ARTICLE

Early Intervention for Personality Disorder

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Both the *DSM-5* Section III Alternative Model for Personality Disorders and the *ICD-11* have introduced a genuinely developmental approach to personality disorder. Among young people with personality disorder, compelling evidence demonstrates a high burden of disease, substantial morbidity, and premature mortality, as well as response to treatment. Yet, early diagnosis and treatment for the disorder have struggled to emerge from its identity as a controversial diagnosis to a mainstream focus for mental health services. Key reasons for this include stigma and discrimination, lack of knowledge about and failure to identify personality disorder among young people, along with the belief that personality disorder must always be addressed through lengthy and specialized individual psychotherapy programs. In fact, evidence suggests that early intervention for personality disorder should be a focus for all mental health clinicians who see young people and is feasible by using widely available clinical skills.

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There is now a compelling evidence base demonstrating the reliability and validity of the personality disorder diagnosis across the lifespan, including for people under age 18 (1, 2). Clinically significant personality disorder usually emerges during the developmental period spanning from adolescence to young adulthood (which, for the purposes of this article, is defined as ages 12–25 years [i.e., "young people"]) (2), and has a cumulative prevalence of more than 25% between ages 14–22 years (3). Personality disorder is associated with a high burden of disease, morbidity, and premature mortality. However, the disorder has yet to make the leap from controversial diagnosis to mainstream mental health problem. Many clinicians remain reluctant to embrace early diagnosis and treatment (i.e., early intervention), with rates of detection 10–20 times lower than that suggested by clinical epidemiological data (4, 5).

DEVELOPMENTALLY INFORMED CLASSIFICATION OF PERSONALITY PATHOLOGY AND CLINICAL ONSET

Both the Alternative Model for Personality Disorders in *DSM-5* Section III and the *ICD-11* have introduced a genuinely developmental approach to personality disorder (6). They have adopted a dimensional trait approach to personality pathology that can be applied to all ages and that is consistent both with longstanding approaches to understanding psychopathology among children and adolescents and with substantial research showing that dispositional personality traits are observable among prepubertal children. They also formulate personality pathology in terms of maladaptive self- and interpersonal functioning, allowing for integration of established research on identity functioning into the study of maladaptive personality functioning.

This new approach provides a framework for understanding why the transition from childhood to adulthood appears to herald a sensitive development period, not only for the onset of major mental state disorders (7), but also for the onset of personality pathology, consequently informing a clinical staging approach to prevention and early intervention for personality pathology (6, 8). Although maladaptive personality traits have been studied comprehensively among children and adolescents (9), they provide an incomplete picture for clinical staging. An understanding of self- and interpersonal functioning is fundamental to clinical staging, because it captures the process by which prepubertal maladaptive traits transform into personality disorder among young people (10, 11).

Much of the research on personality disorder among young people has focused on borderline personality disorder; this disorder has been proposed to capture the core of personality pathology and to be most representative of all personality disorders (12, 13). Therefore, in this article, we use the terms "borderline" and "severe" personality disorder interchangeably, extrapolating the borderline personality disorder literature beyond the limits of its categorical diagnosis.

Another key component of a contemporary developmental understanding of personality pathology among young people is recognition that the transition from childhood to adulthood has become more complex and protracted in the

21st century, extending well beyond traditional concepts of adolescence (14, 15). This extended period of developmental challenge and vulnerability coincides with the peak period of clinical onset for the major mental disorders, including personality disorder (16). Knowledge that emerging psychopathology during this period is heterogeneous, and that personality pathology does not occur in isolation from other forms of psychopathology, has led to the emergence of youth mental health as an overarching concept to guide prevention and early intervention and to the application of transdiagnostic clinical staging to include personality disorder (6–8, 14). Transdiagnostic clinical staging recognizes that the early stages of the development of mental illness are marked by substantial changeability and uncertainty and that psychopathology might or might not evolve into more enduring syndromes that are typically seen in adult psychiatric settings. Staging enables more personalized selection of treatments that are proportionate to the young person's current needs and risk of illness progression and provides a pragmatic structure to guide service delivery (7).

