

## Early detection and timely intervention for borderline personality disorder in young people

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## Orygen Youth Health (OYH)

- Australia's largest youth-focused mental health organisation
- Comprised of
  - Specialised clinical program
  - Research centre
  - Training & communications program



## OYH Clinical Program

- Comprehensive public mental health service for youth (aged 15-25)
  - Outpatient
  - Inpatient
  - Outreach
  - 24 hour crisis team
- All severe mental health problems



# Helping Young People Early

## Outcome in adulthood now reliably characterised by

- Attenuation of diagnostic criteria over time...
- ... but severe and continuing functional disability across a broad range of domains
  - Equal or worse than for many mental state disorders
    - (Zanarini, et al. 2010; Gunderson, et al. 2011)
  - High rates of health service utilisation
    - (Horz, et al. 2010; Sansone, et al. 2011)
  - Suicide rate  $\approx$  8%
    - (Pompili, et al. 2005)

## BPD

- **Effective interventions exist for adults with BPD**
  - (e.g., Giesen-Bloo, van Dyck et al. 2006; Linehan, Comtois et al. 2006; Bateman and Fonagy 2009)
- **Overall outcomes from such interventions are modest and their availability is limited**

Prevention and early  
intervention  
have face validity

## PD in adolescence

“The diagnosis that dare not speak its name”

## BPD in young people

- Longstanding agreement that PDs have their roots in childhood and adolescence (APA 1980)
- BPD is a lifespan developmental disorder
  - (Tackett, Balsis et al. 2009)
- As reliable and valid in adolescence as it is in adulthood
  - (Chanen, Jovev et al. 2008; Miller, Muehlenkamp et al. 2008)

## BPD in adolescence

- Phenotypic differences to adult BPD
  - Lack of developmentally appropriate PD criteria
  - Iatrogenic phenomena in adult BPD
- No discontinuity from adolescence to adulthood

*Chanen, et al., Current Psychiatry Reviews 4, 48 (2008); Miller et al. 2008*

## BPD in young people

- Not reducible to Axis I diagnoses
  - (Chanen, Jovev et al. 2007)
- Can be identified in day-to-day clinical practice
  - (Chanen, Jovev et al. 2008)

## BPD is primarily a disorder of young people

## BPD a disorder of younger people

- Rise in prevalence from puberty and a steady decline with each decade from young adulthood
  - > 3% will meet BPD diagnostic criteria from age 14-22
    - (Johnson, Cohen et al. 2000; Samuels, Eaton et al. 2002; Ullrich and Coid 2009)
- Up to 22% of outpatient adolescents and young adults
  - (Chanen, Jackson et al. 2004; Chanen, Jovev et al. 2008).

## First psychiatric contact for adults with BPD is in youth

- **17-18 years** (Zanarini et al. 2001; Clarkin et al. 2004)
- **22 years** (Davidson et al. 2006)

BPD in young people demarcates a group with high morbidity and a particularly poor outcome.

## Uniquely and independently predicts current

- Psychopathology
- General functioning
- Peer relationships
- Self-care
- Family and relationship functioning

• (Chanen, Jovev et al. 2007)

## Uniquely predicts poor outcomes over 2 decades

- Future BPD diagnosis
- Increased risk for axis I disorders (especially substance use and mood disorders)
- Interpersonal problems
- Distress
- Reduced quality of life

• (Cohen, Crawford et al. 2005; Crawford, Cohen et al. 2008; Winograd, Cohen et al. 2008).

**BPD is a leading candidate for developing empirically-based prevention and early intervention programs**

## BPD is a leading candidate

- Common in clinical practice
- Among the most functionally disabling of all mental disorders
- Often associated with help-seeking (cf. schizotypal or antisocial PDs)
- Responds to intervention, even in those with established disorder
- Can be reliably diagnosed in its early stages

## BPD is a leading candidate

- Demarcates a group with high levels of current and future morbidity and mortality
- Key developmental period during which to intervene
- BPD traits in youth flexible & malleable
  - (Lenzenweger and Castro 2005)
- Adolescent BPD features respond to intervention
  - (Chanen, Jackson et al. 2008; Schuppert, Giesen-Bloo et al. 2009).

