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CLINICAL PRACTICE POINT

WORKING WITH YOUNG PEOPLE EXPERIENCING PERSONALITY DISORDER

This resource has been created for mental health professionals who are working with young people experiencing personality disorder. It aims to improve understanding of personality disorder and approaches to care.

This resource brings together evidence from young people and families with lived experience, subject matter experts and research literature.

WHAT IS A PERSONALITY DISORDER?

Personality disorder is a mental health condition where a person's thoughts, feelings, perceptions and behaviours cause difficulty in adapting or responding to their day-to-day tasks as well as to life's challenges. Usually emerging during adolescence or early adulthood, personality disorder leads to enduring difficulties in self-functioning (sense of identity, self-esteem and direction in life) and interpersonal functioning (how they understand other people and how they form and maintain relationships). It is a condition that can cause significant distress and long-term challenges lasting into adulthood.

A young person living with personality disorder can experience:

1. Challenges with self-functioning, including those related to:
   - Sense of self:
     - Stability and coherence of their identity over time and across contexts.
     - Realistic self-appraisal of their abilities and strengths.
     - Ability to regulate their emotions in alignment with their goals and environment.
   - Self-direction:
     - Capacity for goal setting and pursuing meaningful objectives.
     - Consistency of behaviour with their long-term goals and values.
     - Capacity to reflect on these areas productively.
2. Challenges with interpersonal functioning, including those related to:
   - Capacity for relationships:
     - Ability to develop and maintain close and mutually satisfying relationships.
     - Appropriate balance between intimacy and autonomy in relationships.
     - Understands how to behave in appropriate and respectful ways towards others.
   - Empathy:
     - Understands and appreciates the perspectives, feelings and needs of others.
     - Recognises the effects of their behaviour on others.
     - Tolerance for the differing perspectives of others.

Personality disorder is not only associated with significant current difficulties, it can also disrupt development during the transition to adulthood, potentially leading to a wide range of long term impacts, such as incomplete education, unemployment, increased morbidity and premature mortality.(1–3) Importantly, these outcomes are not inevitable and effective support can prevent poor long term outcomes. However, if left undiagnosed or misdiagnosed, young people and families are unlikely to receive effective care.

FROM A CATEGORICAL TO A DIMENSIONAL UNDERSTANDING OF PERSONALITY DISORDER

Previously, diagnostic manuals have described multiple, distinct personality disorder diagnoses, such as borderline or narcissistic. Supported by decades of research, our understanding of personality disorder has now changed to a single, general construct of personality disorder. This approach recognises that all those with personality disorder share challenges in two key domains; self-functioning and interpersonal functioning.(4)

The extent to which the personality disorder impacts a person is rated as mild, moderate or severe.(4) For example, young people who were previously diagnosed with borderline personality disorder would now most likely be assessed to have severe personality disorder. Although, historically, most research on personality disorder has focused on borderline personality disorder, this research can still be applied to severe personality disorder.

This change in language aligns with both the Alternative Model for Personality Disorder in Section III of the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, and the International Classification of Diseases, 11th revision.

KEY FACTS ABOUT PERSONALITY DISORDER

- Personality disorder is a diagnosable mental health condition.
- Its diagnosis in young people from age 12 is reliable and valid.
- It is a developmental disorder, which can fluctuate across different stages of development, during which young people are doing their best to manage life's challenges.
- Relational challenges are part of the nature of personality disorder.
- Self-harm and more extreme risk-taking behaviours are common examples of young people with personality disorder attempting to manage their needs.
- Experiences of trauma are common, but not universal, in people experiencing personality disorder.
- Families are not the cause of the young person's personality disorder.
- When empowered and supported, families are powerful allies in treatment and can positively influence a young person's journey.
- With structured, holistic and tailored relational care, young people experiencing personality disorder can lead fulfilling and meaningful lives.

