EARLY INTERVENTION FOR PERSONALITY DISORDER- PART 1

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H Helping

Y Young

P People

E Early

OUR UNDERSTANDING OF PERSONALITY AND PERSONALITY DISORDER HAS CHANGED

WE ALL HAVE A PERSONALITY

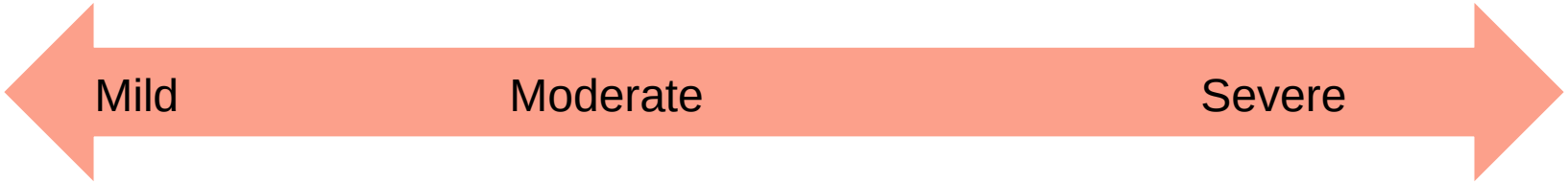
- Personality refers to the collection of enduring characteristics and behaviour that make us who we are
  - Both what makes us similar to others as well as
  - What makes us different and unique
- But we all know that life is unpredictable
- Our personality characteristics shape the way we manage life's ups and downs
  - Some characteristics make it easier for us
    - e.g., if a person is open and friendly
  - But others can make it harder
    - e.g., if a person is overly worried about what others think of them

OUR CLASSIFICATION SYSTEMS FOR PERSONALITY DISORDER HAVE CHANGED

Both the DSM-5 (Section III, AMPD) and the ICD-11 have embraced a dimensional model

- These changes reflect 3 decades of knowledge

Focus on severity



In addition, the features must:

- Have persisted for an extended period of time (2 or more years)
- Not be better explained by social, cultural, or developmental factors
- Not be caused by the use of substances or a medical condition

WHAT IS PERSONALITY DISORDER?

A personality structure that prevents the individual from achieving *adaptive solutions* to universal life tasks

Self-disturbance

- Stability and coherence of identity, stable sense of self-worth
- Accuracy of one's view of one's characteristics, strengths, limitations
- Capacity for self-direction

Interpersonal functioning

- Interest in engaging in relationships with others
- Ability to understand and appreciate others' perspectives
- Ability to develop close and mutually satisfying relationships, and manage conflict

Cohen, Crawford, Johnson, & Kasen, 2005a; Skodol, 2008; Winograd, Cohen, & Chen, 2008; Winsper et al., 2015; Choudray & Gupta, 2020; Livesley, 2011

THESE DIFFICULTIES ARE DISPLAYED IN THE WAY A PERSON FUNCTIONS ACROSS THREE AREAS

Ability to manage emotions:

- Ability to recognize and manage their emotions (especially unwanted emotions)

Ability to think rationally and reasonably:

- Especially under stress
- Ability to recognize situations, and interactions with others (without distortion)
- Belief systems are both stable as well as being flexible (enough to grow and change)

Ability to behave in helpful ways:

- Unhelpful impulses are controlled
- Behaviour is matched to situations effectively and changed if unhelpful.

PERSONALITY DISORDER IS A DEVELOPMENTAL DISORDER

- We must consider what is typical (normative) functioning across the lifespan
- Cultural and social norms inform how we view an individual's functioning

- 'Adaptive failure' disrupts development
  - Fosters vicious circles that further impairs achievement of adult role functioning
  - Borderline personality disorder in <18 yo predicts long term problems in interpersonal functioning, vocation and finances

A BRIEF FOOTNOTE

- Most research in young people has focused on borderline personality disorder (BPD)
- The features associated with BPD capture the core of personality pathology, and are most representative of all personality disorders

- Therefore, the terms *BPD* and *severe PD* can be used interchangeably

Clark & Ro, 2014; Sharp et al., 2015

WHY IS EARLY DETECTION OF PERSONALITY DISORDER IMPORTANT?

