and Borderline Personality Disorder (BPD)

Approximately 4% of individuals with ASD also have BPD May 2021

Challenges in treatment  
Severe challenges in psychosocial and occupational functioning

3

## Challenges in diagnosis

- Overlapping symptoms like interpersonal difficulties, emotion dysregulation, and identity disturbance, impulsivity, and self-harm
- Gender biases and late diagnosis of ASD are common, especially in women
- If not diagnosed in childhood, other diagnoses given priority and ASD overlooked (Jadav & Bal 2022; Kentrou et al 2021)
- Misdiagnosis or delayed diagnosis ~ poorer QoL (Atherton 2022), more mental health issues (Jadav 2022) and) increased suicide risk (Cassidy 2022; Mantenuto 2023).

4

## Similarities and differences between BPD and autism

Dudas, R. B., & Cheney, L. (2025). Good psychiatric management of borderline personality disorder and co-occurring autism spectrum disorder. *American Journal of Psychotherapy*, 78(1), 35-45.

	BPD	Autism
Affective instability, intense anger	Focus on fairness, hypersensitivity to injustice	
	Interpersonal hypersensitivity	Sensory overload Changes in person's routine "burnout" from social interaction
Difficulties in social relationships	Starting from childhood Strong focus on a few people High moral standards	
	Intolerance of being alone Strong emotional reactions → rejection "Social chameleon"	Social withdrawal as coping Difficulty fitting in with neurotypical social norms/neurotypical people having difficulty understanding autistic social behaviour → rejection/bullying  Camouflaging, masking

5

## Similarities and differences between BPD and autism

Dudas, R. B., & Cheney, L. (2025). Good psychiatric management of borderline personality disorder and co-occurring autism spectrum disorder. *American Journal of Psychotherapy*, 78(1), 35-45.

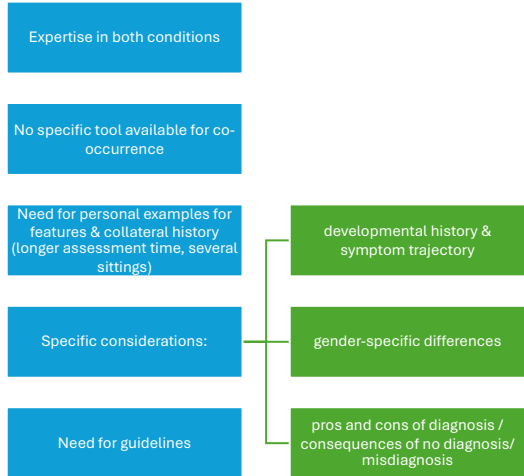
	BPD	Autism
Identity disturbance	Mental exhaustion from not being oneself in order to fit in with mainstream social expectations Negative/unbalanced self-appraisals	
	Changeable interests	Enduring interests
Impulsivity	Co-occurring ADHD common	
	Reckless spending/driving	Rigid pattern of thinking and behaving
Self-harm and suicidal behaviour	Linked to unmet needs (loneliness, inadequate support) Suicide can become a strong focus of interest	
	Associated with alexithymia	
	Interpersonal stressors	Camouflaging

6

## Expert consensus studies on diagnostic principles

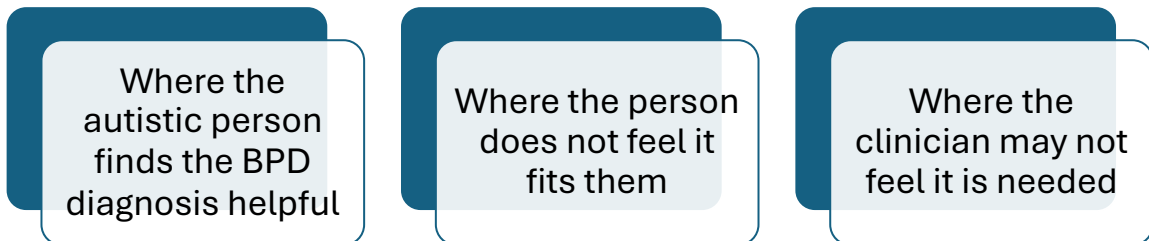
Cumin et al. Positive and differential diagnosis of autism in verbal women of typical intelligence. *Autism*. 2022 Jul;26(5):1153-1164.

Sarr et al. Differential diagnosis of autism, attachment disorders, complex post-traumatic stress disorder and emotionally unstable personality disorder: a Delphi study. *Br J Psychol*. 2025 Feb;116(1):1-33.



7

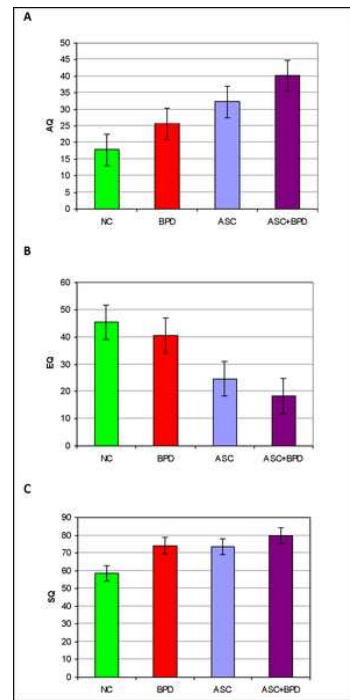
## To diagnose or not to diagnose BPD...



8

## The overlap between autistic spectrum conditions and borderline personality disorder

Dudas et al. (2017). PLOS ONE 12(9): e0184447.  
<https://doi.org/10.1371/journal.pone.0184447>



9

## Good Psychiatric Management (GPM)

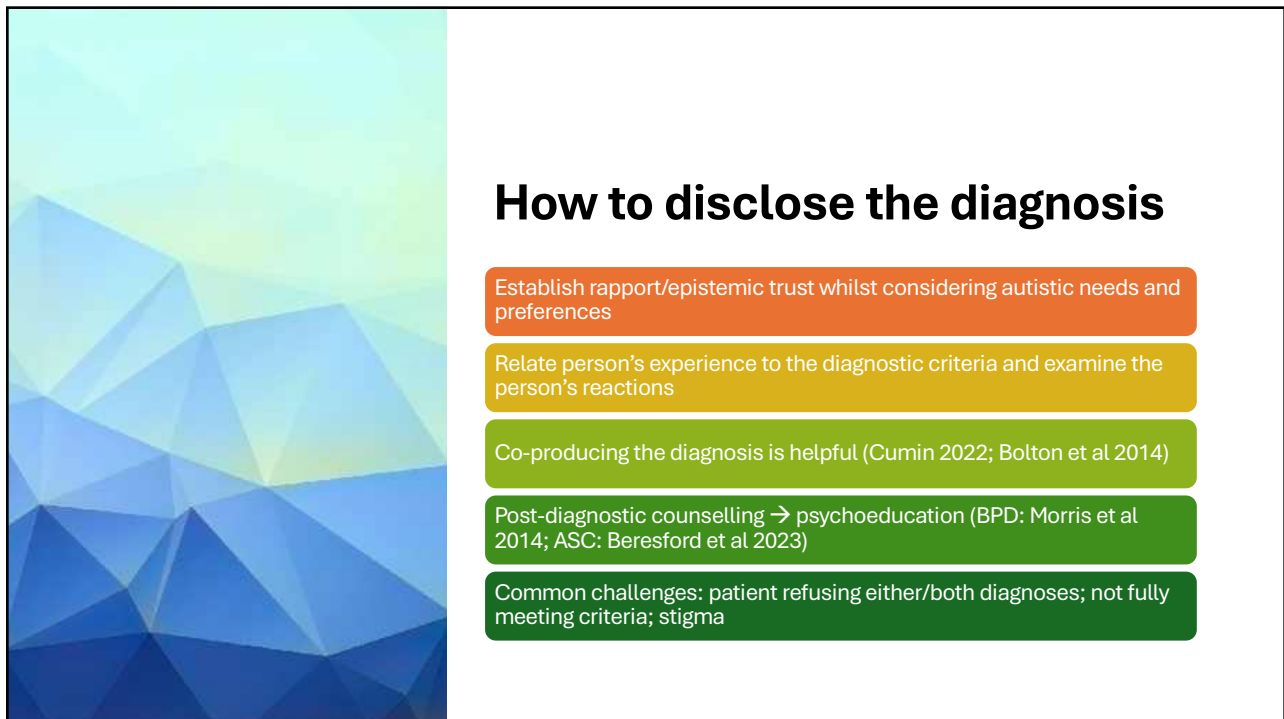
### GPM domains:

- Disclosing the diagnosis
- Psychoeducation
- Managing suicidality
- Medications
- Managing comorbidities
- Multimodal treatments (groups and family)

10



11



12

# Psychoeducation

Psychoeducation is crucial for managing this co-occurrence, focusing on aetiology, symptoms, adaptations/treatment options.

Tailored, face-to-face, multi-session psychoeducational programs are recommended for individuals and their families

Heritability + life experiences; adaptations to accommodate autistic needs → potential improvement

13

## Treatment framework 1

- Social understanding challenged → avoid neurotypical group setting
  - High sensory sensitivity → environmental adaptations (Autistic SPACE framework)
  - Difficulty with abstract concepts → specific modifications
  - Map personal neurocognitive, social cognitive, and sensory profile
  - Adapt goal setting to achieve & maintain functional autonomy
- 

14



## Treatment framework 2

### Adjust goals:

- Informed workplace can accommodate differences and maximize strengths
  - Explore a different range of occupations and employment activities that fit with the person's interests
- 

15

## Safety management

- Heightened risk of self-harm and suicide
- Crisis management includes collaborative chain analysis to identify the triggers – be mindful of exhaustion from camouflaging & unmet support needs
- Personalized crisis plan – reduce sensory overload; self-soothing techniques; low-dose, short-term medication treatment; clear communication; avoid multiple clinicians; minimize hospitalization
- The best way we can stop suicides is by making lives worth (Moseley 2026)

16

## Managing co-occurring conditions

---

ADHD, PTSD, eating disorders, OCD, sleep disturbances, gastrointestinal issues, epilepsy, and sensory processing difficulties

---

Treatment should address these alongside BPD and ASD

---

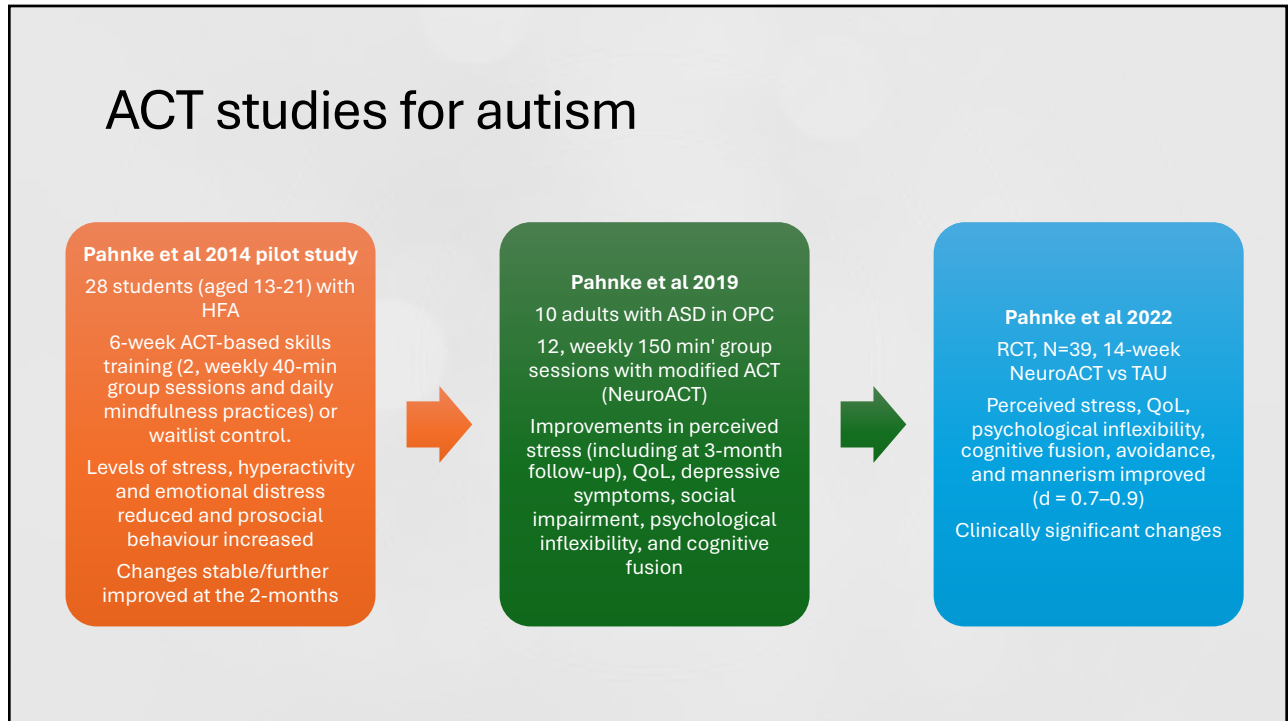
Medications is an important tool but consistent relationships and occupational functioning (where possible) are still the core

