

GPM-A

General Psychiatric Management for

Adolescents With BPD — *Brazilian Implementation*

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Disclosures

Financial conflicts of interest

Marcos S. Croci, MD

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Marcelo Brañas, MD, PhD

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Why?

The scale of the problem in Brazil

A population-level demand that specialist care cannot meet

Demand

- 6.8% any PD in São Paulo (*Santana et al., 2018*)
- 1.8% BPD in São Paulo (*BHRC**)
- 20–30% of outpatient mental-health attendees ·
35–40% in CAPS
- Brazilian High-Risk Cohort: ~20% BPD among severely symptomatic young adults
- 17.4% adolescent NSSI rate (*Angelo, Pan, Miguel, Brañas & Croci, 2026, in submission*)

Supply

- 6.39 psychiatrists per 100,000 — OECD average 17.83 (*Scheffer et al., 2025*)
- 61.4% of psychiatrists concentrated in state capitals
- ~1.25 DBT therapists per 10,000 people with BPD
- Mental health = 2.54% of the health budget (WHO recommends 5%)

80% treatment gap — specialist-led BPD care is unreachable for most Brazilians who need it.

Self-harm in Brazil: Rising Trends

Population-level evidence from recent health information system data

The rising trends of self-harm in Brazil: an ecological analysis of notifications, hospitalisations, and mortality between 2011 and 2022

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Summary

Background Self-harm is considered an important public health issue and is comprised by a wide range of definitions and behaviours. It is estimated that suicide affects more than 700,000 individuals every year, although, globally, there is a lack of evidence on other self-harm behaviour, such as attempted suicide. The objective of this study is to report and examine temporal trends of notifications, hospitalisations related to self-harm and suicide rates in Brazil between 2011 and 2022, as well as investigating differences in sociodemographic characteristics, methods, and region.

The Lancet Regional Health - Americas 2024;31: 100691
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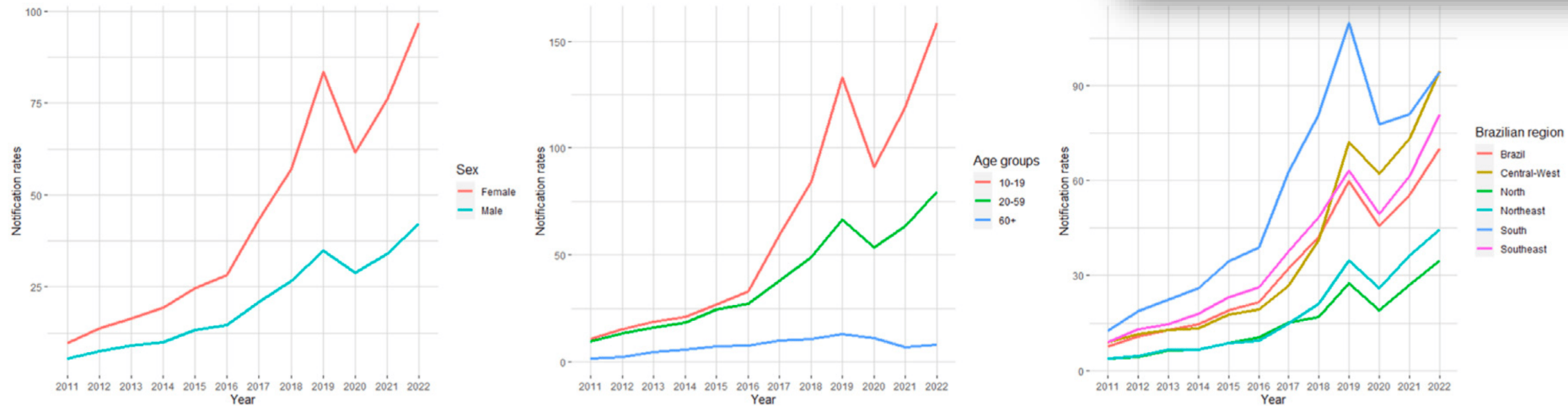


Fig. 1: Self-harm notifications rates by age, sex, and Brazilian regions. Brazil. 2011–2022.