Early intervention programs should **prevent poor outcomes**, not diagnostic categories

Alter the life-course trajectory of personality pathology in young people

Who would argue for late intervention?

Prevention?  
Early intervention?

What's realistic?

## Risk factors for BPD

- **Genetic, neurobiological, psychopathological and environmental risk factors**
- **Specificity for BPD limited**
  - (Chanen & Kaess 2012)
- **Heritability of BPD around 40%**
  - (Distel, Trull et al. 2008; Kendler, Aggen et al. 2008; Distel, Carlier et al. 2011)
- **No specific genes identified as causative of BPD**
  - Findings difficult to replicate
    - (Chanen and Kaess 2012).

## What form should intervention take?

- **Stand-alone universal (whole population) prevention of BPD not currently feasible**
  - BPD not sufficiently prevalent
  - What form of intervention would be appropriate?

## What form should intervention take?

- **Selective prevention (targeting those with risk factors for BPD) currently impractical**
  - Many risk factors for BPD (esp. environmental factors) more commonly lead to, or associated with, outcomes other than BPD
    - 'multifinality' (Cicchetti and Toth 2009)

## What form should intervention take?

- **Intervention for some risk factors important as a primary aim**
  - e.g., child abuse and neglect
  - but unlikely to have a major impact on BPD prevention in the near future
- **Difficult to design studies with adequate statistical power to demonstrate the efficacy or effectiveness of universal and selective prevention** (Cuijpers 2003)

## What form should intervention take?

- Problems could be improved or overcome if current universal and selective programs (e.g., parent training programs) measured multiple syndromes as outcomes, including BPD

## *Indicated prevention is the 'best bet' for prevention of BPD*

Targets individuals displaying precursor (i.e., early) signs and symptoms of BPD

Underlying dimensions of BPD can be measured, appear to be relatively stable and could be directly targeted

*Chanen, et al., Current Psychiatry Reviews 4, 48 (2008)*

## *Indicated prevention is the 'best bet' for prevention of BPD*

- Typical child and adolescent psychopathology are targets for indicated prevention of BPD
  - e.g., disruptive behaviour disorders, self-harm, substance use, depressive disorders
- Rather than separate domains of psychopathology that might then be renamed in adulthood

## Early detection and intervention

- Now justified and practical in adolescence and emerging adulthood
  - (Chanen, Jovev et al. 2008; National Collaborating Centre for Mental Health 2009)
- Different from conventional BPD treatment applied to individuals who have established, complex and severe BPD but happen to be less than 18 years old
- Should be considered part of routine clinical practice in adolescent mental health

## What can be done?

What does an early intervention program for BPD look like?

## Helping Young People Early

### Early intervention for BPD is possible

- “Proof of concept”

*Chanen et al., British Journal of Psychiatry 193, 477 (2008)*

*Chanen et al., Australian and New Zealand Journal of Psychiatry 43, 397 (2009)*

- Patients 11-15 years younger than in recent RCTs

*e.g.; Giesen-Bloo et al., 2006; Linehan et al., 2006; Davidson et al., 2006; Clarkin et al., 2007; McMMain et al., 2010; Doering et al., 2010; etc.*

- Basic reforms to existing services might have important effects

- Rapidly achieved

### Aims

- Improve

- Adaptive functioning
- Psychopathology

- Divert young people from unhelpful engagement with mental health system

- Promote appropriate help seeking

## Principles of early intervention

- Broad inclusion criteria
- Limited exclusions for co-occurring psychopathology
- View BPD dimensionally, combining sub-syndromal (indicated prevention) and syndromal (early intervention) BPD

## Principles of early intervention

- Careful diagnosis, often supported by semi-structured interview
- Time-limited: 16 – 24 sessions
- Can adapt interventions designed for adults with BPD to make them developmentally suitable
  - HYPE uses Cognitive Analytic Therapy (CAT; Ryle and Kerr 2002)
  - ERT uses Systems Training for Emotional Predictability and Problem Solving (STEPPS; Blum, St John et al. 2008).