PERSONALITY DISORDER (PD) IS COMMON AMONG YOUNG PEOPLE

- More than 10% of the population will have PD
- Severe PD
  - **approx. 3% in the community**
  - **1/5 attending tertiary youth mental health services**
- By age 24:
  - 1/5 young people will have had PD
  - 1/5 of these will have had severe PD

Winsper et al., 2020; Chanen et al., 2017; Schandrin et al., 2022; Chanen et al., 2017; Johnson et al., 2008; Moran et al., 2006

THE PD DIAGNOSIS IS ASSOCIATION WITH SEVERE CURRENT PROBLEMS

- High distress
- High levels of current mental health symptoms (compared with no PD)
  - 99% report self-harm at least once, 89% in past year
  - 82% diagnosed with mood disorder, high rates of anxiety disorders, substance use
- Poor physical, sexual and reproductive health
- Functional impairment is significant
  - 40% drop-out from education, employment and training (‘NEET’)
- Increased risk of being a victim or perpetrator of interpersonal, family violence and non-violent offences,
- Quality of life scores lower than for any similar-aged disease group (including cancer)

Chanen, Sharp, et al., 2022; Chanen 2017 & 2021; Gunderson, et al. 2011;Quirk et al. 2014; Scalzo et al., 2017; Fok et al. 2014; Thompson et al. 2017; Cavelti, et al. 2021 & 2022; Juurlink et al. 2021

FUTURE PROBLEMS & POOR OUTCOMES

- Many of these problems persist well into adulthood
  - Risk of psychotic & hypomanic symptoms, depression, personality difficulties, poor mental health
  - Poor functional outcomes
  - Perpetrator or victim of violence
  - Poorer educational and vocational outcomes as early as age 20, persisting for at least 2 decades

Cavelti, et al., 2021a & 2021b; Wertz et al., 2020; Winsper et al., 2020; Ostby et al., 2014
Hastrup et al., 2019 & 2022; Winograd et al., 2008

‘RECENT-ONSET’ PD MORTALITY IS

10 TIMES THAT OF GENERAL POPULATION

LIFE EXPECTANCY REDUCED BY TWO DECADES

10% SUICIDE

PEOPLE WITH PD AT GREATER RISK OF DEATH BY

SUICIDE THAN OTHER SEVERE MENTAL DISORDERS

Fok et al., 2012; Nordentoft et al., 2013; Pompili, et al., 2005

THOSE WHO CARE FOR PEOPLE WITH BPD ALSO STRUGGLE

- Greater negative experiences of care
- Less positive experiences of care
- Higher levels of expressed emotion
- These experiences are worse than for caregivers of young people with first-episode psychosis
  - e.g., stigma, problems with services, effects on the family, loss, dependency

Chanen, Sharp, Hoffman 2017; Cotton et al., 2022

SO WHY IS PERSONALITY DISORDER STILL CONSIDERED A ‘CONTROVERSIAL DIAGNOSIS’, ESPECIALLY IN YOUNG PEOPLE?

THE BEST TIME TO DETECT AND INTERVENE IN PERSONALITY DISORDER

- Compelling evidence for reliability and validity across the lifespan
- Clinically significant disorder usually emerges between the ages of 12-25 years
  - Cumulative prevalence >25% from age 14-22
- Associated with a high burden of disease, morbidity & premature mortality

- Yet… many clinicians are reluctant to embrace early diagnosis and treatment
- Detection rates 10-20 times lower than suggested by clinical epidemiological data

Chanen, et al., 2020; Newton-Howes et al., 2015; Johnson et al., 2008; Chanen & Nicol, 2021; O'Dwyer et al., 2020

CONCERNS ABOUT MAKING A DIAGNOSIS IN YOUNG PEOPLE

- *“BPD type problems are part of normal adolescence”*
- *“BPD is not treatable”, or is “only treatable with long-term psychotherapy”*
  - *“The focus of treatment should be self-harm”*
- *“BPD is the same as Complex Trauma” or “Emotion Dysregulation”*
- *“Hallucinations are not real when occurring in BPD”*
- *“Stigma, labelling, is a life sentence”*

ARE THESE PROBLEMS A NORMAL PART OF ADOLESCENCE?