UNDERSTANDING THE DEVELOPMENT OF PERSONALITY DISORDER

There is no single cause of personality disorder and no risk factors that are unique or specific to personality disorder.(5) There are likely to be several different pathways,(4) and to understand these it is important to consider biological, psychological and social factors and their complex interactions. All of these factors, including genetic risks, can increase the risk of developing a range of mental health challenges at some point during one's life.

While traumatic experiences are common among people with personality disorder, it's important to recognise that trauma is not universal. About 30 per cent of adults with severe personality disorder report no trauma history,(6) although trauma can be a consequence of living with personality disorder. Experiences of trauma are common across all mental health conditions, and so trauma-informed care remains a core feature of all good mental healthcare.

Personality disorder is a developmental disorder and young people experiencing personality disorder are doing their best to manage life's challenges.

Young people experiencing personality disorder are usually trying, but struggling, to manage challenges that their developmental experience has not yet equipped them with the skills to manage. These challenges include the normal developmental tasks associated with the transition to adulthood in the domains of social development, emerging autonomy, and education and vocation. Because a young person experiencing personality disorder tends to use ineffective, unhelpful or self-defeating ways of managing these challenges, such as self-harm, avoidance or excessive anger, their development can fall behind that of their peers.

The transition to adulthood highlights the mismatch between self-management and interpersonal skills, and the increasing complexity of the psychosocial demands on young people. For young people experiencing personality disorder, this mismatch is greater and heightens the risk that their efforts to manage challenges might perpetuate or amplify their difficulties, leading to worse outcomes.

ASSESSMENT

Personality disorder is a recognised mental health condition in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) Alternative Model for Personality Disorder (AMPD) and the International Classification of Diseases, 11th (ICD-11) revision.

Even though personality disorder occurs in 10 per cent of the population,(7) with severe personality disorder occurring in around three per cent of young people,(6) it frequently goes undetected in clinical settings.(8,9) While not all mental health professionals will be diagnosing personality disorder, understanding the diagnostic process is important for all mental health professionals because personality disorder is common in clinical practice. Understanding the diagnostic elements can help clinicians to recognise features of personality disorder, contributing valuable observations to the diagnostic process, and guiding clinicians toward interventions to address specific areas of difficulty.

Researchers in personality disorder in young people recommend integrating personality disorder assessment into routine clinical care, promoting early intervention across the healthcare system.(3)

SCREENING

The Level of Personality Functioning Scale-Brief Form 2.0 can be used as a screening tool.(10) It is a brief (12-item) self-report questionnaire that highlights the level of personality functioning, with higher scores indicating more severe impairment.

DIAGNOSIS

The ICD-11 and DSM-5 AMPD follow a similar diagnostic process, first determining the presence of personality disorder and then assessing the severity of impairment. Both diagnostic manuals refer to personality trait domain qualifiers (dimensions of personality difficulties) that provide a sense of typical ways of perceiving, thinking, feeling and acting.

Table 1. A stepped process for using the DSM-5 AMPD to guide diagnosis of personality disorder

