Invited Article

AUSTRALASIAN PSYCHIATRY

Bringing personality disorder in from the cold: Why personality disorder is a fundamental concern for youth mental health

Australasian Psychiatry
2023, Vol. 0(0) 1–3

DOI: 10.1177/10398562231159511
journals.sagepub.com/home/apy
SAGE

Andrew M Chanen Orygen, Melbourne, Australia; Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia

Abstract

Objective: Personality disorder (PD) has its peak incidence between puberty and young adulthood. By any measure, it is among the most severe mental health problems occurring in young people, uniquely predicting debilitating current problems and acting as a 'gateway' to diverse and serious future problems. Yet, PD still struggles for legitimacy and parity of access to services, including early intervention.

Conclusion: Addressing PD is fundamental to youth mental health, and early intervention for PD has reached 'proof of concept'. Yet, reform is hindered by bigotry and sectarianism. Successful early intervention calls for a shift in the culture of services, countering damaging myths, addressing bigotry, and fostering hope. Such reforms are well within the reach of youth mental health.

Keywords: early intervention, adolescence, psychiatry, stigma, youth

What you were taught about personality disorder is probably past its 'use by' date

Personality disorder (PD) is actually a single construct, not multiple and discrete categories, such as borderline or antisocial.[1] This is reflected in the ICD-11 and the DSM-5 Alternative Model for PDs (AMPD). Both emphasise that, what is common to all forms of PD is enduring disturbance of self- and/or interpersonal functioning.[2] ICD-11 and AMPD relegate borderline personality disorder (BPD) to an option. However, strong evidence indicates that BPD captures the core of PD,[3] as reflected in the ICD-11/AMPD general PD definition. Pragmatically, the terms 'borderline' and 'severe' are interchangeable, with continuity with extant BPD research. Arguably, 'severe' has the advantage of eschewing misleading associations with 'borderline'.

Like other major mental disorders, PD has its clinical onset and peak incidence from puberty to early adulthood.[4] Robust evidence and international consensus demonstrate that PD can be validly diagnosed during this developmental epoch.[2,5]

Categorical PD diagnoses (introduced in DSM-III) have only moderate stability at all ages, and personality pathology is changeable across the life course.[1] While abnormal personality traits are more stable, these also change over the life course. Nonetheless, instability is not a barrier to clinical utility.[6]

Finally, while developmental trauma is common among people with BPD (and an important clinical focus), it is not universal, with 30% of adults with BPD having no history of trauma. Moreover, relatively few people with a history of developmental trauma develop BPD.[7]

Why is PD important in youth mental health?

PD occurs in 10% of the population.[8] Severe PD occurs in around 3% of young people in the community and around one fifth of those attending tertiary youth mental health services.[5,9]

Among young people, the PD diagnosis uniquely predicts severe and harmful current and future problems, which have been comprehensively documented elsewhere.[4] In short, PD ranks in the top ten causes of burden of disease (fourth among all age groups). Young people with PD

Corresponding author:
Andrew Chanen, Centre for Youth Mental Health, The University of Melbourne, Orygen, 35 Poplar Rd, Parkville, VIC 3052, Australia.
Email: andrew.chanen@orygen.org.au

have the lowest published quality of life scores of any similar-aged 'disease group' (e.g. psychosis or cancers), experience significantly greater levels of psychopathology than patients without PD, and have worse physical and sexual health, higher rates of drop out from education, employment and training, and higher rates of interpersonal violence, family violence, and non-violent offences. Their families also experience high levels of distress and negative caregiving experiences.

PD also increases the complexity of clinical presentation and treatment delivery, with high rates of treatment drop out[10] and poorer response to treatment for related disorders, such as depression.[11] Young people with first-episode psychosis (FEP) and BPD features have a more severe clinical picture than those with FEP alone[9] and experience greater difficulty accessing standard FEP care.[12]

PD also acts as a 'gateway' to diverse and serious problems later in life,[4] independently predicting future personality difficulties, depressive disorder, psychotic and hypomanic symptoms, becoming a perpetrator or victim of violence, and increased health care costs as early as at age 20 years.[13] Educational and employment outcomes are among the worst for all mental disorders and persist for decades.[14] Strikingly, the mortality rate is tenfold that of the general population, life expectancy is reduced by nearly two decades, and suicide risk (up to 10%) is among the highest for any mental disorder.[15,16]

What are we aiming to change for young people living with PD?