www.thelancet.com Vol 31 March, 2024

Brazilian healthcare — two parallel systems

Most professionals work in both

Public — SUS

Entirely free at point of service

for any person — including foreigners

Primary, secondary, and tertiary

levels of care

Tertiary care = HC-FMUSP / ADRE

Private

Insurance-based

offered by employers or purchased individually

Out-of-pocket

access to private hospitals, labs, and clinics

Specialist BPD care is almost entirely private

Healthcare professionals usually work in more than one system

BPD adolescents scatter — myths block proper care

Patients fall between clinics while institutional beliefs delay treatment

Scattered across clinics

- Patients migrate between symptoms and clinics
- Mood, impulsivity, and substance-use labels obscure BPD
- No coherent framework for BPD's core symptoms
- Frequent, unnecessary, prolonged hospitalizations

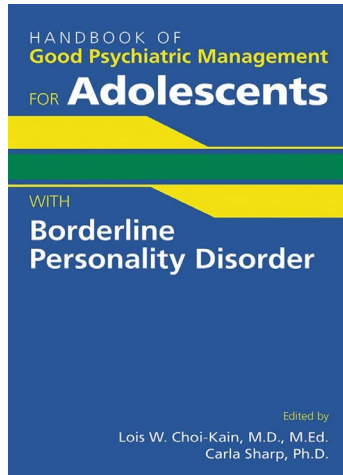
Institutional myths

- ✗ *“Can't diagnose BPD in adolescents”*
- ✗ *“BPD is untreatable”*
- ✗ *“Let them mature by themselves”*
- ✗ *“General training is enough to treat BPD”*

Delaying well-informed BPD care worsens long-term outcomes — we need a curriculum update.

Generalist models needed — and now available

Theory, clinical manual, and Portuguese translation make GPM-A deliverable in Brazil



Clinical manual


*Choi-Kain & Sharp, Eds.
APA Publishing, 2024*

Handbook of Good Psychiatric Management for Adolescents with Borderline Personality Disorder — the training text behind GPM-A implementation.



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

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

 hogrefe

Portuguese translation

Hogrefe (Brazilian ed.)

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

A clinical manual and a Portuguese translation — GPM-A is ready for Brazilian implementation.

Why generalist-first — and why GPM-A

At population scale, only structured generalist care can reach most patients

Why generalist-first

- **As effective as EBTs** — structured generalist care is non-inferior to CAT and DBT-A

Ilagan & Choi-Kain, 2021

- **Feasible workforce** — deliverable by general-psychiatry residents under supervision

Unruh & Gunderson, 2016

- **Sustainable cost** — less resource-intensive than specialist EBT programs

Choi-Kain, 2016

Why GPM-A among generalist options

- **Public-system fit** — built for nationwide, SUS-style dissemination

Gunderson, 2016

- **Common language** — shared framework across therapy schools (DBT, MBT, TFP, psychodynamic)

Kramer et al., 2017

- **One clinician, one relationship** — meds and therapy integrated in the same dyadic frame

- **Function over symptoms** — school, relationships, and daily life as treatment targets

GPM-A — eight basic principles

1

**Early diagnosis
is routine**

Lower threshold to 3+ DSM-5
criteria

2

**Psycho-
education**

Patient, family, school, peers

3

**Be active,
not reactive**

Role-model “thinking first”

4

**Focus on life
situations**

School, work, relationships

5

**Real &
professional relationship**

Dyadic; balance splitting

6

**Change is
expected**

Re-examine if not improving

7

**Foster
accountability**

Own actions; learn from
mistakes

8

**Ensure family
involvement**

Alliance; crisis management

Today's question: what does it take to deliver this in a Brazilian tertiary-care public setting?