17

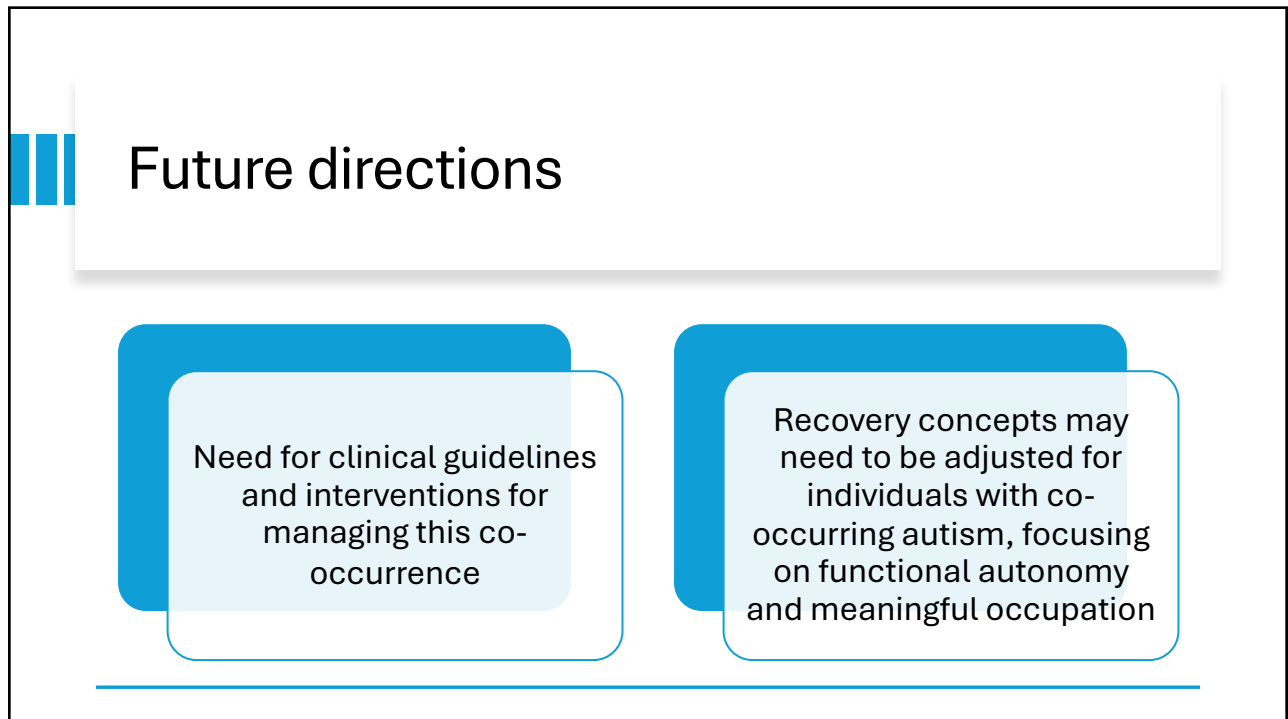
## Multimodal treatments

- GPM encourages integrating additional therapeutic approaches
- Treatment must be personalized to accommodate the heterogeneity of autism
- Medications for comorbid conditions - careful consideration needed due to sensitivities and overdose risks
- DBT skills training, cognitive enhancement therapy (Eack 2018), and family involvement
- MBT-ASD (Kramer 2021), adapted DBT (Bemmouna 2023), or adapted ACT (Pahnke 2019, 2022) show promise but require further research

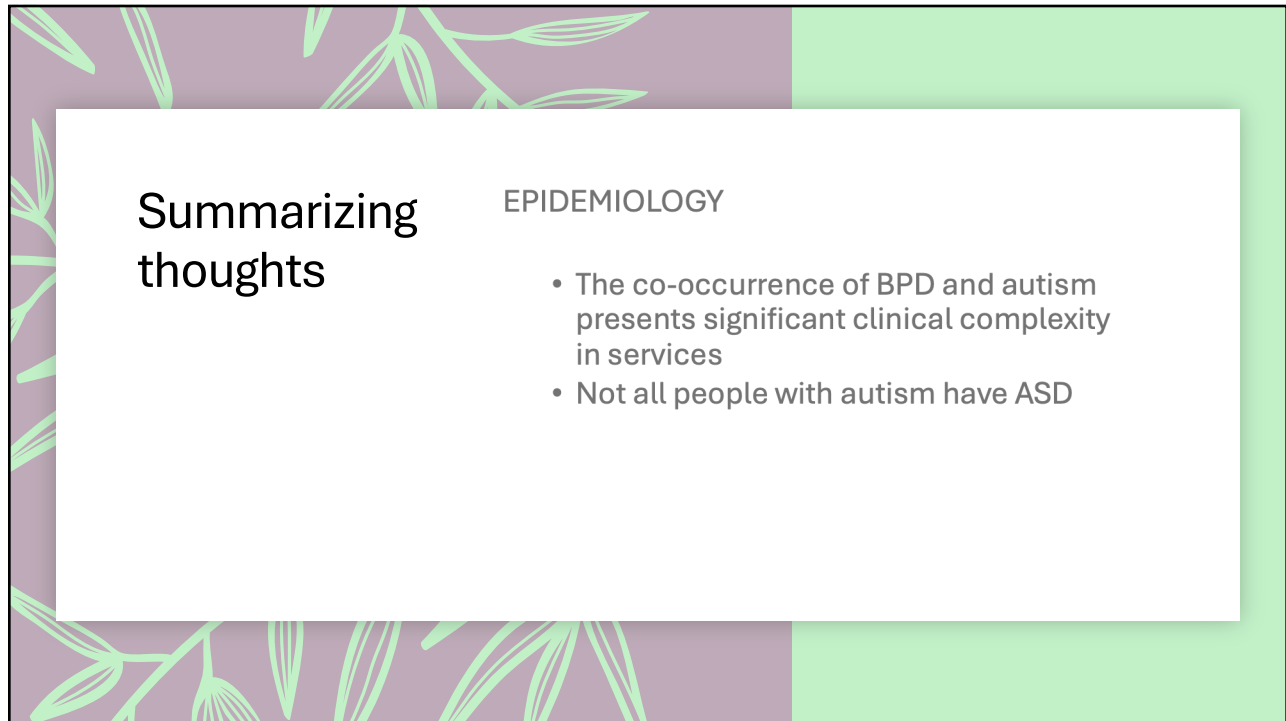
18



19



20

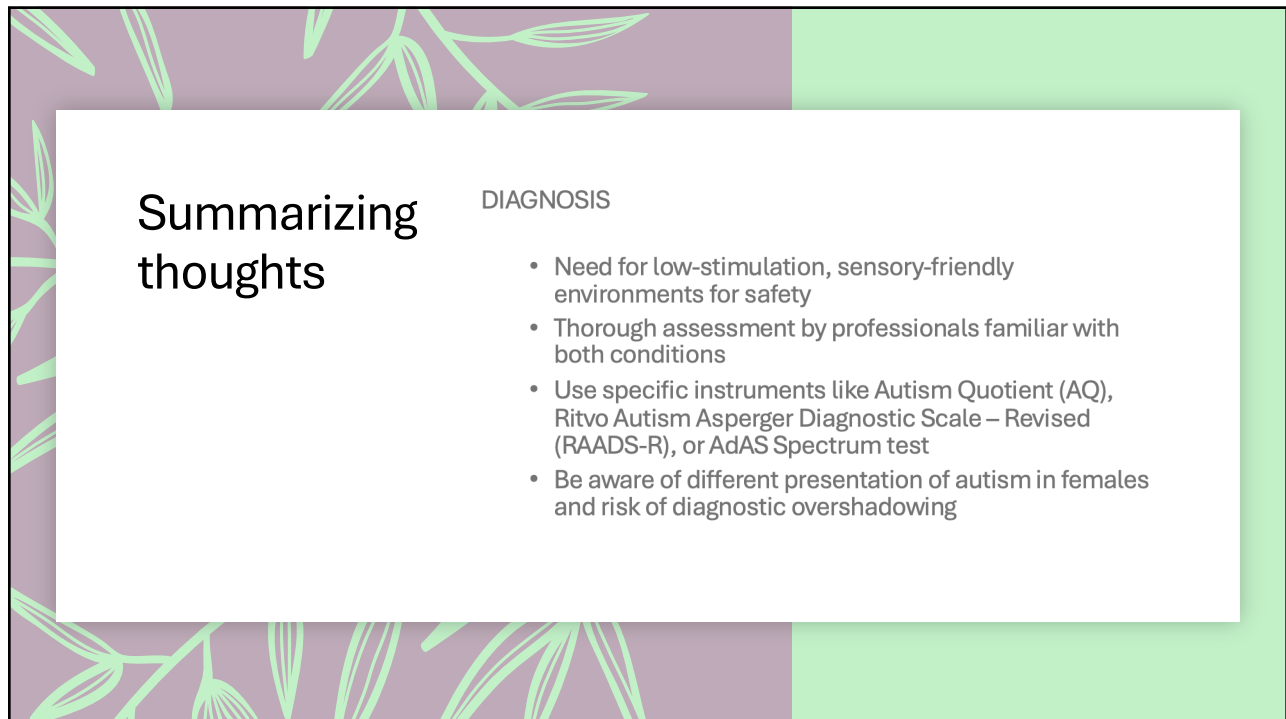


**Summarizing thoughts**

**EPIDEMIOLOGY**

- The co-occurrence of BPD and autism presents significant clinical complexity in services
- Not all people with autism have ASD

21



**Summarizing thoughts**

**DIAGNOSIS**

- Need for low-stimulation, sensory-friendly environments for safety
- Thorough assessment by professionals familiar with both conditions
- Use specific instruments like Autism Quotient (AQ), Ritvo Autism Asperger Diagnostic Scale – Revised (RAADS-R), or AdAS Spectrum test
- Be aware of different presentation of autism in females and risk of diagnostic overshadowing

22

## Summarizing thoughts

### TREATMENT

- Create environments with reduced sensory input
- Use direct communication
- Be aware of increased risks of suicidality, depression, and trauma
- Treatment must address both emotional dysregulation (BPD) and sensory/cognitive needs (ASD) simultaneously
- Need for highly personalised treatment plans
- Modalities used in BPD treatment (DBT, MBT, ACT) may work but need to be adapted
- GPM provides a foundational framework while emphasizing recovery, occupational functioning, and consistent therapeutic relationships
- Reducing loneliness and inclusion in society = key to recovery

23

Thank you for  
your attention!