“STORM AND STRESS” THEORY DEBUNKED, BPD IS NOT NORMATIVE

- Adolescence is a time of greater novelty seeking and experimentation
  - Normative changes in personality occurs in other phases of life
  - The majority (~80%) of young people are not experiencing serious ongoing difficulties
- Behaviour of adolescents with BPD is significantly different from their peers
  - Impulsivity
  - Substance use
  - Sexual behaviour
  - Self-harm and suicide attempts
  - Interpersonal and vocational dysfunction

Chanen, 2017; Sharp, 2017, Edmonds et al, 2016, Lawrence et al., 2010; Scalzo et al., 2017; Thompson et al., 2017; Andrewes, et al., 2017; Goodman et al., 2017; Kramer et al., 2017

IS BPD TREATABLE?

THERE IS A LARGE BODY OF EVIDENCE SUPPORTING DETECTION AND TREATMENT OF PD

Three decades of research have resulted in a large number of studies demonstrating reduced symptom severity compared to no treatment or waiting list

- A wide variety of treatments for BPD have demonstrated improvement
- Based on different models (psychodynamic, cognitive, integrative…)
- No one modality has demonstrated superiority

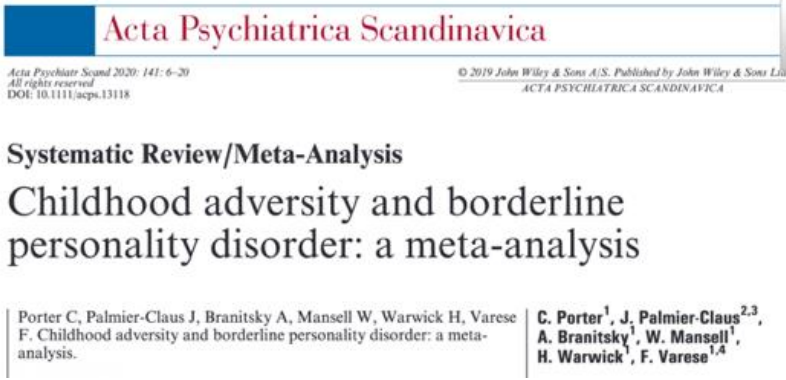
Resulting in detection and intervention being core in most guidelines

Cristea eta al., 2017; Storeb et al., 2020

COMPLEX TRAUMA AND PSYCHOTIC SYMPTOMS

TRAUMA IS COMMON
BUT IS NEITHER NECESSARY NOR SUFFICIENT FOR DEVELOPING BPD

- 29% of BPD participants report NO childhood adversity
- BPD among CSA victims 1.8 to 29.3%



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ACTA PSYCHIATRICA SCANDINAVICA

Systematic Review/Meta-Analysis

Childhood adversity and borderline personality disorder: a meta-analysis

Porter C, Palmier-Claus J, Branitsky A, Mansell W, Warwick H, Varese F. Childhood adversity and borderline personality disorder: a meta-analysis.

C. Porter[1], J. Palmier-Claus[2,3], A. Branitsky[1], W. Mansell[1], H. Warwick[1], F. Varese[1,4]

Cutajar et al., 2010; Katerndahl et al., 2005; Widom et al., 2009

CONCURRENT BPD & PSYCHOTIC SYMPTOMS ARE COMMON

- 18.4% of young people with FEP have BPD features.
- Auditory Hallucinations reported by 37% of adolescents with BPD and 22.5% of adolescents with sub-threshold BPD

The phenomenology of Auditory Verbal Hallucinations (AVH) in BPD is indistinguishable from those in First Episode Psychosis

- Frequency, duration, perceived location, loudness, beliefs about origin, amount of negative content, amount of distress, intensity of distress, disruption of life, controllability.
- Delusions are also common
- Disorganised psychotic symptoms are not common

Cavelti et al, 2018; Thompson et al, 2019

PSYCHOTIC SYMPTOMS INDICATE SEVERITY

Psychopathology and clinical risk is greater when AVHs co-occur with BPD

- Self-harm is more severe, severity of BPD is greater
- Greater paranoid ideation, dissociation, anxiety

Implications:

- DSM-5 BPD criterion 9 is an inadequate descriptor of the experience of psychotic symptoms in BPD.
- Labels such as “psychotic-like” symptoms or “quasi-” or “pseudo-hallucinations” to differentiate AVH in BPD from AVH in Schizophrenia are unjustified and disrespectful of the experience of patients with BPD.
- Psychotic symptoms in BPD a marker of illness severity.