It is axiomatic in youth mental health that delays in treatment are linked to poor outcomes. For PD, delay is not only due to under-diagnosis and/or ineffective treatment but also to inappropriate and/or harmful treatment, which is often linked to intentionally delayed diagnosis, non-diagnosis, or use of substitute diagnoses.[5,6] For example, among young Australians attending the headspace national network of enhanced primary youth mental health services, diagnostic rates for BPD features (including subthreshold disorder) are less than 1%[17]; at least one tenth of the expected rate. Treatment engagement is poor (mean of 3 sessions attended), with only a 3–6% improvement in mean levels of quality of life, distress, and social and occupational functioning.[18] Moreover, 69%, 60%, and 45% of participants either did not improve or deteriorated on each outcome, respectively.[17]

It turns out that early intervention for PD isn't that difficult

Long-term individual psychotherapy has been proposed to be the mainstay of treatment for PD. While these specialised psychotherapies are more effective than 'treatment as usual' for reducing symptom severity for adults and young people,[19] structured, high-quality care is as effective as these 'brand name' therapies.[4] However, almost all studies are 'late-stage' interventions, delivered after many years of living with PD.

'Staged care'[20] has been developed so that young people do not have to 'fail treatment' to get to the care that they evidently needed in the first instance. At all levels of care, this requires a functioning and integrated youth mental health system that can welcome, respect, and adapt to the needs of young people with PD (not vice versa).

A recent clinical trial provides proof of concept for the clinical staging model in PD, finding that individual psychotherapy is neither necessary nor sufficient for effective early intervention.[18] In this trial, while all treatments were effective, a treatment program using individual psychotherapy was not superior to two other programs that did not use any individual psychotherapy. These pragmatic treatments included a youth-friendly clinical culture, early diagnosis, a model for understanding PD, time-limited clinical case management, and treatment for co-occurring problems. Such programs lend themselves to successful implementation across youth mental health services, improving access to timely and appropriate care.

Ignorance, prejudice, and discrimination: The final frontier

Early intervention for PD represents a shift in the culture of youth mental health services. Although the science underpinning this innovation is well advanced, arguably, the biggest barriers to reform are bigotry and sectarianism.[7] Disappointingly, this is most often promulgated by clinicians, who have more negative attitudes towards people living with PD than towards those living with other mental disorders.[7,21] This is evident in singling out PD for classificatory or diagnostic problems that are actually common to all mental disorders, in rigid adherence to scientifically unsupported and/or outdated beliefs about aetiology, treatability, and what constitutes effective treatment for PD, and in 'straw man' arguments that early intervention for PD is wedded to the categorical diagnosis of BPD, long-term psychotherapy, and only narrow outcomes based upon categorical BPD or PD criterion counts.[22–24] Lamentably, it gives rise to the disturbing argument that intervention for PD in young people is unjustifiable because there is insufficient evidence that it alters long-term outcome.[23] Such arguments would seem perverse if they were made for major depression or anorexia nervosa.

A pathway for constructive progress

The pathway forward will require proactive dialogue countering damaging myths, addressing bigotry among colleagues, and fostering hope among those living with PD and those who care for and about them. Such reforms are well within the reach of youth mental health, which has cultivated its own evidence-based, open, progressive, and hopeful clinical culture. The Global Alliance for

Prevention and Early Intervention for PD (GAP) was formed in 2014[5] and called for recognition that PD is a severe mental disorder requiring evidence-based policy. GAP works to end discriminatory practices and to advance the evidence base for early intervention for PD. Anyone can join this effort by emailing the author.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

Disclosures

The authors report no conflict of interest in relation to this work.

Ethical approval

No ethical approval and/or consent was required for this research.