GPM-A — five key adaptations from GPM

Driver: BPD as a public-health imperative — 11–22% of adolescent outpatients, 33–49% of inpatients (Chanen et al. 2017)

1

Subthreshold inclusion

≥3 BPD criteria suffice (vs. full-criteria adult diagnosis)

2

Age-appropriate language

Relatable framing for psychoeducation; three developmental scripts (younger / mid / older teens)

3

Amplified family involvement

Family is structural, not adjunctive — confidentiality, mediation, sibling support, mandated reporting

4

Time-limited treatment

Shortened, planned termination — avoid interrupting normative developmental trajectories

5

Explicit developmental focus

Identity formation, school engagement, autonomy, peer relationships

Aligned with DSM-5 AMPD / ICD-11 · Preserves GPM core: “good enough,” “getting a life,” interpersonal hypersensitivity

GPM-A — operational specifics

Family, crisis, multimodal village, planned ending — and updated clinical content

Structural process

- **Age-modulated disclosure** — three developmental scripts (parents-first, family-together, adult-style)
- **Family is structural** — confidentiality, mediation, sibling support, mandated reporting
- **Dyadic crisis planning** — parent coping plan alongside patient safety plan; restrict lethal means
- **Multimodal “village”** — school counselors, college MH, extracurriculars partly substitute for group therapy
- **Planned ending** — time-limited termination, boosters, annual check-ups; teens leave with anxiety, not mourning

Updated clinical content

- **NSSI** — mean onset 13 yrs; sleep & social-media contagion as modifiable risks
- **School & college** — accommodations, transitions; group matching by narrow age bands (12–14, 15–17)
- **FINE cue** — “Feelings I’m Not Expressing” —actively challenge passivity
- **ADHD comorbidity** — 38% in adolescents vs. 14% in adults; treat as you would without BPD



The ADRE program

University of São Paulo • Hospital das Clínicas

The largest university-hospital complex in Latin America

HC-FMUSP

Teaching, research, and specialized care — the reference tertiary-care center for the state

Institute of Psychiatry (IPq)

Hosts the Department of Child & Adolescent Psychiatry

ADRE

Adolescent BPD outpatient program — embedded in residency training



Adolescent BPD Outpatient Program (ADRE)

Tertiary-care clinic embedded in a residency training program

1

Embedded

Sits inside the Department of Child & Adolescent Psychiatry at IPq-HC-FMUSP

2

Tertiary referral

Complex*, comorbid adolescent cases referred other clinics at USP and secondary services

3

Dual mission

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

ADRE pathway — referral, screening, treatment

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

1 By Referral

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

2 Initial Screening

- Zanarini's Childhood Interview for BPD (CI-BPD)
- Psychiatric interview by senior staff

3 Treatment

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

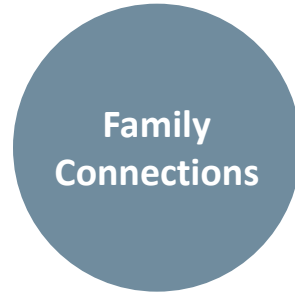
Zanarini et al., 2003 — Childhood Interview for DSM-IV Borderline Personality Disorder

Interventions and structure

Core program + stepped-care add-ons when needed



weekly
6–12 months



group
12 sessions



group · psychoeducation
adjunctive

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



if needed
6 months



if needed
as indicated

The team — multidisciplinary staff

Staffing across clinical and research arms

GPM-A

Residents

3 PGY-3 (general psychiatry) · 3 PGY-4
(child & adolescent psychiatry)

Supervisors

6 psychiatrists + 1 psychiatric nurse

Backgrounds

GPM/GPM-A, MBT/MBT-A, TFP, DBT

Therapists

2 clinical psychologists — family
therapy + waiting-room group
(psychoeducation & art therapy)

Waiting-room group

1 psychiatrist + 1 psychiatric nurse

DBT-A

Skills Group

4 clinical psychologists + 1 supervisor

Individual Sessions

2 psychiatrists + 1 supervisor

1 DBT-A individual therapist

2 psychopharmacologists

Research / shared

Clinical psychologists

2 (shared with GPM-A)

Neuropsychologist

1

Administrative assistant

1

Weekly supervision

How the team stays calibrated and residents stay supported

Case discussion

- **Weekly meeting** — every active case reviewed by the multidisciplinary team.
- **Shared formulation** — diagnosis, risk, and treatment plan re-examined together.
- **Protocol fidelity** — drift from GPM-A principles flagged and corrected early.

Reducing resident anxiety

- **Contained worry** — residents bring high-risk cases to the team instead of carrying them alone.
- **Explicit reassurance** — supervisor names what is being done well, not only what to fix.
- **Prevents defensive medicine** — non-reactive resident, clearer decisions, fewer reactive hospitalizations.

