“Emergent PD: Some evidence”

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Personality Disorders as developmental phenomena: AMPD

CRITERION A
Long term disturbances in **self** and **interpersonal** functioning

Self

Identity
- The experience of oneself as **unique**
- Stability of **self-esteem**
- Emotion **regulation**

Self-direction
- Pursuing meaningful **goals**
- Maintaining **prosocial** standards of behaviour
- Ability to **self-reflec**t productively

Interpersonal

Empathy
- Comprehending and appreciating **others' experiences** and motivations
- Tolerating **differing perspectives**
- Understanding the effects of one's own behaviour on others- **impact awareness**

Intimacy
- Depth and duration of **connection** with others
- Desire and capacity for **closeness**
- **Mutuality** of regard reflected in interpersonal behaviour.

APA, (2013) DSM-5

Personality Disorders as developmental phenomena: AMPD

CRITERION B
Dysfunctional personality **traits**

Personality Trait Domain	Facet
I. Negative Affectivity (vs. Emotional Stability)	1. Anxiousness 2. Emotional lability 3. Hostility 4. Perseveration 5. Separation insecurity 6. Submissiveness
II. Detachment (vs. Extraversion)	7. Anhedonia 8. Depressivity 9. Intimacy avoidance 10. Suspiciousness 11. Withdrawal 12. Restricted affectivity
III. Antagonism (vs. Agreeableness)	13. Attention seeking 14. Callousness 15. Deceitfulness 16. Grandiosity 17. Manipulativeness
IV. Disinhibition (vs. Conscientiousness)	18. Distractibility 19. Impulsivity 20. Irresponsibility 21. (Lack of) rigid perfectionism 22. Risk taking
V. Psychoticism	23. Eccentricity 24. Cognitive perceptual dysregulation 25. Unusual beliefs and experiences

Provides a framework for understanding why the **transition from childhood to adulthood** appears to be a **sensitive period** for the development of personality pathology

Facilitates a developmentally sensitive clinical **staging approach to prevention** of and early intervention for personality pathology

APA, (2013) DSM-5

Diagnosing PD in adolescence: BPD

Fivefold increase in the studies of BPD in youth over the last decade

Clinicians still **hesitate to assign the diagnosis** to people younger than 18 years.

Survey of 52 **British** child and adolescent psychiatrists

- **80% supported the validity** of the BPD diagnosis **in adults**
- Less than **40%** found the diagnosis **valid in adolescents**
- Less than 25% reported using the diagnosis for that age group in practice

556 **Dutch** psychologists

- **60% report** that PDs do **exist** in adolescence
- Less than **10% reported diagnosing** PDs in adolescents

The myths

BPD **cannot be reliably assessed** or diagnosed in young people

BPD cannot be reliably **distinguished** from typical **adolescent development** before age 18

Adolescent **personalities** are **too unstable** and therefore cannot warrant diagnosis

Adult and adolescent BPD are **clinically different,** then causal models for adult BPD might not extend to adolescent BPD

Symptoms are **better explained** by **internalising** or **externalising** disorders

The label is **stigmatising**

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"BPD Cannot Be Reliably Assessed or Diagnosed in Young People"

26% of 556 **psychologists** believed that **DSM-IV did not allow** adolescent PD diagnosis.

- PD diagnosis has **never been disallowed** in young people since the introduction of the modern concept of PD in DSM-III (1987)

DSM-5

- **Criteria are the same** across adolescents and adults
  - Necessary **duration is 1** year in adolescents (**2 years in adults**)

ICD 11

- **No** age-related **caveats**

Nor on clinical guidelines in the UK and Australia

A variety of **diagnostic measures**

Interviews

- e.g. **Childhood Interview for DSM-IV** Borderline Personality Disorder (CI-BPD)
- (Zanarini 2003)

Self-reports

- e.g. **Borderline Personality Features Scale for Children** (BPFS-C)
- (Crick et al. 2005)
- e.g. **Personality Assessment Inventory**—Borderline Subscale – Adolescent Version (PAI-BOR)
- (Morey 2007)

Parent-reports

- e.g. **Borderline Personality Features Scale** for Parents (BPFS-P)
- (Crick et al. 2005)

"BPD Cannot Be Reliably Distinguished From Typical Adolescent Development Before Age 18"

"**40% of psychologists** would not diagnose BPD in adolescence, considering personality problems during that developmental stage **only reflect the "storm and stress**" of adolescence (Laurenssen et al. 2013)