WHY IS EARLY DETECTION OF PERSONALITY DISORDER IMPORTANT?

The personality disorder diagnosis has substantial clinical heuristic value among young people for both current and future problems. Personality disorder is the fourth leading cause of burden of disease among all mental disorders (after depression, anxiety, and schizophrenia) across all ages, and it ranks in the top 10 causes of disease burden among young people (17). Among young people, personality disorder distinguishes a group with high levels of distress, significant impairment in self- and interpersonal functioning, and extreme or inflexible personality traits. When compared with their peers without personality disorder, those with the condition have strikingly elevated levels of current psychopathology, including substance use, self-harm, and suicide attempts. Their problems and needs also extend to poor physical and sexual health, high rates of dropout from education, increased risk of being a victim or perpetrator of interpersonal violence and nonviolent offenses, and family violence (1). Quality of life scores among young people with personality disorder are the lowest for any disease group, worse than those for similar-aged people with cancer (18). Families of young people with personality disorder also struggle, with significantly elevated levels of distress, negative caregiving experiences, expressed emotion, and maladaptive coping strategies, compared with the general population of adults or with caregivers of young people with other severe illnesses, including first-episode psychosis (19, 20).

ELEVATED LEVELS OF PERSONALITY PATHOLOGY PREDICT FUTURE PROBLEMS

Borderline features among young people independently predict future risk of psychotic and hypomanic symptoms, a diagnosis of depression, personality difficulties, poor mental health, poor functional outcomes, and becoming a perpetrator or victim of violence (21–24). Borderline personality disorder features among young people are also associated with poorer educational and vocational outcomes and increased health care costs as early as age 20 (25), and these problems have been shown to persist for at least 2 decades (26). Nine years after first contact with the mental health system, people with the disorder are less likely to be employed or undertaking education, compared with those with other mental disorders, except for those with schizophrenia and schizotypal or delusional disorders (27), and the disorder is more strongly associated with unemployment and receipt of a disability pension than is depression or anxiety (28). Tragically, the mortality rate for people with recent-onset personality disorder is 10 times that of the general population, and life expectancy is reduced by nearly 2 decades (29, 30). Up to 10% of people with personality disorder die by suicide (31), and those with personality disorder are at greater risk of death by suicide than are those with other severe mental disorders (29).

ETIOLOGY AND NEUROBIOLOGY

Contemporary theories of the development of borderline personality disorder are situated within a developmental psychopathology framework (32). Accordingly, these theories identify genetic, biological, and/or psychological vulnerabilities in domains, such as emotion regulation (33), social cognition (34), or self- and identity development (35) that interact with the environment to derail healthy personality development. These theories are empirically supported by prospective studies that suggest a moderate genetic predisposition for personality disorder, in the same range as that for most other psychiatric disorders (36). Developmental psychopathology theories are further supported by research showing reciprocal or mediational associations between environmental risk factors, such as early maternal bonding impairment (37), harsh (38) or insensitive (39) parenting, physical maltreatment and/or maternal negative expressed emotion (40), and bully victimization (41), as well as concurrent or subsequent disruptions in self-control (42), mentalizing (40), emotion regulation (43), and self-representation (44).

Compared with the environmental risk factors, the role of underlying neurobiology in personality disorder lacks evidence, particularly for young people with first-presentation personality pathology. The etiology of biological alterations found among older patients remains unclear, possibly arising because of the chronicity or duration of illness (e.g., substance misuse or unhealthy lifestyle) and/or long-term treatment effects (i.e., polypharmacy) (45). Nonetheless, replicated biological research has suggested a fronto-limbic imbalance (45–47), as well as alterations of the peripheral stress response systems (48) or the hypothalamic-pituitary-adrenal axis (49). Research to date has suggested that these

prefrontal regulatory deficits inhibit top-down control of emotions and impulses, likely leading to emotional dysregulation and subsequent impulsive risk-taking and self-harm behaviors. Regarding the biological stress response, current evidence points to attenuated vagal activity (low parasympathetic functioning) as well as attenuated cortisol response to psychosocial stress (likely a result of chronic hyperactivity of the stress response system). However, these temperamental, biological, and environmental risk factors are nonspecific to personality disorder, and some or all aspects of the etiological pathway are shared with many mental state disorders.