Supervisor sees the patient

- **Threshold for direct review** — any diagnostic uncertainty, safety escalation, or therapeutic impasse.
- **Joint session** — supervisor joins a session with resident and patient, modeling GPM-A stance.
- **Continuity preserved** — patient stays with their resident; supervisor intervenes, not replaces.

Guia do Residente

Resident handbook for the ADRE service — orientation, framework, and case-formulation tools

The handbook



Cover page. Orientation, team structure, treatment phases, admission criteria, and rotation calendar for incoming residents.

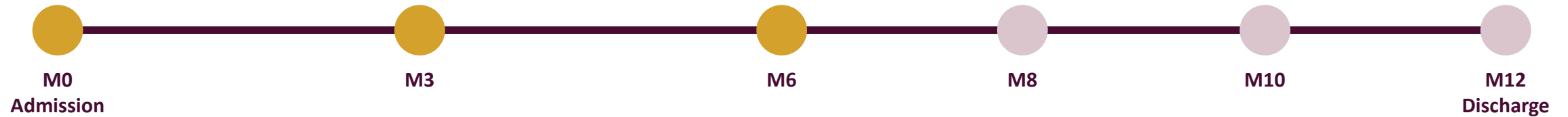
Interpersonal dynamics



Interpersonal dynamics of BPD — adapted from the GPM manual. Shared framework for every resident on the service.

Research protocol — assessment timeline

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



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

Diagnoses and personality functioning	CI-BPD · LPFS-BF 2.0
Repeated assessment	BSL-23 Main & Supplement (monthly) · BPFS-C (quarterly) · ZAN-BPD lability 1-item (weekly)
Trauma / eating / medical	QUESI-CTQ · EAT-26 · Medical Questionnaire (admission & discharge)
Emotional regulation / dissociation	DERS-16 · DES
General psychopathology	CBCL/6-18
Suicidality / self-harm	C-SSRS · DSHI-9 · RSS
SES / functioning / quality of life	SES · WSAS (monthly) · CGI · YQOL-R
Therapist-patient / alliance / stigma	GPM Principles · WAI-SR · GPM-AS · Attitudes toward BPD · Acceptability/Feasibility



Challenges

Diagnosis & differential diagnosis

C1

BPD is heterogeneous — patients present with distinct symptom profiles

Patient A

- Interpersonal hypersensitivity
- Anger issues
- ADHD symptoms

Patient B

- Interpersonal hypersensitivity
- NSSI
- Suicide threats

Patient C

- Interpersonal hypersensitivity
- Dissociative & paranoid symptoms
- Withdrawal
- Substance use

Trainees often default to depression, ADHD, or PTSD — ongoing discussion of BPD psychopathology and the literature is a day-to-day necessity.

Comorbid disorders & other conditions

How the ADRE caseload extends beyond BPD — and how we respond

Gender Dysphoria

Collaboration with a specialized clinic at USP

Eating Disorders

GPM-A for Eating Disorders + collaboration with a specialized clinic at USP

Autism

GPM-A+B

Dudas & Cheney, 2025

cPTSD

DBT-PE and DBT-PTSD elements

Choi-Kain, 2021

ADHD

Frequently the stopping-point diagnosis. Residents read impulsivity and mood reactivity as ADHD alone and miss the BPD formulation. **Our response:** routine CI-BPD screening + formulation supervision.

Mood Disorders

Depressive and bipolar-spectrum features can mask BPD. **Our response:** we teach residents to hold both diagnoses when criteria are met, rather than default to the mood label.

BPD at USP in the last 10 years — from undiagnosed and ignored to a recognized institutional and national priority.

Keeping GPM-A on the rails

Two simultaneous drifts — residents and supervisors

C2

Residents learning GPM + clinical fundamentals at once

Learning psychiatric interview, formulation, and risk assessment at the same time they learn the model.

Framework drift — two directions

GPM is eclectic — the principles are what matter, not the purity. Drift happens in two directions: some supervisors lean too passive (underusing structure, activity, accountability); others narrow onto crisis planning, skills, and suicidality.

Root cause: most supervisors also work in private practice with other models, which shapes what they bring into supervision.