---



24




# Case presentation

Kim Siscoe, MD  
Eating Recovery Center  
Denver CO, USA

1

- **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**



2

## 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.

3

## 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

4

## 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.

5

## 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.

6

## 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.

7

## 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.

8

## 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”.

9

## 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.

10

## 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

11

## Summary and take aways

- 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

12

## 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

13

## 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

14

## 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

15

## 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.

16

## 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”.

17

## 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.

18

## 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.

19

## 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.

20

## 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.

21

## 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.

22

## 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.

23

## 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.

24

## 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.

25

## When eating disorder meets personality disorder:

### The Highlights

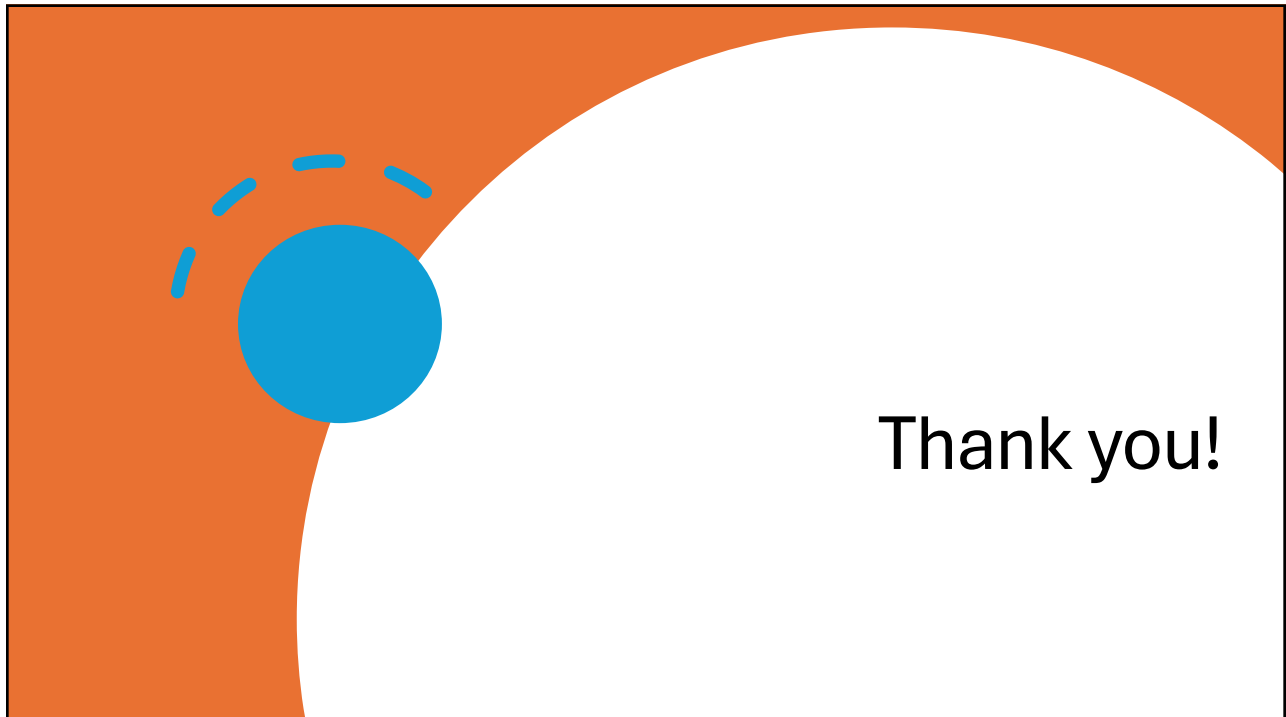
- Malnourishment affects neurocognitive function rendering therapy and medications ineffective.
  - Medical intervention needed first. GPM later!
- GPM-AED is a flexible approach that addresses both disorders and their interaction while focusing on safety, promoting functionality and agency.

26

## 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>

27



28

2nd International Conference on GPM for Personality Disorders  
Karolinska Institutet • 5 May 2026


General Psychiatric Management for

## Adolescents With BPD and *Eating Disorders*

**GPM-AED**

**Marcelo Brañas, MD, PhD | Marcos S. Croci, MD**

- Co-directors, ADRE-USP
- Collaborators, GPMI, McLean Hospital

MEDICINA USP 

1

## Disclosures

**Marcelo Brañas, MD, PhD**  
No personal financial conflicts of interest.

**Marcos S. Croci, MD**  
No personal financial conflicts of interest.

*Both authors receive royalties from Manole Publisher (unrelated; section editors of clinical psychiatry books).*

GPM-AED • 2 / 21

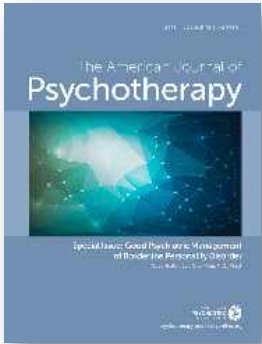
2

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

Marcos S. Croci, M.D., Marcelo J.A.A. Brañas, M.D., Kristin N. Javaras, D.Phil., Ph.D., Esther Dechant, M.D., Julia Jurist, B.A., Georgia Steigerwald, B.A., Lois W. Choi-Kain, M.D., M.Ed.

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.

*Am J Psychother* 2025; 78:24–34;  
doi: 10.1176/appi.psychotherapy.20230045



GPM-AED • 3 / 21

3

## 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

GPM-AED • 4 / 21

4

## Prevalence in adolescents

*Co-occurrence is common, not the exception*

BPD in adolescents		EDs in BPD	
<i>Prevalence across settings</i>		<i>Comorbidity rates</i>	
Community samples	1.4–3%	Adults	17%
Outpatient clinics	11%	Adolescents	31–52%
Inpatient	50–53%	<i>BPD in ED subtypes</i>	
<i>EDs in community (adolescents)</i>		AN (restricting)	5.5–7.9%
AN	0.3–0.4%	BN / AN binge-purge	<b>borderline features</b>
BN	0.3–0.9%	<i>Restricting type → perfectionistic, avoidant traits</i>	
BED	0.62–3.6%	<i>Binge/purge presentations → more BPD features</i>	
Subthreshold ED	5–11%		

**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 GPM-AED • 5 / 21

5

## Shared developmental pathways

*Not just co-occurrence — bidirectional longitudinal prediction*

```

    graph LR
      A["BPD symptoms at age 11 (late childhood)"] -- predicts --> B["Binge eating and purging by adolescence at age 16"]
      C["High disordered eating in early adolescence"] -- predicts --> D["BPD features later in adolescence"]
  
```

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

Lee & Vaillancourt, 2024

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

Brown, 2020 · Lee & Vaillancourt, 2024 · De Poli, 2020 GPM-AED • 6 / 21

6

## 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*

GPM-AED • 7 / 21

7

## 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

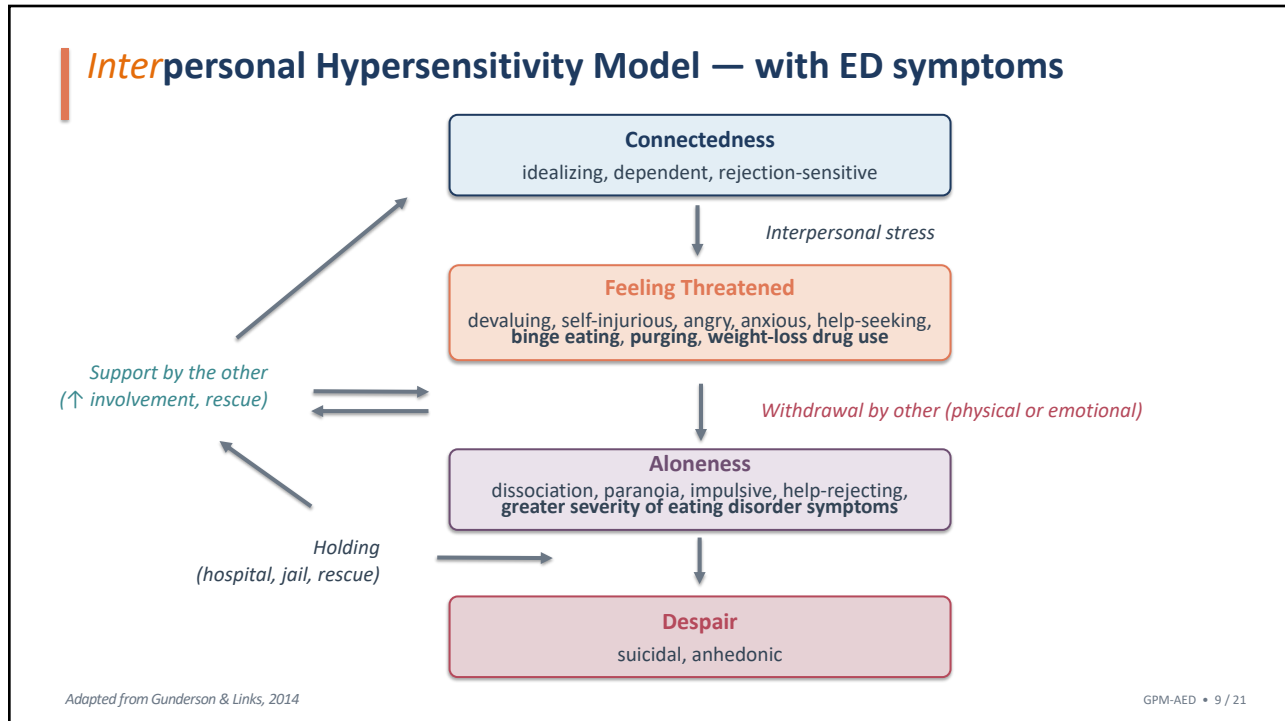
**Specialized care for non-responders**

Step up for severe or treatment-resistant cases.

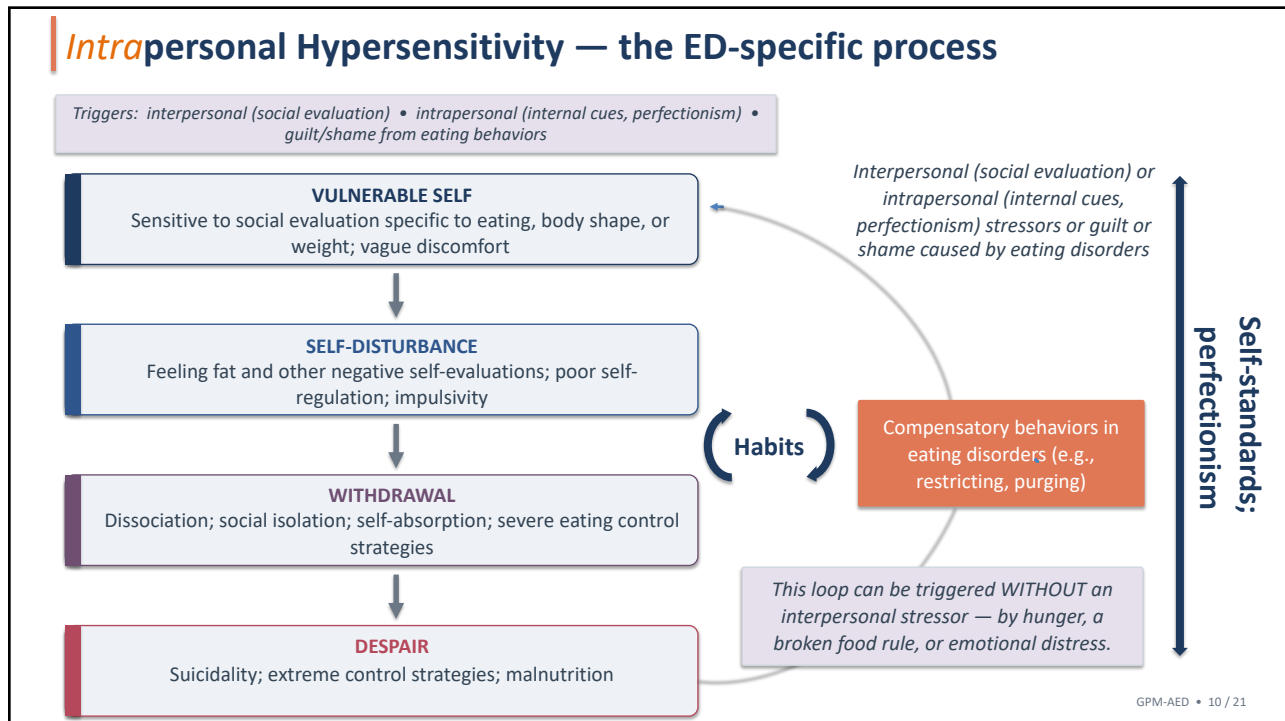
*Generalist-first, specialist-when-needed — same logic as GPM-A.*