Research shows that development is **not restricted** to the period **under 18** years old

→ The argument regarding **persistence** and distinguishing normal from abnormal development also **applies to other developmental stages**

The extent and severity of BPD features is what makes them **pathological**

- **impulsivity**
- **substance** use
- **sexual** behaviour
- psychosocial **functioning**
- **identity** disturbance

- BPD and other maladaptive personality features **peak during adolescence** and decline with adulthood
- The subgroup with the **highest scores**, **do not decline** and increase in symptoms
- Adolescent prevalence **mirrors adult prevalence**
  - Including that of subthreshold disorder

Indeed, given this natural course of the disorder, BPD can be considered a *disorder of young people*

"Adolescent Personality Is Too Unstable to Warrant a Diagnosis of BPD"

Adolescents who display BPD features might "**grow out**" of them as they age

...then **adolescent personalities** are uniquely unstable and adult PD is very stable

Adultlike stability of adolescent PD would need **to be demonstrated**

Research suggests that children (< 10) manifest **remarkably stable** differences in negative and positive **emotion** and in **self-regulation**

Temperament and symptoms reported by teachers and parents in childhood **predicts BPD** onset in adolescence and early adulthood

- **Emotionality** is the strongest predictor (3-4% vs 54%)

Impulsivity, nonconformity and **aggression** assessed at **age 11**

- Predicts **adult BPD features**

Over **30% of self-harming adult** inpatients with BPD **began prior to age 12**

Adolescent BPD demonstrates moderate **to strong rank-order stability** in several studies

- As with normal personality traits in children and adults

- **Categorical diagnosis** is **less stable**
  "Remissions" and "relapses"
- **Functional** impairment **persists**

lower academic and occupational **attainment**

less **partner** involvement

fewer adult developmental **milestones**

poorer adult life **satisfaction**

"Adult and Adolescent BPD are clinically different, then Causal Models for Adult BPD Might Not Extend to Adolescent BPD"

Adolescent BPD

- High rates of **comorbidity**
- Severe **psychosocial** problems
- Symptoms **as severe as** adults
- High rates of **treatment utilization**
- High rates of **hospitalization**
- Higher **medical expenses**
- More **medication trials**

Heterotypic continuity

Underlying traits might be behaviourally different across developmental stages

Younger age groups

- **Externalising** behaviour

→

Adolescents

- Explicit **acute symptoms**
- **Self-harm** and **risk** taking

→

Early adulthood

- **Internalising** becomes **prominent**
- **Externalising decreased** but retained

Impulsivity and affective **instability decrease with age**, independent of severity

Behavioural criteria are the ***heterotypic*** features of BPD

Intra- and interpersonal criteria are the ***homotypic*** features

Costs and burden associated with adolescent BPD might be even **higher than** those associated with BPD in **adults**

"Adolescent BPD Cannot Be Distinguished From Internalising and Externalising Disorders"

Factor analytic studies suggest that **internalising** and **externalising** disorders do **not** fully **account for** the variability in **BPD** features

- **Unique** associations with BPD are particularly strong **in interpersonal domains**

BPD provided **incremental predictive value** for **suicidal outcomes** over and above internalising pathology in a sample of adolescent inpatients

Personality pathology is **more stable than internalising** and **externalising** pathology

Internalising and externalising disorders are a **stepping-stone** on the path to BPD

- While there is no evidence of the opposite

When differentiating, consider **self-other (Criterion A) functioning,** because it is central to personality pathology and will be **more discriminating**

"The label is stigmatising"

Implies **mistaken assumptions** that PD is both **chronic** and **untreatable**

Effective **treatments exist,** and they have been adapted to younger populations

Dialectical Behaviour Therapy (**DBT-A**)

- Includes family members
- Separate family therapy component
- Superior to enhanced usual care in reducing borderline and depressive symptoms
  - Superior in reducing self-harm at 3-year follow-up
- More effective than individual and group supportive therapy in reducing suicide attempts and NSSI

Mentalization-Based Treatment (**MBT-A**)

- Family therapy component
- Focuses on impulsivity and affect regulation
- Greater reduction in self-harm and depressive symptoms, and fewer met criteria for BPD at 12 months
- Group MBT-A
  - Clinically significant change in BPD pathology, mentalizing, and trust

Cognitive Analytic Therapy (**CAT**)

