

Global Alliance for Prevention and Early Intervention for Borderline Personality Disorder: Past, present and future

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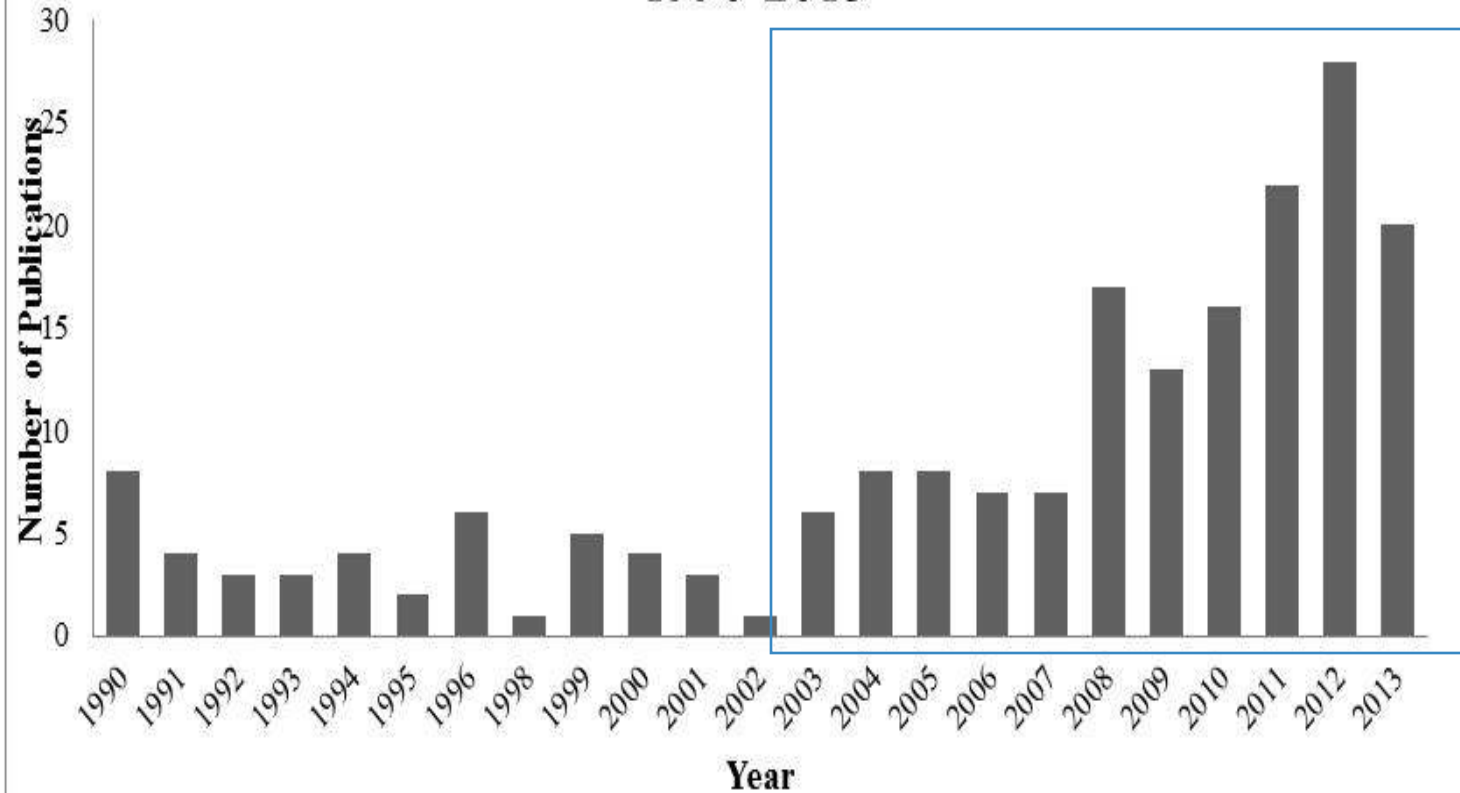
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Westen et al. (2003)

- Randomly select one of your adolescent patients, e.g. “the last patient you saw last week”.
- 296 patients.
- Clinicians:
 - Highly experienced (years post training 13.4)
 - 34.8% psychodynamic; 11.6 CBT; 42% eclectic.
 - Most worked in multiple settings
 - Knew the patients well – more than 20 sessions.
- Clinicians were given assessment tools that contained questions about PD.
- They were also asked to diagnose the adolescent.
- Only 28.4% received PD diagnosis (most common BPD) although 75.3% of patients met criteria based on clinician’s report of PD symptoms.