GPM-AED • 8 / 21

9



11



12

## 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

Crocì et al., 2025 GPM-AED • 11 / 21

13

## 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 over weight (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, Crocì, Brañas et al., Am J Psychother 2025 GPM-AED • 12 / 21

14

## Dual Focus: Assessment and Safety Management

*Two parallel tracks: psychiatric and physical*

INITIAL ASSESSMENT · OUTCOMES	SAFETY MANAGEMENT
<p><b>Actively investigate eating behaviors</b> weight cycles, excessive exercising, compensatory behaviors, dietary rules, body checking — ask early and routinely.</p> <p><b>SCOFF</b> — quick 5-question screen (≥2 “yes” = suspect ED) Sick · Control · One stone · Fat · Food</p> <p><b>EDE-Q</b> Eating Disorder Examination Questionnaire — use at baseline and follow-up as a shared outcome measure.</p>	<p><b>When</b> at initial evaluation · signs of malnourishment/weight loss · binge/purge behaviors</p> <p><b>What</b> physical exam · weight &amp; height · vitals · labs · EKG</p> <p><b>Red flags</b> underweight or rapid weight loss · purging with medication misuse · vital signs · delayed pubertal development · obesity or rapid weight gain</p> <p><b>Severe cases</b> → <i>refer to specialist</i></p>

GPM-AED • 13 / 21

15

## Engagement and Interventions for Initial Sessions

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

1	2	3	4
<p><b>Rapport Building</b></p> <p>Support and validation. A non-judgmental stance toward eating and bodily shame.</p>	<p><b>Building Motivation</b></p> <p>Motivational-interview style questions that elicit the patient’s own reasons to change.</p>	<p><b>Psychoeducation</b></p> <p>Explain ED + BPD in plain language. Use a ‘no blame’ etiology frame — for patient and family.</p>	<p><b>Case Formulation</b></p> <p>Preliminary, collaborative map of triggers, emotions, and behaviors — built in session with the patient.</p>

**Motivational questions** · examples

**01 What does bingeing do for you?**  
*Open the patient’s own account of function — regulation, escape, comfort.*

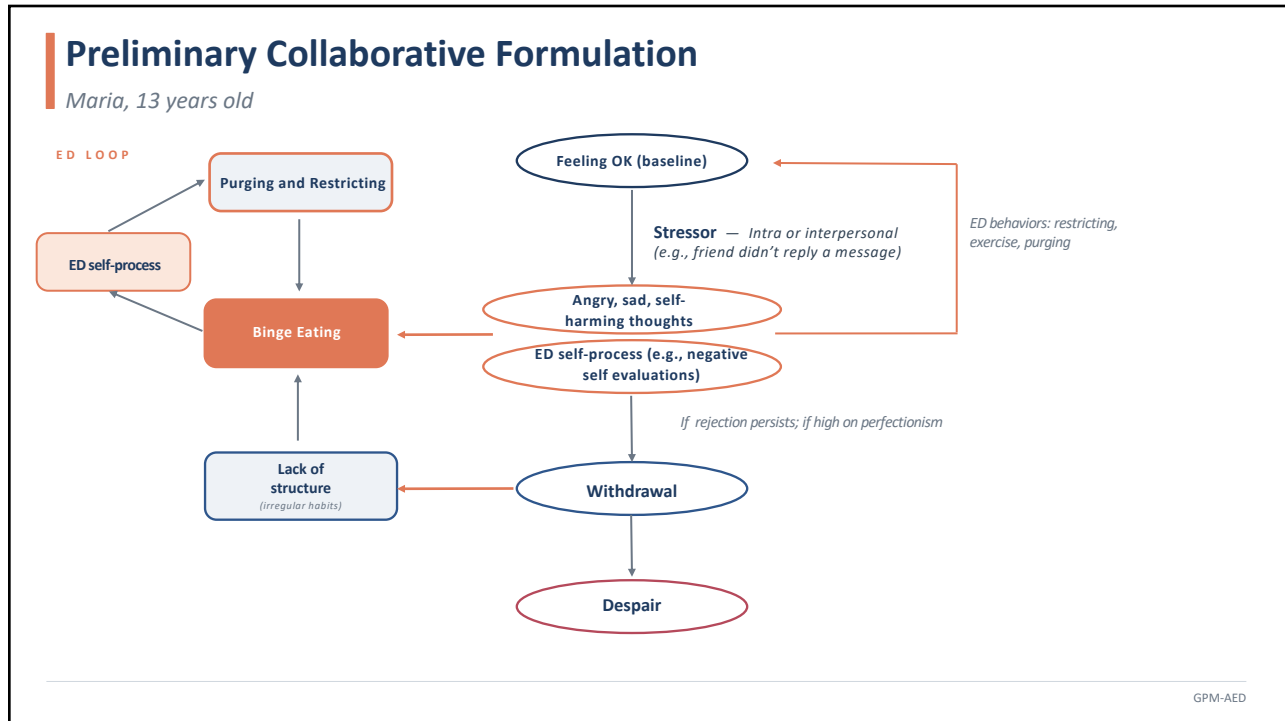
**02 How does it affect your relationships?**  
*Link eating behavior to interpersonal life — the shared terrain of BPD + ED.*

**03 What role do emotions play around bingeing?**  
*Frame eating as a way of not-feeling — opens space for affective work.*

**04 What kind of life do you want — and how does bingeing fit into that?**  
*Bridges to ‘getting a life’ — the GPM core that anchors long-term change.*

GPM-AED • 17 / 25

16



17

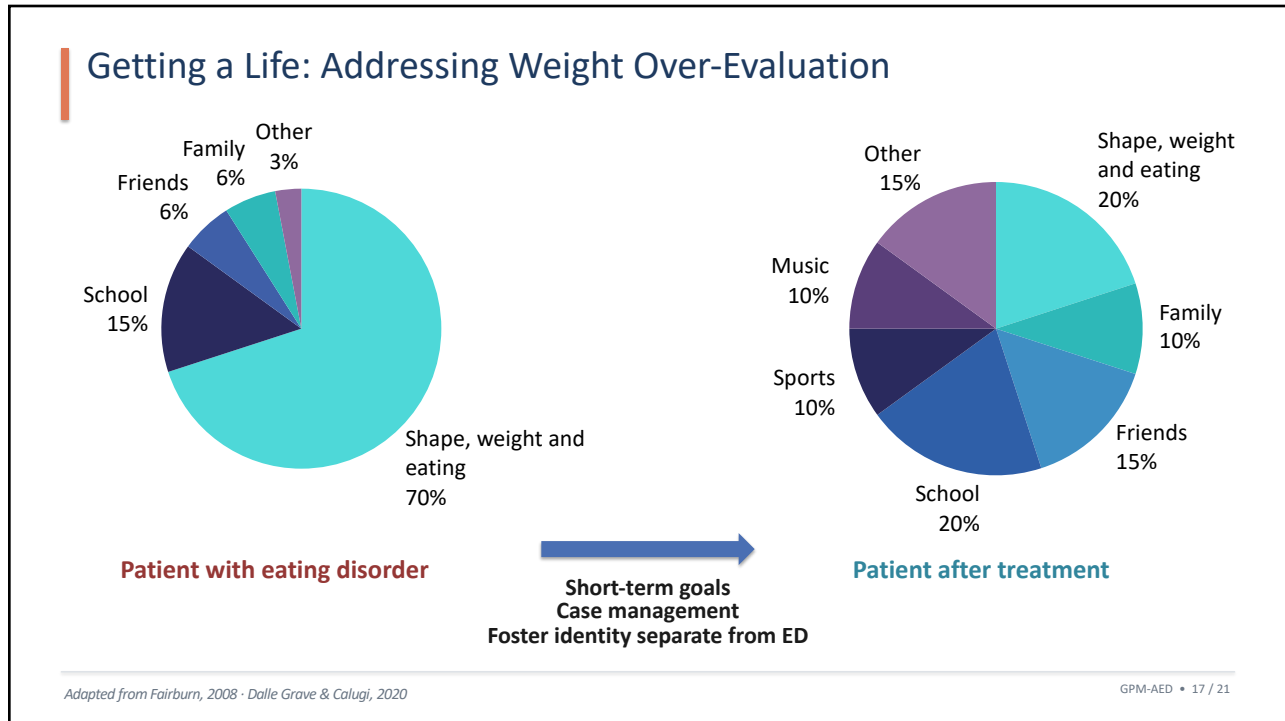
### In session: regular eating and coping with binge/purge

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

REGULAR EATING — most impactful	COPING WITH BINGE / PURGE
<p><b>3 meals + 2–3 snacks / day</b></p> <p><i>planned intervals · seated at a table</i></p> <ul style="list-style-type: none"> <li>■ Patient owns their eating habits when possible</li> <li>■ Parental support when severity requires it</li> <li>■ Avoid grazing, multitasking, fast eating, between-meal eating</li> <li>■ Expose to varied foods and settings</li> <li>■ Dietitian support when available</li> </ul> <p><i>Dalle Grave &amp; Calugi, 2020</i></p>	<p><b>Binge analysis (chain analysis)</b></p> <p>Map triggers: what happened before? feelings? thoughts? relational context?</p> <p><b>Skills for mood lability</b></p> <p>Counting breaths, grounding, calling a friend, short walk — emotions are temporary.</p> <p><b>Environmental structure</b></p> <p>Post-meal plans, avoid the bathroom after meals, eat with family when possible.</p> <p><i>Safer et al., 2017 · Robinson et al., 2019</i></p>

GPM-AED • 16 / 21

18



19

### Involving the family

*Allies — not therapists, not adversaries*

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

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

GPM-AED • 18 / 21

20

## Comorbidity and conservative psychopharmacology

*Medication is adjunctive, not primary*

PRIORITY ASSESSMENT	BE CAREFUL WITH
<p><b>Does the comorbidity block engagement in GPM?</b></p> <p>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.</p> <div style="border: 1px solid #c0392b; padding: 5px; margin-top: 10px;"> <p><b>RULE OF THUMB</b></p> <p><i>Borderline symptoms predict persistence of depression, but the converse is not true — treat BPD to help depression.</i></p> </div>	<div style="margin-bottom: 10px;"> <div style="background-color: #1a3d54; color: white; padding: 5px; border-radius: 5px; display: inline-block;"><b>Stimulants</b></div> <span style="margin-left: 10px;">Appetite suppression → worsens restriction</span> </div> <div style="margin-bottom: 10px;"> <div style="background-color: #1a3d54; color: white; padding: 5px; border-radius: 5px; display: inline-block;"><b>Bupropion</b></div> <span style="margin-left: 10px;">Seizure risk in EDs → avoid</span> </div> <div style="margin-bottom: 10px;"> <div style="background-color: #1a3d54; color: white; padding: 5px; border-radius: 5px; display: inline-block;"><b>Atypical APs</b></div> <span style="margin-left: 10px;">Weight gain → discuss openly if needed</span> </div> <div> <div style="background-color: #1a3d54; color: white; padding: 5px; border-radius: 5px; display: inline-block;"><b>SSRIs</b></div> <span style="margin-left: 10px;">Ineffective in malnourished patients; helpful for persistent depression/anxiety/OCD</span> </div>

GPM-AED • 19 / 21

21

## Take-home

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

GPM-AED • 20 / 21

22

# Tack!

*Thank you!*

**CONTACT**

marcelo.branas@usp.br  
marcos.croci@fm.usp.br

*Karolinska Institutet · 5 May 2026*

## Acknowledgments

**SENIOR AUTHOR**

Lois W. Choi-Kain, MD, Med, DFAPA

**CO-AUTHORS**

Kristin N. Javaras, DPhil, PhD  
Esther Dechant, MD  
Julia Jurist, BA  
Georgia Steigerwald, BA

**ACKNOWLEDGMENTS**

Aline Cho, MD  
Fellipe Augusto, PsyD  
Sofia Senço, MD



**SCAN FOR THE FULL PAPER**  
[doi:10.1176/appi.psychotherapy.20230045](https://doi.org/10.1176/appi.psychotherapy.20230045)

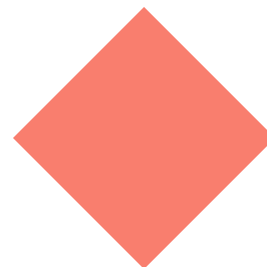
# GPM for patients with severe and enduring eating disorders



1


## Agenda

- Our clinic and our patients
- Our current treatment methods
- Why do we want to implement GPM?
- Pilot and implementations
- What happens next?