TREATMENT STRATEGIES AND EVIDENCE

There is a maturing literature demonstrating the effectiveness of treatment for young people with personality disorder (1, 50), including nine published randomized controlled trials (RCTs) of a structured psychological intervention versus an active comparator (51). In most trials, structured psychological interventions have been superior to comparator treatments with regard to the rate and/or amount of improvement on the primary outcome. However, between groups differences have been clinically modest, and these differences have not been durable across follow-up periods of 12–36 months.

Some caution is required when interpreting these trials, because the clinical stage (e.g., subthreshold features vs. first-presentation vs. enduring disorder) of participants in these trials has been specified infrequently, and many trials have excluded young people with the most severe clinical presentations and/or common problems, such as substance dependence. Importantly, most trials have used insufficiently documented treatment as usual as a comparator, and few have reported on the quality or fidelity of the treatments administered.

Interestingly, among both young people and adults diagnosed as having borderline personality disorder, when well-characterized, high-quality treatments (i.e., not treatment as usual) have been used as comparators against "brand name" psychotherapies (e.g., cognitive analytic therapy, dialectical behavior therapy, mentalization-based treatment, transference-focused psychotherapy), the comparator treatments have performed almost as well or just as well as the better known psychotherapies (52). These results led to a recent high-quality clinical trial, which found that effective early intervention for borderline personality disorder could be achieved without using specialist psychotherapy (51). Rather, early intervention only required the more generally available skills of youth-oriented clinical case management and psychiatric care.

Despite the hopeful state of the treatment literature, globally, relatively few young people have benefited from these findings (5, 53). One key reason is the failure to identify personality disorder among young people presenting for care. Another is the long-held notion that a diagnosis of personality disorder must always be addressed through lengthy and complex specialist psychotherapy programs. Although these programs can be effective, they are usually complex, with high training needs and limited capacity for scaling up throughout health systems, thus severely limiting access to timely and appropriate care (5). The above evidence not only suggests that early intervention for personality disorder might be feasible with skills that are widely available in mainstream psychiatric services, but also that early intervention might be relatively easily scaled up throughout health systems in middle- and high-income countries.

MEDICATION

Systematic review evidence does not support pharmacological intervention for the features of personality disorder (54), and preliminary evidence suggests that this evidence is unlikely to change with the forthcoming update of the Cochrane review (55). This lack of evidence is especially the case among young people with personality disorder, for whom there are no published, high-quality RCTs. Yet, psychotropic medications are frequently prescribed in the absence of clear clinical indications (56, 57), often with multiple medications used for extended periods (56, 58). Furthermore, medications prescribed to manage crises are frequently continued far beyond a helpful time frame, often driven by clinician concern that cessation will destabilize a patient (59).

In contrast, there is also evidence that some mental state disorders among young people, such as first-episode psychosis, might be undertreated with medications when co-occurring with personality disorder (60). Clinical experience suggests that this undermedication frequently occurs when common mental state disorders, such as depression, co-occur with personality disorder.