ORCID iD

Andrew M. Chanen https://orcid.org/0000-0003-4468-622X

References

1. Chanen A, Newton-Howes G and Clark LA. Personality disorder across the life course. *Lancet* 2015; 385: 727–734.
2. Sharp C. Personality disorders. *N Engl J Med* 2022; 387: 916–923.
3. Sharp C, Wright AGC, Fowler JC, et al. The structure of personality pathology: both general ("g") and specific ("s") factors? *J Abnorm Psychol* 2015; 124: 387–398, https://psycnet.apa.org.ezp.lib.unimelb.edu.au/psycarticles/2015-09315-001.html
4. Chanen AM, Sharp C, Nicol K, et al. Early intervention for personality disorder. *Focus (Am Psychiatr Publ)* 2022; 20: 402–408.
5. Chanen A, Sharp C, Hoffman P, et al. Prevention and early intervention for borderline personality disorder: a novel public health priority. *World Psychiatry* 2017; 16: 215–216.
6. Chanen AM. Debate: it is time to stop turning a blind eye to personality disorder in young people. *Child Adolesc Ment Health* 2022; 27: 194–195.
7. Chanen AM. Bigotry and borderline personality disorder. *Australas Psychiatry* 2021; 29: 579–580.
8. Winsper C, Bilgin A, Thompson A, et al. The prevalence of personality disorders in the community: a global systematic review and meta-analysis. *Br J Psychiatry* 2020; 216: 69–78.
9. Schandrin A, Francey S, Nguyen L, et al. Co-occurring first-episode psychosis and borderline personality pathology in an early intervention for psychosis cohort. *Early Interv Psychiatry* 2022: 1–9. Epub ahead of print 26 September 2022. DOI: 10.1111/eip.13352.
10. Jørgensen MS, Storebø OJ, Stoffers-Winterling JM, et al. Psychological therapies for adolescents with borderline personality disorder (BPD) or BPD features—a systematic review of randomized clinical trials with meta-analysis and trial sequential analysis. *PLoS One* 2021; 16: e0245331.
11. Ramleth R-K, Groholt B, Diep LM, et al. The impact of borderline personality disorder and sub-threshold borderline personality disorder on the course of self-reported and clinician-rated depression in self-harming adolescents. *Borderline Personal Disord Emot Dysregul* 2017; 4: 22.
12. Francey SM, Jovev M, Phassouliotis C, et al. Does co-occurring borderline personality disorder influence acute phase treatment for first-episode psychosis? *Early Interv Psychiatry* 2018; 12: 1166–1172.
13. Hastrup LH, Jennum P, Ibsen R, et al. Welfare consequences of early-onset borderline personality disorder: a nationwide register-based case-control study. *Eur Child Adolesc Psychiatry* 2022; 31: 253–260.
14. Hastrup LH, Kongerslev MT and Simonsen E. Low vocational outcome among people diagnosed with borderline personality disorder during first admission to mental health services in Denmark: a nationwide 9-year register-based study. *J Pers Disord* 2019; 33: 326–340.
15. Nordentoft M, Wahlbeck K, Hällgren J, et al. Excess mortality, causes of death and life expectancy in 270,770 patients with recent onset of mental disorders in Denmark, Finland and Sweden. *PLoS One* 2013; 8: e55176.
16. Fok ML-Y, Hayes RD, Chang C-K, et al. Life expectancy at birth and all-cause mortality among people with personality disorder. *J Psychosom Res* 2012; 73: 104–107.
17. O'Dwyer N, Rickwood D, Buckmaster D, et al. Therapeutic interventions in Australian primary care, youth mental health settings for young people with borderline personality disorder or borderline traits. *Borderline Personal Disord Emot Dysregul* 2020; 7: 23.
18. Chanen AM, Betts JK, Jackson H, et al. Effect of 3 forms of early intervention for young people with borderline personality disorder: the MOBY randomized clinical trial. *JAMA Psychiatry* 2022; 79: 109–119.
19. Storebø OJ, Stoffers-Winterling JM, Völlm BA, et al. Psychological therapies for people with borderline personality disorder. *Cochrane Database Syst Rev* 2020; 5: CD012955.
20. McGorry PD and Mei C. Clinical staging for youth mental disorders: progress in reforming diagnosis and clinical care. *Annu Rev Dev Psychol* 2021; 3: 15–39.
21. McKenzie K, Gregory J and Hogg L. Mental health workers' attitudes towards individuals with a diagnosis of borderline personality disorder: a systematic literature review. *J Pers Disord* 2022; 36: 70–98.
22. Hartley S, Baker C, Birtwhistle M, et al. Commentary: bringing together lived experience, clinical and research expertise - a commentary on the May 2022 debate (should CAMH professionals be diagnosing personality disorder in adolescence?). *Child Adolesc Ment Health* 2022; 27: 246–249.
23. Allison S, Bastiampillai T, Looi JC, et al. Adolescent borderline personality disorder: does early intervention "bend the curve"? *Australas Psychiatry* 2022; 30: 698–700.
24. Kulkarni J. Complex PTSD - a better description for borderline personality disorder? *Australas Psychiatry* 2017; 25: 333–335.