- Integrates elements of psychoanalytic object relations theory and cognitive psychology
- Demonstrated effectiveness and more rapid recovery compared with treatment as usual
  - Differences were less marked at 2-year follow-up
- Ongoing research continues to evaluate its efficacy

Emotion Regulation Training

- Brief group training for adolescents with two or more BPD criteria
- Combines systems components with cognitive-behavioural elements and DBT skills training
- An RCT found that symptoms decreased at 6-month follow-up
  - No additional benefits compared with TAU

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Common elements of effective treatment

Effort to maintain **engagement** in treatment through **validation**
- Address treatment-interfering behaviour

Explanation of a valid and evidence-based model **of pathology**
- Experienced as relevant by the patient

Maintenance of an **active therapist stance**

Facilitation and **reinforcement of epistemic trust**

Focus on **emotion processing**
- Connecting action and feeling

Inquiry about mental states
- Using behavioural analysis, clarification, and challenge

Structure that provides **increased** activity, proactivity, and **self-agency**

Monitored adherence to a **manualized structure**

Commitment of the therapist and client **to the approach**

Supervision to identify deviation from the manualized structure
- Provide support for adherence

Avoiding diagnosis **perpetuates** negative **stereotypes**
- by further implying it is devastating and unchanging

It denies the opportunity to make **informed treatment decisions**
- Excludes BPD from health care policy

Diagnosis **validates** the **patient's experience**
- There is something wrong with me
- Hope for change

Receiving a **diagnosis** of BPD is **helpful to adolescents**
- As preliminary evidence demonstrates

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Developmental Understanding of the AMPD

Adolescence **is a sensitive** period **for** the onset of Criterion A problems

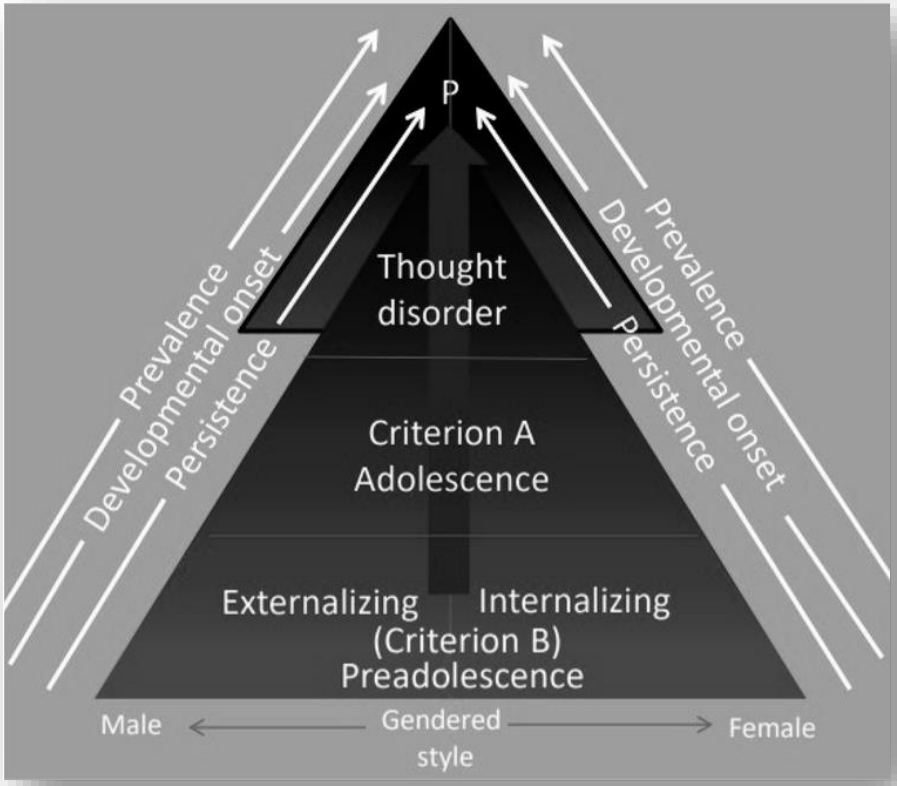
- Self, identity, intimacy, and empathy

Criterion B is the internalizing-externalizing spectra symptoms

Maladaptive trait function (**Criterion B**) lays the **foundation** in pre-adolescence upon which maladaptive self and interpersonal functioning (Criterion A) is built.