2

## Öppenvård Vuxna 2- Our clinic at Stockholm's Center for Eating Disorders

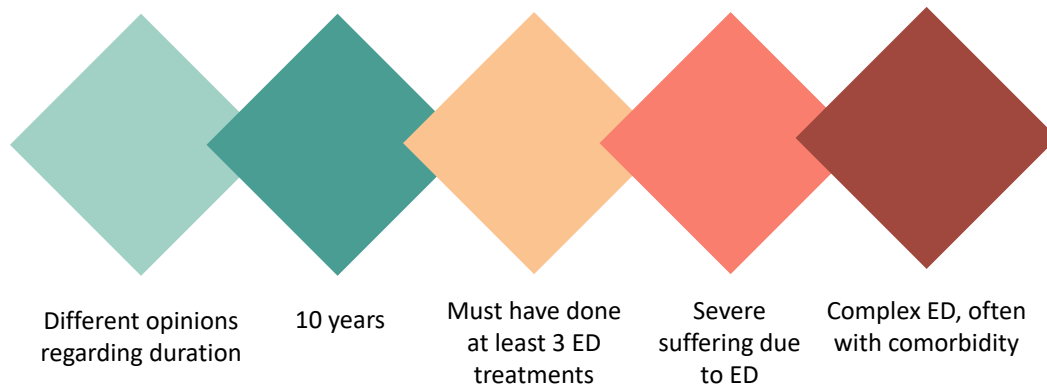


The only specialist clinic in Sweden for patients with severe and enduring eating disorders (SEED/SE-AN patients)

For patients who, even though they have done several eating disorder (ED) treatments, have not become free from their ED and have been ill for at least 10 years.

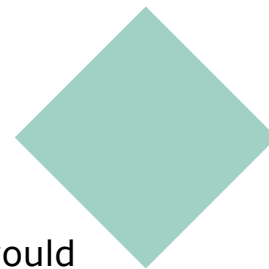
3

## SEED patients and our referral criteria



4

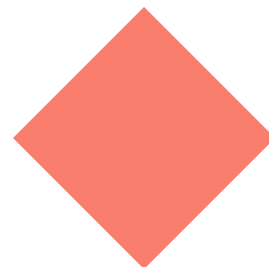
## Our treatment hopes



- That a more flexible and long-term treatment would generate better outcomes in treating SEED patients' ED symptoms
- Increase patients' Quality of Life (QoL)
- Decrease hospitalization
- Give quicker treatment to other patients

5

## Our patients



91 patients

Median age: 40 years old

Been ill between 9 & 50 years





98% women

99% of them have another psychiatric diagnosis

Different EDs but mostly Anorexia Nervosa (AN)

6

## Good to know

-  Approx. 10-30 % of patients diagnosed with an ED become ill long term
-  Harder to treat SEED patients but not impossible
-  These patients should not get excluded from ED clinics but instead be offered a low intensity and adapted eating disorder treatment with a wider life quality focus.
-  Currently there is no treatment with good evidence for SEED patients

 **Stockholms centrum för ätstörningar**  
REGION STOCKHOLM

7

## Research regarding relapses

Studies show that after a 10-year follow-up approx 40–50 % of patients with AN have relapsed and 30-40 % of patients with BN and BED have relapsed.

\*Sala M, Keshishian A, Song S, Moskowitz R, Bulik CM, Roos CR, Levinson CA. Predictors of relapse in eating disorders: A meta-analysis. J Psychiatr Res. 2023 Feb;158:281-299. doi: 10.1016/j.jpsychires.2023.01.002. Epub 2023 Jan 4. PMID: 36623362.

 **Stockholms centrum för ätstörningar**  
REGION STOCKHOLM

8

## Our most common comorbidity

Autism

ADHD

Borderline personality disorder

PTSD & Trauma

Depression, OCD & anxiety

9

## Our offered treatments

CBT-E

SSCM- Specialist Supportive Clinical Management

MI

ACT & Compassion

DBT & MBT-influenced groups

2026: GPM! 😊

10

# Why do we want to implement GPM?



11

## Why GPM?



We think the core principles of GPM align with the treatments we already use and hope that it will help SEED patients to reduce their ED symptoms



We are curious if a more structured method regarding the "Get a life" approach could improve these patients' QoL



GPM fits in a multiprofessional team where everyone can be trained in this method.



12

## The Pilot, Fall 2026

We are experts on SEED patients but new to GPM!

Our hope today is to learn more about GPM and all ideas and thoughts are most welcome.

Please help us 😊



13

## Inclusion criteria

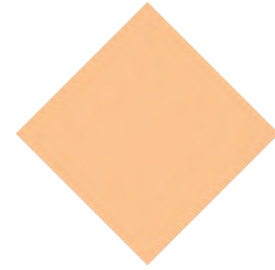
- Medically stable
- Motivated to try GPM
- Want to “get a life” and make a change regarding their eating disorder
- Able to participate in group treatment
- Employed, involved in other activities, or plan to start employment/activity



14

## Exclusion criteria

- Benzodiazepines
- Active substance abuse and/or severe alcohol addiction
- In need of other level of care, for example inpatient psychiatric care
- Severe self-harm and/or high suicide risk
- Active psychotic symptoms



15

## What the Pilot will look like

- Group size will be maximum 10 patients
- Introduction to GPM– 4 sessions done in a group setting. Then we evaluate which patients can do the full GPM course.
- Full Course: 24 sessions
  - 12 weekly group sessions (90 min)
  - 12 weekly individual sessions
- Two group therapists: a counselor and a psychologist
- The individual therapy sessions will be conducted by the patient's current individual therapist (different health professionals)

16

## Patient introduction to GPM group:

Group session 1: Eating disorders and GPM

Group session 2: Get a life- approach, psychoeducation about therapy, problem-solving skills and individual goal setting

Group session 3: Emotions and emotion regulation

Group session 4: Problem-solving and tools



17

## GPM treatment course:

Theme 1: Problem-solving and tools

Theme 2: Get a life (in terms of work, social activities, hobbies, etc.) and why this is important

Theme 3: Emotions and emotion regulation

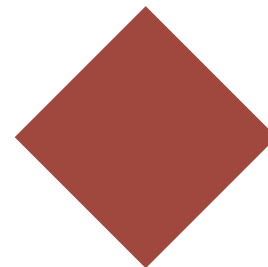
Theme 4: Relationships

Every theme is 3 sessions



18

## How to know if it works?



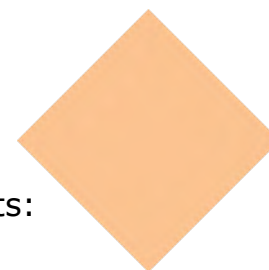
We will conduct:

- quantitative measurements and
- qualitative interviews

Everyone will be interviewed, including the patients who drop out.

19

## Quantitative measurements



Quantitative measurements in the form of self reports:

- EDE-Q (Eating Disorders Examination)
- CIA (Clinical Impairment Assessment Questionnaire)
- PHQ-9 (Patient Health Questionnaire)
- GAD-7 (Generalized Anxiety Disorder 7-item Scale)
- WHODAS-12 (WHO Disability Assessment Schedule)
- BBQ (Brunnsvikens Brief Quality of Life Scale)

20

# Questions and tips



 **Stockholms centrum för ätstörningar**  
REGION STOCKHOLM

2<sup>nd</sup> International Conference on Good Psychiatric Management (GPM) for Personality Disorders



Source: Free from Pixels: <https://www.pexels.com/@-fr/stock/mer-homme-tabou-pain-346271/>

## GOOD PSYCHIATRIC MANAGEMENT (GPM) FOR ADHD

Jihed Sehli, MD - Consultant Psychiatrist - Le Jolimont, Fribourg, Switzerland  
Karolinska Institutet, Stockholm - May 4 & 5, 2026

1

## DISCLOSURE

No conflicts of interest to declare.

2

**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?**

- 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.**



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

3

**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 & Phillips, 2014*

**WORSE OUTCOMES**

↑↑

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

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

**TREATMENT GAP**

○

No integrated treatment guidelines exist for BPD+ADHD → GPM as a candidate framework

4

## 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 → emotion regulation

Amad et al. (2014); Dilrich et al. (2021)

5

### 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 between 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  
Volonen 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

Conrad 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

6

**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.

Phillipsen 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).

Prado 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

7

**CLINICAL FEATURES**

## BPD vs. ADHD vs. OVERLAP

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

8

## REJECTION SENSITIVITY: ADHD VS BPD

### ADHD — Rejection Sensitivity Dysphoria RSD

Trigger	Criticism of performance / reliability
Core fear	"Something is wrong with me"
Onset	Explosive, seconds to peak
Duration	Brief, minutes to hours
Self-state	Shame-dominant. Intact self between episodes.
Mechanism	CEN fails → neurobiological event

### BPD — Interpersonal Hypersensitivity IH

Trigger	Perceived rejection / distance
Core fear	"No one will stay"
Onset	Builds, hypervigilance, scanning
Duration	Prolonged, hours to days
Self-state	Diffuse self
Mechanism	DMN overwhelms CEN → relational pattern