## Major difference

- ERT: group format, adjunctive to usual treatment (TAU)
- HYPE: comprehensive, team-based, integrated intervention
- ERT + TAU not substantially different to TAU alone (Schuppert, Giesen-Bloo et al. 2009)
- HYPE vs. TAU (Chanen, Jackson et al. 2009)
  - HYPE faster rates of improvement in internalising and externalising psychopathology & lower levels of psychopathology at 2-year follow-up

## Elements of HYPE might be important

1. Assertive, 'psychologically informed' case management integrated with the delivery of individual psychotherapy
2. Active engagement of families/carers, with psychoeducation and time-limited family intervention, using the same model as individual psychotherapy

## Elements of HYPE might be important

3. General psychiatric care by the same team, with specific assessment and treatment of 'comorbidity', including the use of pharmacotherapy, where indicated for such syndromes
4. Capacity for 'outreach' care in the community, with flexible timing and location of intervention

## Elements of HYPE might be important

5. Crisis team and inpatient care, with a clear model of brief and goal-directed inpatient care
6. Access to a psychosocial recovery program that is shared with other Orygen programs
7. Individual and group supervision of staff
8. Quality assurance program.

## Potential risks

- Early diagnosis of PDs remains controversial (Chanen and McCutcheon 2008)
- BPD highly stigmatised among professionals (Aviram, Brodsky et al. 2006)
- Patient 'self-stigma' (Rusch, Holzer et al. 2006)

## Potential risks

- Well-intentioned clinicians deliberately avoid the label
- Perpetuate negative stereotypes
- Reduced prospect of applying specific interventions for BPD
- Increased likelihood of inappropriate interventions & iatrogenic harm (e.g. polypharmacy)

## Possible risks

- Iatrogenic harm
- Unnecessary fear of illness
- Restriction of life goals
- Medication use, polypharmacy & side-effects

*Chanen, et al., Current Psychiatry Reviews 4, 48 (2008)*

## Detection and entry into HYPE

## Simple screening measure

- SCID-II PQ BPD
- $\geq 11$  (out of 15) 'direct to HYPE'
  - Diagnostic assessment to confirm BPD traits
- Threshold can be adjusted according to available resources

*Chanen et al., Journal of Personality Disorders 22, 353 (2008)*

## HYPE entry criteria

- $\geq 3$  BPD criteria
  - $\geq 50\%$  have full threshold BPD ( $\geq 5$ )
- Careful assessment of each BPD criterion
- Informed consent & **informed refusal**
- No specific exclusions for 'comorbidity'
  - Include learning disability, substance use, antisocial PD

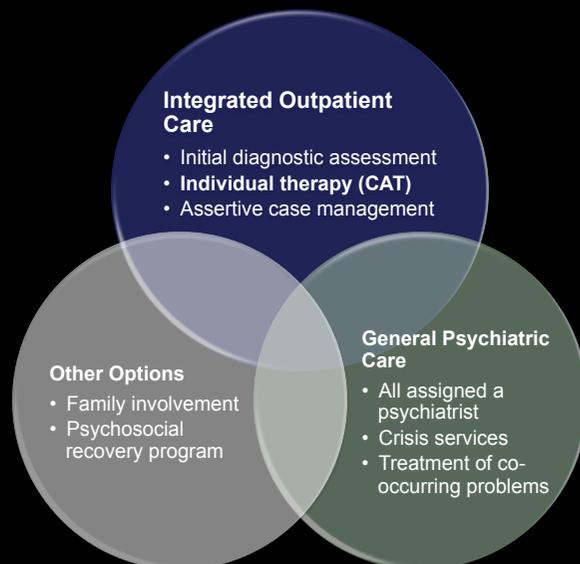
## Presenting problems

- **Comorbidity is the norm in BPD**
  - 60 – 90% Major Depression
  - 40% Anxiety Disorder
  - 60% Substance Use Disorder
  - 60% another Personality Disorder
  - 30% Eating Disorder
  - 5 – 10% Bipolar Disorder