Maladaptive **Criterion A function comes online in adolescence**

Enough **metacognitive capacity to build a narrative identity** and to hold in balance different views of the **self-in-relation**n-to-others



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Clinical Staging - AMPD

- The progression of disorder through five stages
  - 0 = “at risk,” asymptomatic
  - 4 = late or end stage of disorder
- **Interventions should be differentiated according to the stage**
- **Progression** to later stages of disorder is **not inevitable**
  - Regressions to earlier-stage disorder are common

- Viewing **stages as separate domains**
  - Reification and withholding of treatment
  - Especially when subthreshold

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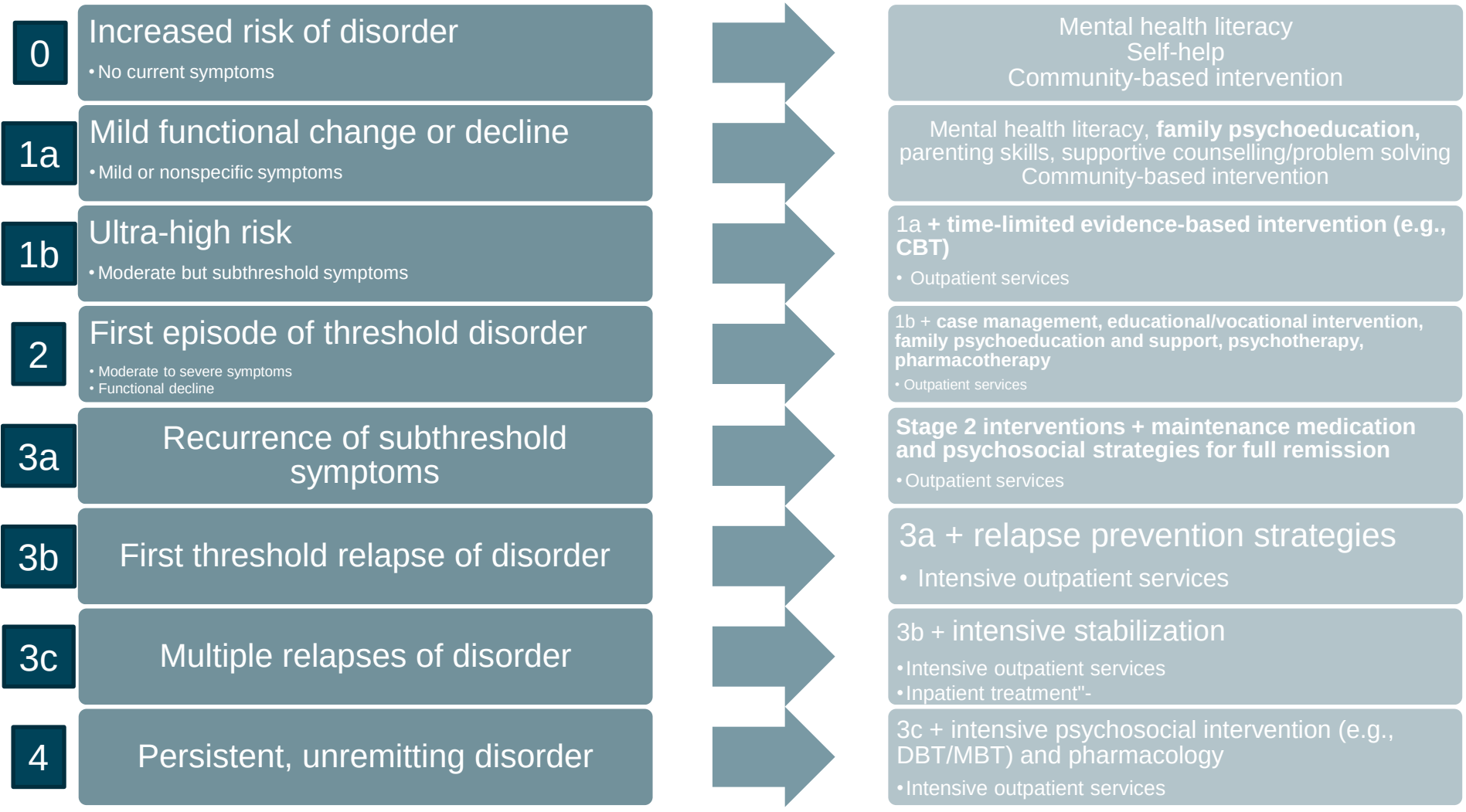
Clinical Staging - AMPD



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