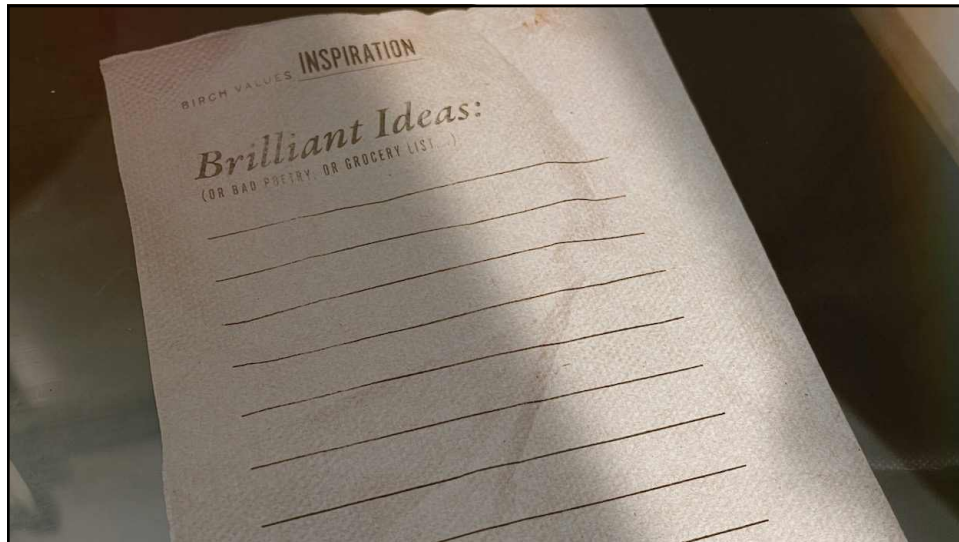
CEN: CENTRAL EXECUTIVE NETWORK  
DMN: DEFAULT MODE NETWORK

9

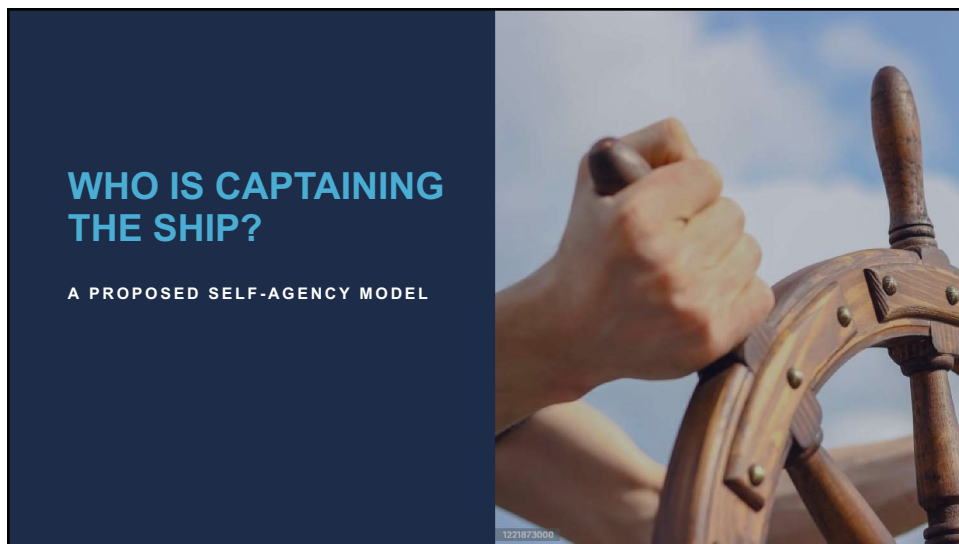
## WHY GPM FOR ADHD?

- 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

10



11



12

## 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)

13

## 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.

Ayduk et al. (2009); Choi-Kain et al. (2022) ; Shaw et al. (2014)

14

### 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. (2022)

15

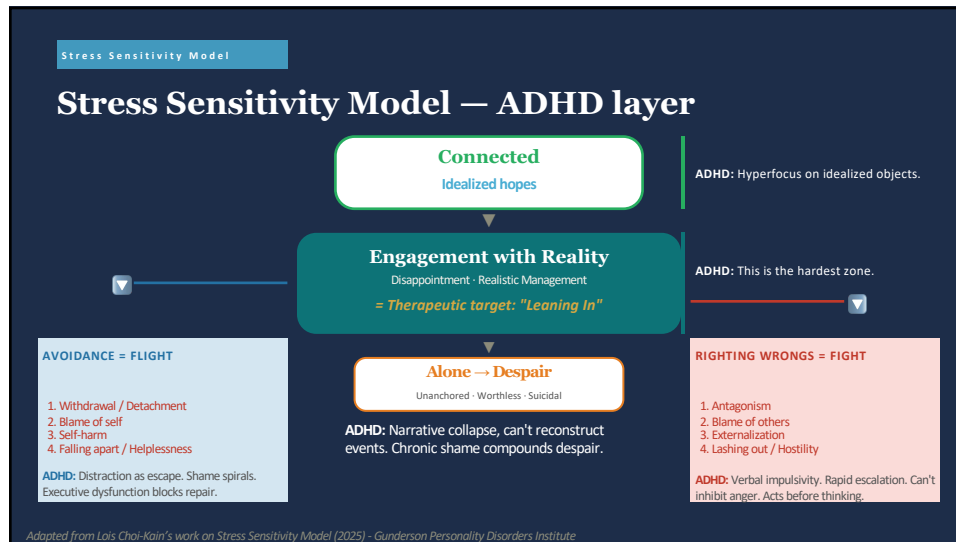
### STRESS SENSITIVITY MODEL

## GPM Stress Sensitivity Model – ADHD layer

<div style="border: 1px solid green; border-radius: 10px; padding: 5px; margin-bottom: 5px;"> <p><b>Connected</b></p> <p>Idealized hopes</p> </div> <div style="text-align: center;">↓</div> <div style="border: 1px solid orange; border-radius: 10px; padding: 5px; margin-bottom: 5px;"> <p><b>Threatened</b></p> <p>Disappointment / fight or flight</p> </div> <div style="text-align: center;">↓</div> <div style="border: 1px solid orange; border-radius: 10px; padding: 5px; margin-bottom: 5px;"> <p><b>Alone</b></p> <p>Unanchored from reality</p> </div> <div style="text-align: center;">↓</div> <div style="border: 1px solid red; border-radius: 10px; padding: 5px;"> <p><b>Despair</b></p> <p>Worthless, hopeless, suicidal</p> </div>	<p><b>ADHD at this stage</b> Hyperfocus on idealized object. Impulsive attachment, novelty-driven bonding.</p> <p><b>ADHD accelerates the drop</b> Inconsistent availability ("I forgot to call") misread as lack of caring.</p> <p><b>ADHD deepens the aloneness</b> 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.</p> <p><b>ADHD compounds the despair</b> Chronic shame from lifetime of failures. Identity confusion amplified by inconsistent performance. Self-blame spirals reinforced by repeated inability to "just do better."</p>
--	--

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

16



17

## "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."

18

## MULTIMODAL — NOT JUST MEDICATION

A GPM-INFORMED FRAMEWORK FOR ADHD

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

19

## TAKE-HOME

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

20

## Good Psychiatric Management for Conduct Disorder

A comprehensive inpatient adaptation for adolescents with trauma, attachment insecurity, and conduct disorder

World GPM Congress

Kiely Foley MSN, MSW, PMHNP-BC, RN

This presentation covers

- Definition + risks if untreated
- Current treatment evidence
- Comorbidities and medication logic
- Interpersonal hypersensitivity in CD
- Hospital, family, and community alignment

Good Psychiatric Management is used here as a pragmatic framework for explaining, coordinating, and delivering care — not as a substitute for evidence-based family, behavioral, or trauma treatment.

1

## What is conduct disorder?

A diagnosis defined by pattern, persistence, and impact

**DSM framework**

**A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms are violated.**

At least 3 of 15 criteria in the past 12 months

At least 1 criterion present in the past 6 months

Symptoms cluster in 4 domains and must be impairing

**Aggression to people/animals**

Threats, fights, intimidation, cruelty

**Property destruction**

Vandalism, fire-setting, deliberate damage

**Deceitfulness / theft**

Lying, stealing, manipulation, breaking trust

**Serious rule violations**

Truancy, running away, repeated major rule breaches

DSM-5-TR criteria summary; AAFP 2018

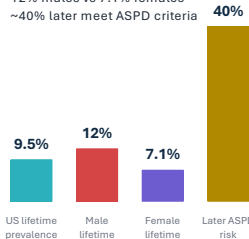
2

## Why early treatment matters

Conduct disorder is common, impairing, and associated with long-term risk if symptoms persist

### Selected epidemiology and risk markers

9.5% = estimated U.S. lifetime prevalence  
 12% males vs 7.1% females  
 ~40% later meet ASPD criteria



AAFP 2018; APA patient page; NICE guideline intro

**Up to 40%**

Looked-after / abused youth in UK surveys had a conduct disorder

**16–20%**

Youth with conduct disorder also have ADHD in AAFP review

**Untreated course**

Associated with school failure, substance use, and criminal behavior

**Clinical point:** untreated conduct disorder predicts a worse developmental trajectory; even when symptoms improve, the longer the pattern is rehearsed, the harder it becomes to restore school attachment, family trust, and safe peer relationships.

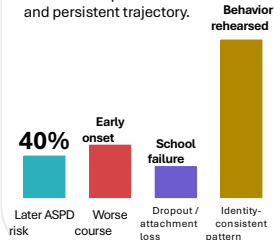
3

## Risks of untreated conduct disorder

Developmental trajectory: why early treatment changes outcome

### Selected developmental risks

~40% later meet criteria for Antisocial Personality Disorder; earlier onset predicts a more severe and persistent trajectory.



AAFP 2018; APA; NICE; AHRQ 2025; JAACAP 2025

**Developmental momentum**

Escalation from oppositionality to aggression to entrenched antisocial behavior becomes more likely over time.

**Functional impact**

School failure, loss of prosocial peers, and rupture with caregivers and institutions accumulate.

**Clinical point**

**We are not only treating behavior in the moment — we are interrupting a developmental trajectory.**

The longer the pattern is rehearsed, the harder it becomes to restore school attachment, family trust, and safe peer relationships.

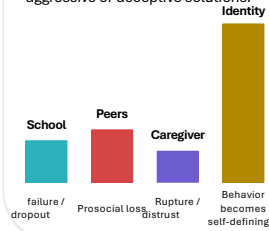
4

## Risks of untreated conduct disorder

Developmental trajectory: how untreated symptoms change identity and function

### Selected developmental risks

Untreated conduct disorder narrows school, peer, and family pathways while strengthening aggressive or deceptive solutions.



#### Identity risk

Aggression, deceit, and major rule-breaking can become part of how the adolescent understands self and status — not just a situational reaction.

#### Why timing matters

Early coordinated intervention changes trajectory more than late intervention after antisocial behavior is already entrenched.

#### Clinical point

**The goal is not symptom perfection on the unit — it is trajectory shift.**

This is why early, coherent inpatient, family, school, and community action matters.

AAFP 2018; NICE; AHRQ 2025; JAACAP 2025

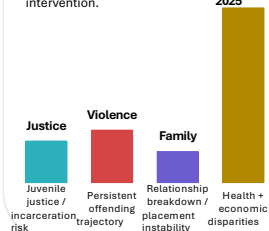
5

## Risks of untreated conduct disorder

Public health and systems impact: conduct disorder becomes a multi-system burden

### Selected public health risks

Persistent disruptive behavior disorders are linked to long-term health, legal, and economic burden; earlier intervention changes trajectory more than later <sup>AHRQ 2025</sup> intervention.



#### Systems

Untreated CD predicts downstream involvement across schools, emergency settings, courts, probation, and residential care.

#### Costs

Healthcare, legal, educational, and lost-productivity costs accumulate across adolescence and adulthood.

#### Clinical point

**Untreated conduct disorder is one of the strongest predictors of system involvement in child psychiatry.**

CD is not simply a family or school problem; it is a public-health problem with developmental, legal, and economic consequences.

AHRQ 2025 systematic review; JAACAP 2025 meta-analysis; NICE; AAFP 2018

6

## Risks of untreated conduct disorder

Public health and systems impact: why alignment across hospital, family, school, and community matters

**Selected public health risks**

The more systems become involved without one coherent therapeutic story, the more the adolescent experiences care as fragmented, punitive, and unstable.

**School**  
Exclusion / attendance failure

**Emergency**  
Crisis / restraint / repeat use

**Courts / care**  
Probation / residential

**Early**  
Intervention works better

**Alignment need** Hospital, family, school, and community should use one trigger map, one behavior plan, and one crisis script whenever possible.

**Research message** Recent syntheses support early, coordinated, caregiver-involved intervention and are less optimistic about late-stage change in entrenched adolescent conduct problems.

**Clinical point** **A world-conference message: CD is a public-health problem that requires integrated systems action.**

That is exactly where a GPM framework becomes useful: it gives teams one language and one plan across settings.

AHRQ 2025; Lee 2024; Hunkin 2025; NICE

7

## A developmental formulation is more useful than a moral one

Conduct disorder is best understood as an adaptation to chronic threat, disrupted attachment, and maladaptive reinforcement

**Trauma load**  
Physical abuse, domestic violence, chaotic caregiving, repeated humiliation

**Attachment insecurity**  
Expectations of abandonment, betrayal, or punitive control

**Conduct disorder**

**Social learning + peers**  
Aggression reinforced by status, safety, escape, or affiliation

*Framing implication: understanding a behavior as adaptive in its original context does not remove accountability; it tells the team where to intervene.*

AAFP 2018 risk factors; NICE introduction and principles of care

8

## Common co-morbidities change how conduct disorder looks

Co-occurring disorders often determine the trigger, tempo, and treatment priorities

**ADHD**

Impulsivity, reward-seeking, poor inhibition, rapid retaliation

AAFP: about 16–20% of youth with CD also have ADHD; NICE notes ADHD as a key complicating factor.