QUESTIONS AND CONTROVERSIES

Stigma, Prejudice, and Discrimination

Young people living with personality disorder, and those who care for them, still struggle to be respected and taken seriously (61). They experience significantly greater stigma than those with other severe mental disorders (but without personality disorder), and more severe personality disorder is associated with increased stigma, regardless of co-occurring diagnoses (62). Negative attitudes and mistaken beliefs about personality disorder are common and widespread, especially among health professionals (63, 64). In many countries, there is a longstanding and deeply rooted clinical culture, including among psychiatrists, in which people living with personality disorder are seen as less worthy of care than people with other mental health diagnoses (65), and in which clinicians experience purposelessness in working with this group (64). Despite evidence supporting the effectiveness of treatment, appropriate, evidence-based, and considered care is less likely to be offered to young people with personality disorder (60), and discrimination in clinical settings can result in lack of engagement in treatment or early withdrawal from services

(66, 67). Given the immense stigma of the disorder in many (but not all) health systems, it is unsurprising that many health care professionals want to protect young people by avoiding the diagnosis of personality disorder (61, 68). However, this approach risks colluding with and reinforcing discriminatory beliefs and behaviors, thereby creating further harm, and thus jeopardizing the opportunity for early intervention.

Trauma and Personality Disorder

Misguided beliefs regarding the etiology of personality disorder can also be harmful (61). Established empirical literature has shown that childhood adversity (e.g., abuse and neglect), a nonspecific risk factor associated with almost every major mental disorder, is neither necessary nor sufficient for development of personality disorder (69). Recent meta-analytic data (70) have confirmed this finding by showing that, although childhood adversity is three times more commonly reported among those living with borderline personality disorder than among other clinical populations, 29% of adults living with the disorder report no childhood adversity. Yet, reductionist thinking about the etiology of personality disorder persists and risks blinding clinicians to other relevant factors, including the complex interaction between environmental exposures and genetic vulnerabilities. Another important consequence is that families of young people with personality disorder are frequently blamed and marginalized, thereby discouraging them from seeking treatment and risking poor outcomes.

Notwithstanding this evidence, borderline personality disorder and posttraumatic stress disorder (PTSD) co-occur in approximately one-third of young people (51), leading some to suggest that borderline personality disorder is a variant of PTSD, rather than a distinct disorder, and should be renamed as complex PTSD (C-PTSD). Again, this view ignores the evidence supporting nontraumatic pathways to borderline personality disorder for a large minority of people (61, 70), that borderline personality disorder and C-PTSD are distinguishable from one another (71), and that two-thirds of young people with borderline personality disorder do not report symptoms consistent with PTSD (51). Importantly, when borderline personality disorder and PTSD do co-occur, people show significantly impaired functioning, compared with those with either disorder alone (72).

Psychotic Symptoms

Psychotic symptoms, especially auditory verbal hallucinations (AVH), have recently been studied among 15–25-year-olds with newly diagnosed borderline personality disorder or schizophrenia spectrum disorder. Consistent with studies among samples of adults with borderline personality disorder (73), AVH were indistinguishable between the two groups with regard to physical, cognitive, or emotional characteristics (74). Clinically relevant differences were that the young people with borderline personality disorder and AVH had less severe delusions and difficulties with abstract thinking, compared with the schizophrenia spectrum group.

The presence of AVH in particular among people with borderline personality disorder is associated with a higher incidence of suicidal plans and attempts and more hospitalizations (75) and increased severity of comorbid difficulties, such as anxiety and depression (74, 76). These findings suggest that psychotic symptoms among young people with borderline personality disorder require acknowledgment and consideration in treatment plans.

CONCLUSIONS AND RECOMMENDATIONS

Young people with personality disorder are often seen as "someone else's business." The evidence above suggests that early intervention for personality disorder is the business of all mental health clinicians, in particular of those who see young people.

Diagnosis and Outcome Measurement

To facilitate diagnosis, treatment, and evaluation of treatment outcome among young people with personality difficulties, inclusion of assessment of personality functioning in routine clinical care is recommended. There is growing evidence that personality disorder can be reliably diagnosed from age 12 (77), and associated features can be clinically detected even before puberty. Clinical staging assessment approaches for personality disorder assist with matching more specific and proportionate treatment recommendations on the basis of disorder progression (8, 78). Following the *ICD-11* conceptualization of personality disorder, the International Consortium for Health Outcomes Measurement recommended validated measures to cover 11 core outcomes, and three optional outcomes, across four health domains (mental health, behavior, functioning, and recovery) for assessment of personality disorder across the lifespan (79).