Published Research Articles on BPD in Youth* 1990-2013



*Literature searches conducted via *PSYCIInfo* and *Web of Science* with search terms of Borderline Personality (Disorder, Pathology) or BPD and Adolescent(s), Child(ren), Youth(s), Juvenile,(s) Girl(s), or Boys(s). Search results yielded 196 published empirical articles from 1990 to 2013.

Sharp & Tackett (2013), *BPD in children and adolescents*, Springer

Legitimization of PD diagnosis in psychiatric nomenclature

- DSM-5.
- ICD-11.
- National treatment guidelines:
 - National Institute for Health and Care Excellent (NICE): UK.
 - Australian National Health and Medical Research Council (NHMRC).

Laurensen et al. (2013)

- 596 psychologists in the Netherlands.
- 75% female; mean age 40; average 12 years in clinical practice.
- 27% primary care; 58% in secondary care; 14% in psychiatric hospitals.
- 57.8% agreed that PDs can be diagnosed in adolescents.
- However, only 8.7% reported that they diagnose PDs and only 6.5% offered specialized treatment:
 - 25% MBT
 - 17.7% ERT
 - 12.5% SFT
 - 12.5% DBT

Griffiths et al. (2011)

- Annual general meeting: 2009 child psychiatry conference.
- 52 child and adolescent psychiatrists.
- 82% accepted overall validity of BPD for adult populations vs. 37% for adolescent BPD; 2% accepted validity for children <12.
- 23% used the diagnosis in regular clinical practice; and of those only 60% feed back the diagnosis to young people and families.
- Qualitative feedback:
 - ‘The diagnosis can help families and young people understand their experiences and difficulties.’ ‘It may also help young people access appropriate interventions such as dialectical behaviour therapy (DBT).’
 - “The label may have stigmatizing, marginalizing and objectifying effects on young people”
 - “Making the diagnosis can lead to a worsening of the difficulties”
 - “The diagnosis leads to therapeutic pessimism and a belief that change is impossible.”
 - “The diagnosis is conceptually problematic, as it omits crucial developmental factors and makes assumptions about the enduring nature of certain personality variables, which is considered developmentally naive in adolescent populations”
- Concludes: “conceptually problematic, empirically insufficiently supported, lacking in clinical utility”

Personality and Mental Health
2: 35–41 (2008)
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Complex Case

Personality disorder in adolescence:

The diagnosis that dare not speak its name

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Beliefs (myths?) about adolescent BPD

1. Psychiatric nomenclature does not allow the diagnosis of PD in adolescence.
2. Certain features of BPD are normative and not particularly symptomatic of personality disturbance.
3. The symptoms of BPD are better explained by traditional Axis I disorders.
4. Adolescents' personalities are still developing and therefore too unstable to warrant a PD diagnosis.
5. Because PD is long-lasting, treatment-resistant and unpopular to treat, it would be stigmatizing to label an adolescent with BPD.



The Global Alliance for Prevention
and Early Intervention for BPD



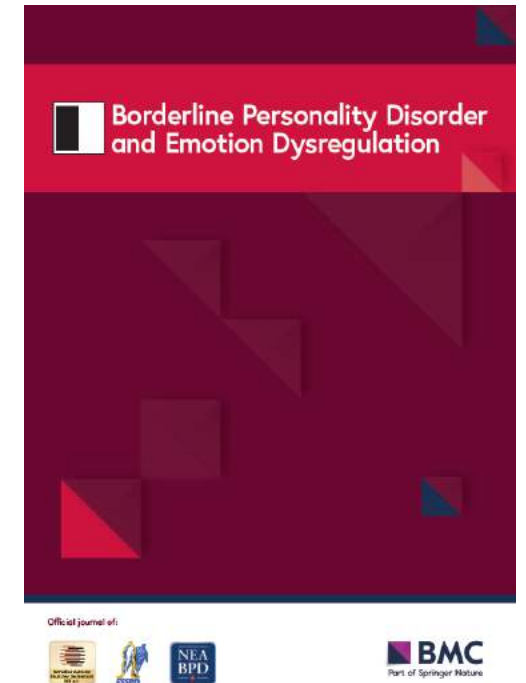
- Promote early detection and timely intervention for borderline personality pathology
- Match treatments to individual development and to the phase and stage of disorder
- Work with families at all stages of intervention
- Improve access to evidence-based treatments
- Increase the variety of available treatments across all levels of the health system
- To develop the mental health workforce by updating knowledge, culture, and practice in relation to borderline personality pathology in young people.
- To address problems of stigma surrounding BPD from the individual and family standpoint.
- To integrate service user advocacy in the above aims.