Cavelti et al, 2018; Thompson et al, 2019; Kingdon et al. 2010; Tschoeke et al. 2014; Slotema et al. 2012; Hepworth et al. 2013; Cavelti et al. 2018

THE MOST INTRACTABLE PROBLEM OF ALL…

Editorial

AUSTRALASIAN PSYCHIATRY

Bigotry and borderline personality disorder

Australasian Psychiatry
1–2

DOI: 10.1177/10398562211045151
journals.sagepub.com/home/apy
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‘LATE INTERVENTION’ IS ROUTINE IN BPD

- Diagnosis delayed
- Specialised treatments only
- Offered late in the course of the disorder
- Only a few patients can access treatments
- Wait until disability and problems are entrenched

Chanen et al. 2020; Chanen & McCutcheon 2013;

Bateman et al. 2015; Gunderson et al. 2011

TREATMENT SHOULD AIM HIGHER THAN JUST ‘SURVIVAL’

The bar for effectiveness of treatment is only set at ‘survival’, not meaningful living, or quality of life.

- Self-harm and suicide are common treatment targets
  - No study has shown that reducing self-harm protects individuals from suicide
  - Neither severity nor frequency of self-harm appear to be predictive of suicide attempt frequency in young people with BPD
- Functional impairments persist, even when diagnostic ‘remission’ is achieved,
  - No treatment has proven effective at producing durable functional improvements in BPD
  - Unemployment in young people can have long term ‘scarring’ effects

Andrewes et al., 2017; Álvarez-Tomás et al., 2019; Gunderson et al., 2011; Bateman et al., 2015; Nilsen & Reiso, 2011; Hastrup et al., 2019

THE GUIDELINES WE USE SUPPORT THE DETECTION AND INTERVENTION OF PERSONALITY DISORDER IN YOUNG PEOPLE

- NICE guideline (UK)
- NHMRC (Australian) guideline
- DSM-5- Both Section II and Section III
- ICD-11

(Newton-Howes et al. 2015)

WHAT ARE WE AIMING TO CHANGE?

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- Delays in treatment are linked to poor outcomes in youth mental health
  - Under-diagnosis and/or ineffective treatment
  - Inappropriate and/or harmful treatment
  - Intentionally delayed diagnosis, non-diagnosis, or use of substitute diagnoses
- Among young Australians attending the headspace diagnostic rates for BPD features (including subthreshold disorder) < 1%
  - At least one tenth of the expected rate

Chanen et al., 2017; Chanen, 2022; O'Dwyer et al., 2020

EARLY INTERVENTION FOR PD REPRESENTS A SHIFT IN THE CULTURE OF YOUTH MENTAL HEALTH SERVICES

- Science is well advanced
- Biggest barriers to reform are bigotry
- Stigma and prejudice is most often perpetuated by clinicians
  - Sometimes these people are “well-intentioned”
  - Want to change the name to protect people
  - Soft bigotry of low expectations

Chanen, 2021; McKenzie et al., 2022

ACCESS TO SERVICES IS AN ISSUE OF SOCIAL JUSTICE

- Most clinicians already have the necessary skills
- Not having staff trained in a ‘brand name’ psychotherapy should no longer be a barrier to accessing early intervention care
- Youth mental health has cultivated its own evidence-based, open, progressive, and hopeful clinical culture, making it well placed to achieve such cultural change