**PTSD / trauma-related symptoms**

Hypervigilance, hostile attribution bias, shutdown or fight

PTSD is a complicating factor in NICE guidance; trauma exposure is a major risk factor in AAFP.

**Mood / anxiety disorders**

Irritability, shame, hopelessness, suicidal risk, social withdrawal

Mood and anxiety symptoms increase shame, hopelessness, and overall psychiatric burden.

**Substance use disorders**

Disinhibition, intoxication-related aggression, peer contagion, legal risk

SUD magnifies risk-taking, peer contagion, and community harm.

AAFP 2018; NICE Q559 / CG158

## ADHD + conduct disorder: the fastest route to reactive aggression

When attention and inhibition problems combine with coercive or antisocial learning, fights happen faster and consequences matter less in the moment

**Mechanism**

Poor inhibition	➤	More rapid retaliation
High reward sensitivity	➤	More rapid retaliation
Low frustration tolerance	➤	Less pause before aggression
Rapid action before reflection	➤	Less pause before aggression

**Medication logic when ADHD is present**

No FDA-approved medication for conduct disorder itself  
Treat ADHD first: methylphenidate or atomoxetine within licensed indications  
AHRQ 2025: stimulants and/or antipsychotics outperform placebo for short-term aggression response, but evidence beyond that is sparse

**Practical inpatient implication**

If the unit is trying to manage “conduct disorder aggression” in a youth whose untreated ADHD is driving impulsive fights, treatment will look punitive and feel ineffective. A more accurate formulation reduces blame and improves sequencing.

NICE 1.6.1–1.6.3; AAFP 2018; AHRQ 2025

### Trauma / PTSD + conduct disorder: when threat is everywhere

Trauma does not excuse aggression — but it does change the trigger map

```

    graph LR
      A[Cue of rejection or humiliation] --> B[Trauma-linked appraisal: threat]
      B --> C[Autonomic arousal (shame, fear, anger)]
      C --> D[Action urge to attack, escape, or dominate]
      D --> E[Aggression, property destruction, risk-taking]
  
```

**Clinical pearl**  
Many adolescents with trauma histories misread neutral peer or staff behavior as contempt, exclusion, or impending control. In that moment, aggression can feel like self-protection rather than "bad behavior."

**Treatment implication**  
Use trauma-informed de-escalation in the moment; treat full PTSD with trauma-focused therapy once safe enough; keep accountability intact throughout.

AAFP 2018 differential and risk factors; NICE complicating factors and engagement principles

11

### Mood disorders, anxiety, suicidality and substance use complicate the picture

These syndromes increase volatility, shame, suicidality, and legal risk — and they need direct treatment

**Mood / anxiety/suicidality**

- May present as irritability instead of sadness
- Can intensify shame after aggressive episodes
- Treat when a full syndrome is present; do not collapse everything into "behavior"
- Adolescents with conduct disorder have a **5-fold increased risk of suicide attempts**

**Substance use**

- Intoxication and withdrawal lower inhibition
- Peers, access, and probation pressures increase relapse risk
- Integrated SUD treatment is part of the conduct-disorder plan, not an "extra"
- Adolescents suffering from CD, the risk of suicidal behavior is considerably increased by co-morbid alcohol dependence

AAFP 2018; NICE Q559 complicating factors

12

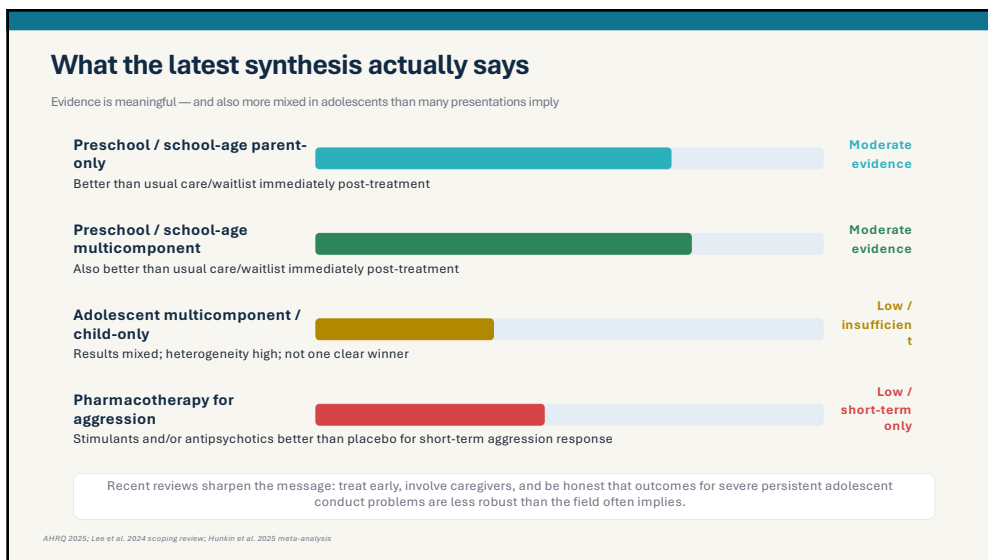
### Current psychosocial treatment options

What is evidence-based, for whom, and what each model tries to change

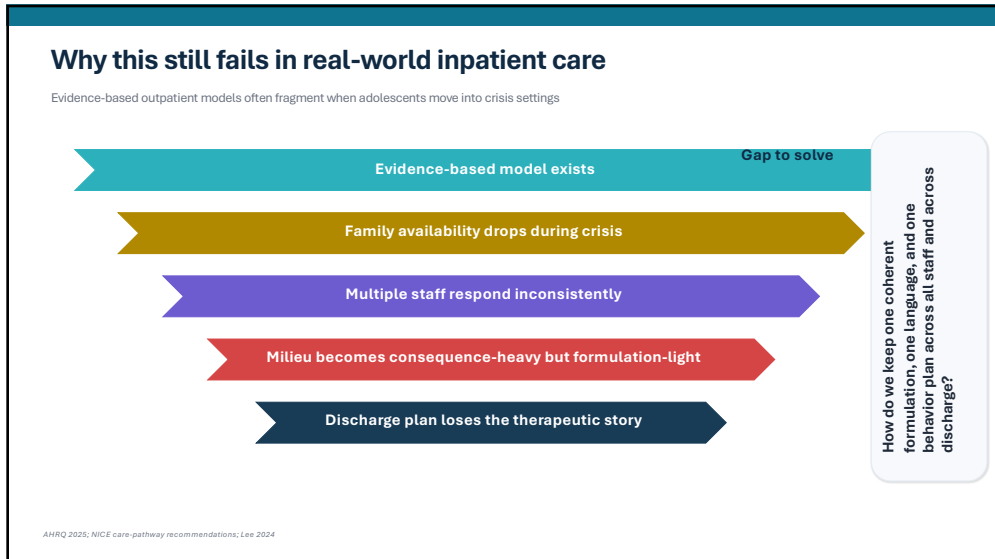
Intervention	Best fit	Core target
Parent management training / parent-only	Younger children; family can participate regularly	Reduce coercive cycles; strengthen reinforcement, routines, monitoring
Parent + child multicomponent programs	Preschool and school-age youth	Combine parent skill building with child social/problem-solving work
CBT / problem-solving skills training	School-age and some adolescents	Hostile attribution bias, anger regulation, perspective-taking, choice points
Multisystemic therapy (MST)	Older adolescents; justice/system involved	Home, school, peers, legal context, supervision, community ecology
FFT / family-focused adolescent work	Adolescents with entrenched family conflict	Reduce blame/escalation; improve communication, supervision, alliance
Treatment Foster Care Oregon / intensive placement-based models	Youth whose home setting cannot currently sustain safety	Structured behavior support with parallel family work

*Bottom line: the evidence base is strongest when an intervention changes the caregiver system and the child's decision-making environment — not just the child's insight.*  
AHRQ 2005 systematic review; NICE 2015a, 2015b, 2015c

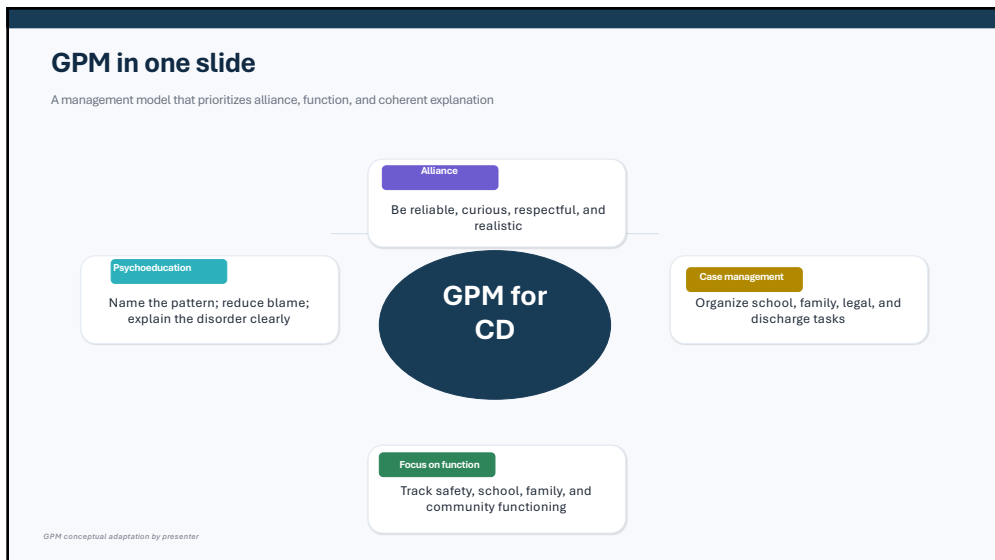
13



14



15



16

## Adapting GPM specifically for conduct disorder

The adaptation shifts the focal problem from "instability of self and relationships" to "interpersonal threat, control, and rights violations"

**Accountability + empathy**

Understand why the behavior happens without excusing it

**Structure as treatment**

Predictability reduces chaos and clarifies consequences

**One story across staff**

Prevent splitting, bargaining, and mixed messages

**Function over confession**

Target safety, school, family, and discharge readiness

**Developmental hope**

The goal is a trajectory shift, not a perfect unit stay

GPM adaptation by presenter, consistent with NICE engagement and pathway principles

17

## Interpersonal hypersensitivity model: a useful bridge from BPD to conduct disorder

In conduct disorder, perceived abandonment, humiliation, disrespect, or loss of control can rapidly activate retaliatory behavior

**Trigger themes**

- Rejection
- Abandonment
- Humiliation
- Status loss
- Adult control

**Internal appraisal**

"I'm being disrespected."  
 "They are against me."  
 "I have to act now."

**Action tendency**

- Attack
- Dominate
- Damage
- Escape
- Recruit peers

*This model matters because it changes the staff question from "How do we stop defiance?" to "What interpersonal cue just made aggression feel necessary?"*

GPM-informed adaptation by presenter, consistent with trauma and engagement principles in NICE / AAFP

18



19

### Clinical vignette: the same event through two lenses

A GPM frame changes what staff notice, say, and prioritize

**Typical reading**

Peer laughs after basketball game. Patient says, “You think I’m a joke?” He shoves the peer, punches the wall, and kicks a chair when staff intervene.

- “He is manipulative and refusing limits.”
- Staff react to the aggression only.
- Intervention becomes consequence-heavy and relationship-light.

**Likely outcome: brief compliance, persistent resentment, repeated replay**

**GPM reading**

Same event, different formulation: perceived humiliation → shame/anger spike → urgent need to restore status. Staff name the feeling, set a limit, offer a choice, and return later for repair.