## Presenting problems

- **Often occur with social and other problems**
  - Learning disability
  - Low rate of school completion
  - Vocational problems
  - Family conflict & problems
  - Family mental illness
  - Abuse, neglect, & victimisation

## The HYPE model



## Accessibility and flexibility

- **Outpatient**
  - Assertive case management integrated with therapy
- **Shared formulation**
- **Integrated intervention – ‘whatever works’**

## Accessibility and flexibility

- Referrals “off the street”
- Not specifically requesting psychotherapy
- ‘Psychological mindedness’ a goal of therapy
  - not a pre-requisite
- Individual therapy not the *sine qua non* of intervention

## You can't have your cake and eat it too...

- If young people with BPD lack self-management skills, how can they be expected to manage the process of therapy?
- Strong emphasis on engagement
- Flexible location and timing of sessions
- Changes throughout treatment

## Engagement

- Balancing engagement with some limits
  - The therapy contract
  - Some expectations are important to set up
  - Other limits are discussed when they arise
- Young people don't necessarily know what they are refusing
- ‘Informed refusal’

## Episodic care

- Young people often drop out or have gaps in treatment ....whether we like it or not!
- Intermittent therapy
  - Promotes autonomy
  - Discourages unnecessary dependence (Paris 2008)
  - Increases throughput

## Who is involved?

- Primarily individual
- Family involvement encouraged
  - Patient's vs. family's wishes
  - Respect emerging autonomy of individual
- Also aim to work with others in the system
- Access to shared group activity program
- After hours crisis response

## Family involvement

- Family members encouraged to be involved in
  - Assessment
  - Feedback & Treatment planning
  - Medical reviews
  - By phone or in person
- Sometimes included in the therapy

## Many families have their own difficulties

- BPD is a complex problem that has multifactorial origins
- Families are usually doing their best
- Parents/careers often expect to be blamed
- Young people are trying to make independent decisions

## What do we do?

- Cognitive Analytic Therapy BPD intervention (Ryle 1997)
- A relationally (object relations) informed approach to cognitive therapy
  - Modified for use in youth
  - 16 weekly sessions (up to 24)
  - 4 follow-up appointments
    - 1, 2, 4 & 6 months

## What actually happens?

- 30% disengage prior to starting CAT
  - Some return later
- 30% complete an agreed number of sessions
- Median = 11 sessions

## What actually happens?

- Most young people only have relatively brief episodes of care
  - Average length 7 months
  - Can have multiple episodes of care
  - Up to 2 years maximum (we would like to have longer)
- Most patients are discharged 1 month after therapy ends
  - Follow-up options are often limited

Early intervention is a platform  
for investigating BPD

## Conclusions

- BPD a lifespan developmental disorder with substantial ramifications across subsequent decades
- Intervention at any stage should aim to alter the life-course trajectory of BPD, not just its diagnostic features
- Robust evidence to support routine clinical practice of diagnosing & treating BPD when it first becomes evident
  - ICD-11, DSM5, NICE guideline

## Conclusions

- **Subsyndromal BPD pathology relatively stable in young people**
  - Associated with current and future morbidity
- **Indicated prevention promising**
  - Benefits appear to outweigh the risks
  - Evaluation over longer periods to ensure no adverse 'downstream' effects

## Conclusions

- **Universal or selective preventive approaches likely to require the joint effort of research groups aiming to prevent the range of major mental disorders**
- **Indicated prevention and early intervention offer a unique platform for investigating BPD earlier in its developmental course**
  - duration of illness factors minimised

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