REVOLUTION IN MIND orygen

Questions

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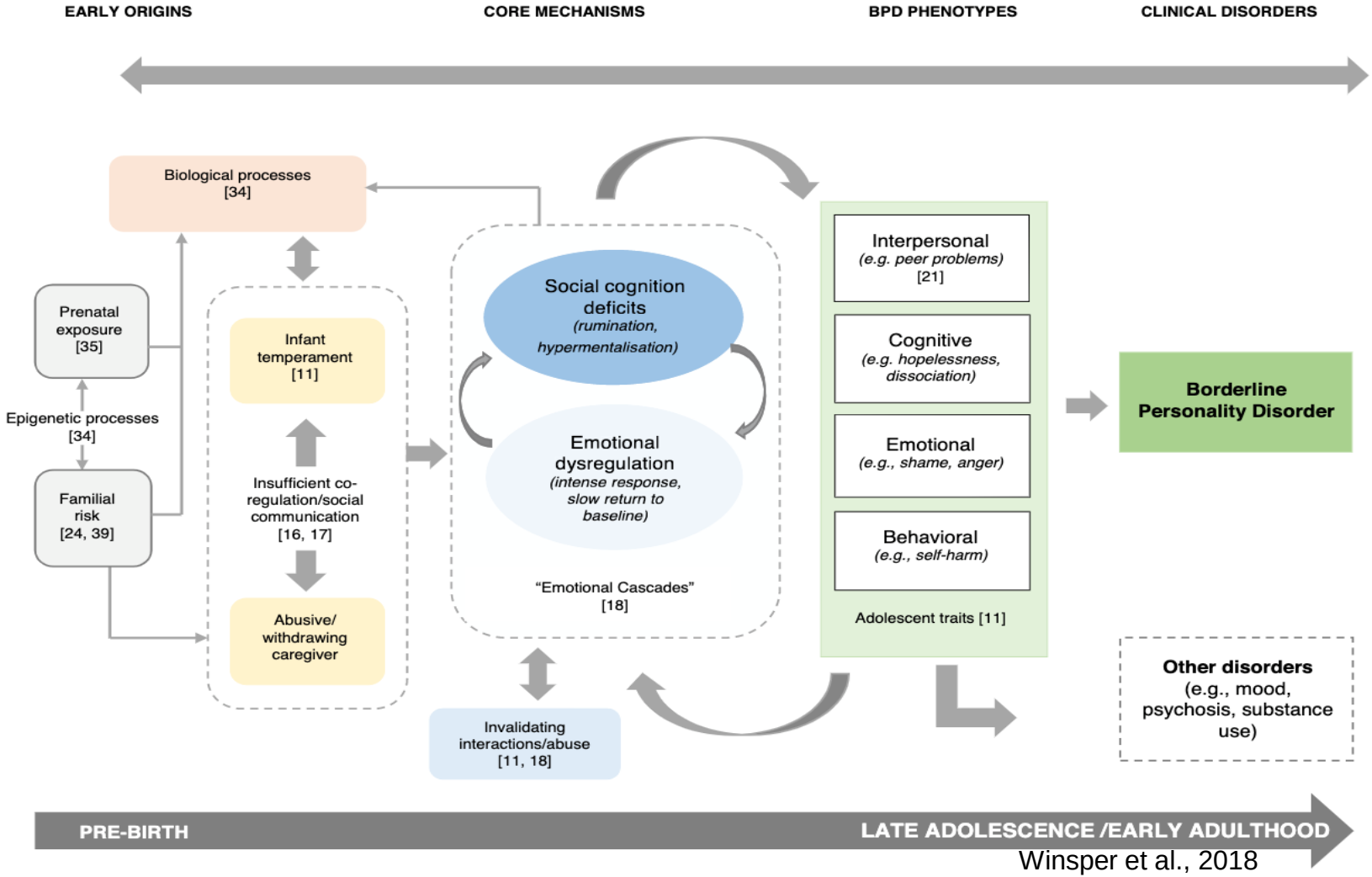
IN THE NEXT TWO SESSIONS:

1. Assessment and screening for PD
   - What should we look for?

2. A simple good quality approach to early intervention for PD
   - Relational Clinical Care
   - An approach that uses existing skills



Winsper et al., 2018