Our response: GPM-AS scoring + framework-specific teaching

- **Weekly case supervision** with the **GPM-AS** adherence scale used routinely
- GPM-framework teaching in parallel to general-psychiatry training.

Diagnostic drift

Some residents prefer ADHD or PTSD labels and reframe any trauma history as PTSD.

Our response: routine CI-BPD + formulation supervision, reinforcing that BPD can coexist with ADHD/PTSD rather than be replaced by them.

The waiting-room problem

C3

From a contagion hot-spot to a structured group intervention

Long commutes, unpredictable arrivals

Many adolescents and their parents travel hours by public transit and arrive well before their appointments — leaving patients gathered together in the same waiting room.

Serious peer contagion incidents

Covert NSSI behaviors went undetected — on one occasion adolescents **shared shaving blades** in the waiting room. Substance exchange also occurred, and one adolescent developed a significant **MDMA intoxication** requiring emergency department transfer.

Our response: the Waiting-Room Group

A semi-structured group held by **two clinicians (a psychiatrist and a psychiatric nurse)** while adolescents wait for their resident appointment, alternating with group art-therapy sessions. In parallel, parents attend family interventions such as **Family Connections**.

Nation-wide dissemination

C4

ADRE graduates move into services where GPM is unknown — we built materials, publications, and events to seed them

Materials

- **GPM Manual** translated to Portuguese
- **Harvard Medical School** online course
- **Psychoeducation videos** — multi-site

Publications

- **Original publications** — PT, ES, EN
- **Book chapters** on BPD / GPM
- **Free podcast episodes** for clinicians

National Events

- **Brazilian Psychiatric Association** Annual Meeting
- **Brain, Emotions and Behavior** Congress
- **Workshops** at partner universities and services

Implementation partnerships & next frontier

ADRE-trained clinicians seeding GPM programs — and pushing beyond clinicians to leadership

CESUPA → GPM-A

Belém, Brazil



**Yasmin
Nascimento, MD**



Silvana Costa, MD

FAMERP → GPM

São José do Rio Preto, Brazil



Larissa Fares, MD



Bruno Soleman, MD

Périgueux → GPM-A

Centre Hospitalier Périgueux, France



Vinicius Freitas, MD

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

BPD Awareness Day: ongoing project in the Brazilian Senate.

Residency training is the implementation lever

“ While the burden posed by BPD rivals that associated with other major **mental illnesses**, the prevailing disposition of psychiatrists remains characterized by **misinformation, stigma, aversive attitudes, and insufficient familiarity** with effective generalist treatments.

Residency training programs are **well positioned** to better equip the next generation of psychiatrists.

— Unruh & Gunderson, 2016

ADRE as a training ground

Evidence that the residency lever works

TOP 2

out of 35 rotation options

for 8 consecutive years

*Ranked 1st or 2nd every year among PGY-3
psychiatry residents at USP.*

2024 Prize for Excellence in Teaching

Awarded by the 5th-year medical students and
the Department of Psychiatry at USP

to the ADRE directors

Future directions — GPM-NSSI

A generalist brief adaptation under development for NSSI in youth

Authors

Marcos S. Croci • Carole Kapp • Sebastien Urben • Natalia Saldanha • Lois W. Choi-Kain • Marcelo J.A. Brañas • Ueli Kramer

What we're building next

- **17.4% / 13.4%** NSSI rates in adolescents / young adults — yet most don't access DBT-A
- **Generalist adaptation** deliverable in primary / non-specialist settings
- **Shared ingredients with effective self-harm care** — formulation, diagnostic disclosure, psychoeducation, safety, family
- **NSSI-specific strategies** — functional analysis, peer influence, motivation, mindful clinician stance
- **Stepped-care referral** for complex or non-responding cases

Take-home

01

Adolescent BPD is a valid, treatable diagnosis

Under-diagnosed despite severity comparable to adult BPD.

02

Generalist-first where specialists are scarce

GPM-A is deliverable in a tertiary-care public system.

03

Local adaptations matter

FC + individualized parenting + structured waiting group solved real operational problems.

04

Residency is the implementation lever

Training the next cohort is how GPM spreads through a public system.

05

Systemic change requires institutional work

Leadership-level engagement + dissemination + international partnerships.

Tack!

Thank you!

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*GPM for Latin America
paper*

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