- “That felt disrespectful. Throwing chairs is not okay.”
- “You can step out with me now, or we move to a higher level of containment.”
- Later: reconnect, review the trigger, plan a better move next time.

**Likely outcome: less escalation, preserved alliance, better learning window**

Illustrative clinical vignette by presenter

20

## Hospital staff are the intervention

On an inpatient unit, the treatment is not one clinician; it is the consistency of the whole system

- **Psychiatry / NP**      Diagnosis, medication sequencing, shared formulation
  - **Nursing**              Moment-to-moment regulation, predictable limits, observation
  - **Milieu counselors**      Relationship continuity, coaching, consequence delivery
  - **Social work**              Family alignment, systems coordination, discharge bridge
  - **Psychology / therapy**      Skills, repair, behavior analysis, trauma work when ready
  - **School / recreation**      Restore mastery, routine, and prosocial identity
- Shared stance**      Calm • brief • non-punitive • consequence-based • one story across shifts



NICE staff competence, supervision, and integrated pathway principles; team photo: Advisory Board

21

## What staff actually do on the unit

These are small moves — but they only work when everybody makes them the same way

- Keep it brief**      Long lectures usually strengthen opposition or shame
- Name the trigger**      "That felt disrespectful to you."
- Set the limit**              "Threatening or hitting is not okay."
- Offer structured choice**      "Step out now or we move to a higher level of containment."
- Return for repair**      After safety is restored, revisit the cue and plan another move

### Sample language

"You can be angry here. You cannot threaten staff."

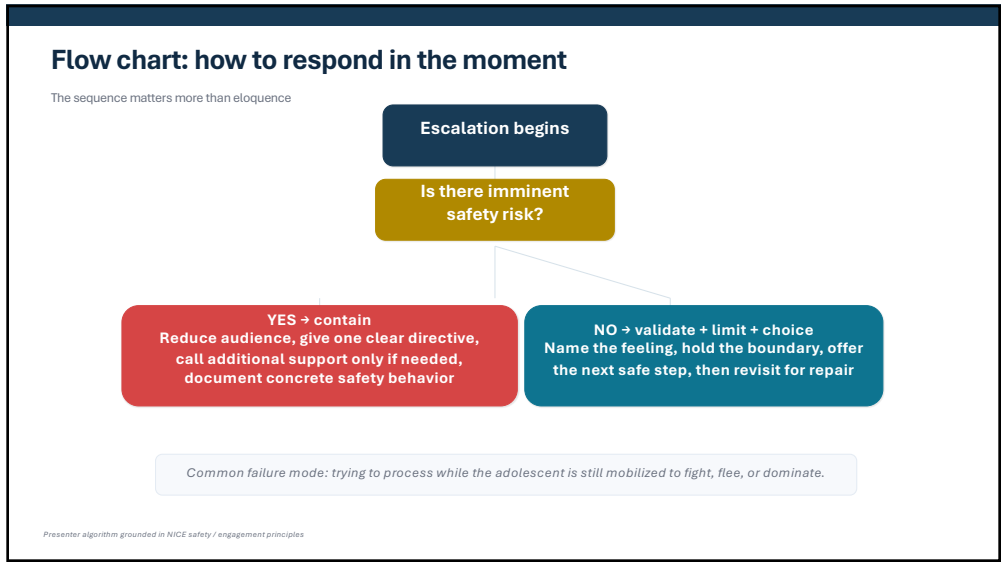
"I'm not arguing with you. I'm telling you the next safe step."

"We will talk more after you're regulated enough to use words."

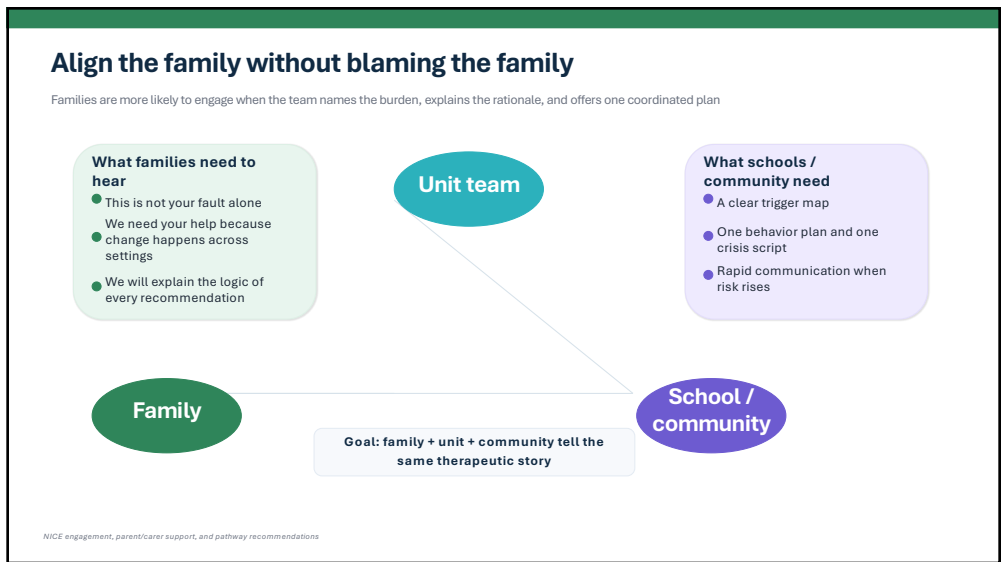
"This consequence is about safety and repair, not about punishment."

Presenter framework for unit language and stance

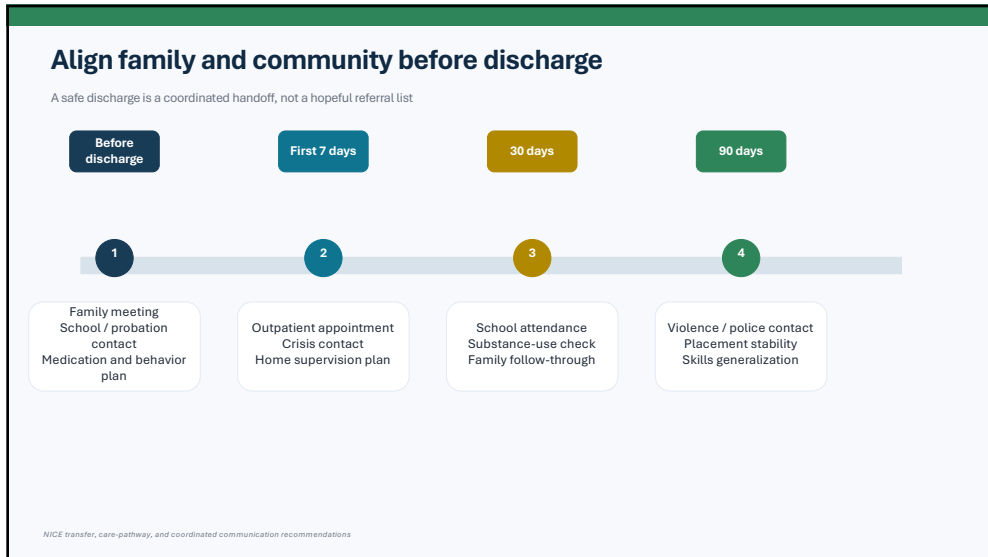
22



23



24



25

### Medication: important, limited, and often misunderstood

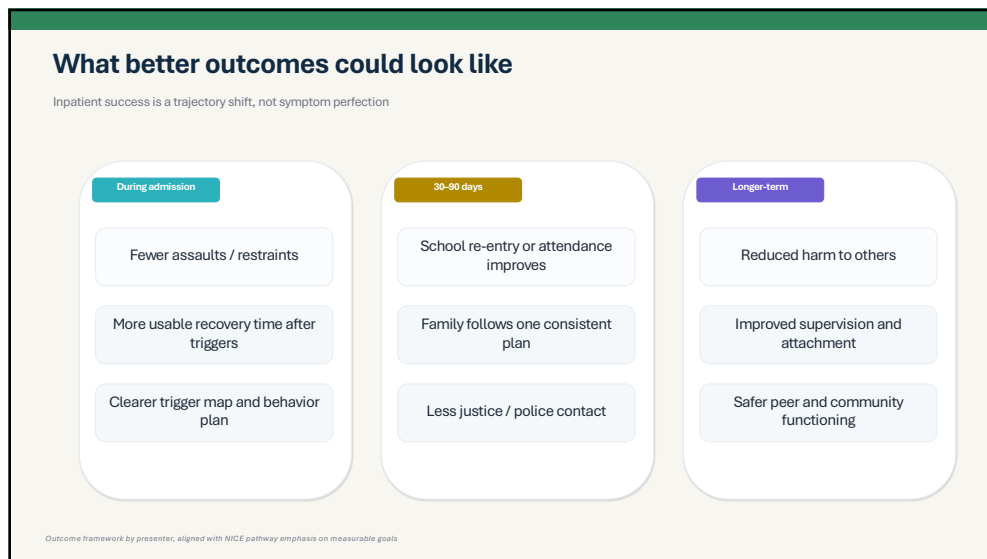
There is no FDA-approved medication for conduct disorder itself

**Do not routine-medicate "behavior problems" in CD. Use medication to treat a co-occurring syndrome or short-term severe aggression when psychosocial treatment alone has not been enough.**

ADHD present	Severe explosive aggression	Mood / PTSD / SUD
<b>Stimulants or atomoxetine within usual indications</b>  Best medication-supported route when impulsivity is a major driver of aggression	<b>Consider short-term risperidone only after psychosocial work and ADHD treatment are addressed</b>  Monitor metabolic, movement, cardiovascular, and prolactin risks; review at 3–4 weeks and stop by 6 weeks if no important response	<b>Treat the diagnosed syndrome with its own evidence-based protocol</b>  Medication choice follows the comorbid disorder, not the conduct-disorder label

NICE 1.6.1–1.6.7; AAFP 2018; AHRQ 2025

26



27

## Key takeaways

- Conduct disorder is defined by persistent rights violations and major rule-breaking — not simply “noncompliance.”
- Untreated symptoms are associated with school failure, substance use, justice involvement, and later antisocial personality disorder risk.
- Current evidence supports psychosocial treatment first; medication mainly targets co-morbidity or short-term severe aggression.
- A GPM frame helps inpatient teams keep one coherent formulation: accountability with empathy, function over blame, and one story across staff.
- The interpersonal hypersensitivity model explains how abandonment, humiliation, and status loss can become aggression, property destruction, or high-risk behavior.
- Outcomes improve when hospital staff, family, school, and community are aligned before discharge.

28

## Selected references

References used for claims and slide content

1. Selph SS, Skelly AC, Dana T, et al. Psychosocial and Pharmacologic Interventions for Disruptive Behavior in Children and Adolescents: A Systematic Review. AHRQ Publication No. 25-EHC024. April 2025.
2. NICE. Antisocial behaviour and conduct disorders in children and young people: recognition and management (CG158). Published 2013; current guidance pages reviewed through 2024–2025.
3. Lillig M, et al. Conduct Disorder: Recognition and Management. American Family Physician. 2018;98(10):584-592.
4. American Psychiatric Association. What are Disruptive, Impulse Control and Conduct Disorders? patient/family resource page accessed 2026.
5. Lee V, Watson S, Shlonsky A, Tarren-Sweeney M. A scoping review of randomized controlled trials of parenting and family-based interventions for 10–17 year-olds with severe and persistent conduct problems. J Evid Based Soc Work. 2024.
6. Hunkin H, et al. Systematic review and meta-analysis of prominent community-based interventions for delinquent and antisocial behavior. JAACAP. 2025.
7. Helander M, et al. The efficacy of Parent Management Training with or without adjunctive treatment for children with clinical levels of disruptive behavior: systematic review and meta-analysis. Clin Child Fam Psychol Rev. 2024.
8. Rajkumar RP. Antipsychotics in the management of disruptive behavior disorders in children and adolescents: an update and critical review. 2022.

Full URLs and source notes embedded in slide notes