- Loosely organized group that may influence existing societies (ISSPD, ESSPD, NASSPD, NEABPD, APA, APA, AACAP, etc.).
- *An Effort of Collaboration* of organizations and individuals to advance the agenda on BPD and youth. It is not a separate organization but rather a cooperation between organizations and individuals.
- Open to all who publish or work clinically with young people with personality pathology.
- Meet face to face once a year:
 - Organizing a local GAP conference.
 - Taking the lead on a GAP paper.
 - Organizing a special section in a journal consistent with GAP goals.
 - Submitting a paper to the special series in BPD/ED that is associated with the GAP “brand”.
 - Engage in collaborative work with other GAP members.
 - Do specific work on the major GAP priorities.
- Email reminder of GAP goals and progress mid-year point.



- Global expansion: The Global Alliance for the Early Prevention and Intervention of BPD (GAP)
- +100 participants
- Position paper: *World Psychiatry*
- Special series in BPD/ED: 1st 5 papers
- Local conferences
 - Houston May 2016
 - San Juan September 2017
 - Atlanta
 - Houston November 2017
- Resource library
 - Completed
 - Monthly solicitation
- Training syllabi (Stephanie Stepp)
- Monthly call-in series on youth personality pathology open to the public (Perry Hoffman)
- US Congressional briefing on youth suicide and self injury (Perry Hoffman)





- New position paper
- BPD/ED special section
- Data sharing
- Replication studies
- Funding
- Next face to face meeting: NASSPD 13/14 April 2018
- Face to face meeting ESSPD Barcelona September 2018

Clinical priorities

- early intervention (i.e., diagnosis and treatment of BPD when an individual first meets DSM-5 criteria for the disorder, regardless of his/her age) should be a routine part of child and youth mental health practice;
- training of mental health professionals in evidence-based early interventions should be prioritized;
- indicated prevention (preventing the onset of new “cases” by targeting individuals showing subthreshold features of BPD) currently represents the best starting point toward developing a comprehensive prevention strategy for BPD;
- workforce development strategies (knowledge disseminated; programs should address clinician centered discomfort with the label, mistaken beliefs, and prejudicial and discriminatory attitudes and behavior);
- the diagnosis should not be delayed (non-diagnosis of BPD is discriminatory because it denies individuals the opportunity to make informed and evidence-based treatment decisions, and excludes BPD from health care planning, policy and service implementation, ultimately harming the young people’s prospects);
- misleading terms, or the intentional use of substitute diagnoses, should be discouraged (when sub-threshold BPD is present, terms such as “BPD features” or “borderline pathology” are preferred);
- family and friends should be actively involved as collaborators in prevention and early intervention (typically, family and friends are the “front line” for young people with BPD, and their central role should be recognized and supported).

Research priorities

- prevention and early intervention for BPD must be integrated with similar efforts for other severe mental disorders, acknowledging the “equifinal” and “multifinal” pathways for the development of psychopathology;
- building a knowledge base for a health care system response to prevention and early intervention for BPD can take two approaches (risk factors for persistence/worsening vs. risk factors of onset);
- novel, lowcost preventive interventions should be developed and evaluated (such interventions will need to be developmentally appropriate, and stage/phase specific, incorporating stepped care service models);
- education and skill development programs for families with a young person with BPD are a key priority for treatment research;
- research needs to fully quantify the educational, vocational and social outcomes;
- further development and validation of brief and “user-friendly” assessment tools is
- detailed health economic data are needed
- research identifying methods to improve access to evidence-based treatments and reduce treatment dropout is a priority (this should include novel locations and formats for delivery

Social and policy priorities

- BPD needs to be recognized as a severe mental disorder at all levels of the health system
- evidence-based policy is needed to address BPD from primary through to specialist care, with the aim of building a health care system response to prevention and early intervention with young people and those who care for them as its focus, and including young people and families as partners in the design of such systems;
- Discriminatory practices in health care systems must be eliminated, especially regarding BPD as a “diagnosis of exclusion” from services and refusing health insurance coverage for people with BPD.

Questions and discussion