Care Planning

Care plans focusing on structured clinical case management and psychiatric care, in the absence of a specialist setting or brand name psychotherapy, yield significant improvements and can be implemented widely without the need for additional resources (51, 80, 81). Many clinicians lack the confidence to treat personality disorder, convinced that they must deliver intensive, specialist care, and feeling ill-equipped to do so. With mounting evidence to the contrary, refusing to provide routine care to patients with a personality disorder diagnosis should not be accepted practice. It is the responsibility of all mental health professionals to challenge negative and damaging beliefs regarding personality disorder in the workplace and beyond.

Functional Outcomes

Maintaining a focus on interpersonal and vocational functional outcomes is crucial, because these are the areas of persistent impairment over decades for young people living with personality disorder (82, 83). Pursuit of these goals is often overshadowed by an exclusive focus on acute behavioral problems,

especially self-harm and suicidal behavior (82). The longer a young person is derailed from the crucial developmental tasks of building meaningful relationships and finding a vocational pathway into adulthood, the more difficult it is to recover. Practical and common-sense approaches should aim to support young people in building or maintaining social networks and in completing education or entering the workforce as they make the transition to adult role functioning (81–83). Lengthy hospital stays or long-stay residential programs are likely to hinder such goals and are not supported by clinical trial or other evidence. Rather, assisting young people to function better in their families and communities is crucial. To this end, family engagement and psychoeducation are important pillars of treatment planning. Families commonly have highly negative experiences with psychiatric care, often feeling blamed, vilified, and marginalized (20); such experiences can be prevented through early family engagement, psychoeducation, and treatment planning.

Nonsuicidal Self-Injury and Suicidal Behavior

Nonsuicidal self-injury (NSSI) and suicidal behavior will inevitably draw some of the short-term focus of care and should not be ignored. Structured crisis planning and a clear framework for risk management help to keep the patient safe, and allow clinician, caregiver, and patient to determine clear expectations of care. Established risk management procedures and brief manualized psychotherapeutic interventions that specifically target management of self-harm have proven effectiveness and can be easily implemented (84). During acute suicidal crises, there might be a role for short-term, goal-directed inpatient care until a community-based management plan can be established (85, 86). Clinicians should be attuned to the risk of iatrogenic harm from prolonged and/or coercive inpatient care.

Although most NSSI is intended to regulate extreme emotion (87), or as self-punishment, one in four young people cannot identify the reasons for their self-harm (88). Unlike persistent functional impairment, it is now established that all forms of self-harm naturally attenuate over relatively few years in personality disorder and in community samples of young people (89–91). Understanding the functional role of NSSI and supporting the development of adaptive skills are central tasks. This process can take time, and there is no evidence to support prolonged hospitalization or other institutional care in the management of NSSI. Moreover, the utility of suicidal ideation or self-harm as a test for later suicide is limited by modest sensitivity and low positive predictive value (92, 93). In fact, among young people with borderline personality disorder, habitual patterns of NSSI have been associated with lower severity and fewer suicide attempts than random patterns of NSSI (94), and the frequency of NSSI over the previous 12 months has been found to be unrelated to the number of suicide attempts (95).

Psychotic Symptoms

Clinicians should routinely inquire whether patients with borderline personality disorder experience AVH or other psychotic symptoms. Dismissing psychotic symptoms in borderline personality disorder as "quasipsychotic" or "psuedohallucinations" is disrespectful and not supported by evidence. Clinicians should be alert to a potential false dichotomy in differential diagnosis. Some patients will have borderline personality disorder *and* psychosis and this joint occurrence should be considered to be a marker of more severe disorder (including suicide risk), as it is for young people with mood disorders. Notably, disorganized behavior and negative psychotic symptoms are uncommon in severe personality disorder and might indicate the presence of an even more extensive psychotic illness, such as schizophrenia spectrum disorder.

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