STEP	ACTION	COMMENTARY
Step 1	**Determine the presence of personality disorder.**	To confirm the presence of personality disorder, look for moderate or greater impairment across the two domains of personality functioning (self-functioning and interpersonal functioning), considering the features across: **Self-functioning** • Identity: – Stability and coherence of their identity over time and across contexts. – Realistic self-appraisal of their abilities and strengths. – Ability to regulate their emotions effectively in alignment with their goals and environment. • Self-direction: – Capacity for goal setting and pursuing meaningful objectives. – Consistency of behaviour with their long-term goals and values. – Capacity to reflect on these areas productively. **Interpersonal functioning** • Intimacy and capacity for relationships: – Ability to develop and maintain close and mutually satisfying relationships. – Appropriate balance between intimacy and autonomy in relationships. – Understands how to behave in appropriate and respectful ways towards others. • Empathy: – Understanding and appreciating the perspectives, feelings and needs of others. – Recognising the effects of their behaviour on others. – Tolerance for the differing perspectives of others.
Step 2	**Assess the severity.**	If personality disorder is present, the level of personality problems is rated as mild, moderate, or severe. This rating is based on the degree of impairment in self-functioning, interpersonal functioning and other functioning (for example, personal, family, social, educational and occupational). These difficulties are demonstrated in the way a person functions in terms of their thinking, their ability to manage emotions and their behaviour. For example a young person with: • severe impairment in self-functioning could have a very unstable sense of self or a self-view characterised by self-contempt; and one with • moderate impairment in interpersonal functioning could have relationships characterised by conflict, avoidance, withdrawal or very high degrees of dependency. This may be seen as persistent conflict in relationships at work and school leading to negative consequences.
Step 3	**Assign trait domain qualifiers.**	This step can be used to characterise the pattern of difficulties experienced by a young person, with several trait domain qualifiers assigned if appropriate. They include: • Negative affectivity – tendency toward emotional instability, anxiety, and fearfulness. • Detachment – withdrawal from social interactions and limited emotional expression. • Antagonism – tendency toward hostility, callousness and grandiosity. • Disinhibition – impulsivity, risk-taking, and irresponsibility. • Psychoticism – unusual beliefs, perceptual disturbances and eccentric behaviour. For more information, see DSM-5 AMPD.

Note: the DSM also requires criteria C-G to be met	Criterion C: The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning. Criterion D: The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood. Criterion E: The enduring pattern is not better explained as a manifestation or consequence of another mental disorder. Criterion F: The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma). Criterion G (specific to the Alternative DSM-5 Model for Personality Disorders): The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment

STIGMA AND BELIEFS ABOUT PERSONALITY DISORDER DIAGNOSIS

Personality disorder is one of the most stigmatised mental health diagnoses. Many of the negative attitudes associated with personality disorder have emerged because health systems are ill-equipped to meet the needs of young people living with personality disorder, which often leaves mental health professionals feeling frustrated and ineffective. Understanding that young people with personality disorder are doing their best with the coping strategies available to them to navigate life's challenges, will help health professionals, families and others to take a more flexible and understanding approach.

Clinicians often avoid diagnosing personality disorder because they fear that making a diagnosis of personality disorder will have negative consequences for a young person. Although often done with good intentions, withholding a diagnosis or using euphemisms or substitute diagnoses (such as borderline features, attachment trauma or complex post-traumatic stress disorder) contributes to stigma and discrimination by colluding with the notion that the diagnosis is illegitimate and shameful.(5) This also delays or denies young people access to effective care, prolonging challenges and difficulties and increasing the likelihood of inappropriate or ineffective treatments and poor outcomes.(4,11)

IS PERSONALITY DISORDER A FORM OF POST-TRAUMATIC STRESS DISORDER (PTSD)?

No, personality disorder is not a form of post-traumatic stress disorder even though some groups have advocated that severe personality disorder should be renamed 'complex PTSD'. This argument is used most often by mental health professionals seeking to reduce the harmful effects of stigma, particularly in relation to the diagnosis of borderline personality disorder.(12)

An unintended consequence of this argument is that it invalidates the experiences of people who have not experienced trauma. It also risks exacerbating stigma by reinforcing the belief that personality disorder is an inappropriate diagnosis and the person is behaving badly.

There are key symptom differences between complex PTSD and severe personality disorder that require different treatment approaches.(13)

DIAGNOSIS IN YOUNG PEOPLE UNDER 18

Mental health professionals may be cautious about diagnosing personality disorder in young people under the age of 18 years, even when they have identifying features of personality disorder.(14) However, the onset, peak incidence and prevalence of personality disorder occurs in adolescence and early adulthood and personality disorder can be identified in young people as early as 12 years old.(15,16) There is international consensus that diagnosing personality disorder in young people from age 12 is both reliable and valid.(4,17)

Caution around diagnosis may arise because mental health professionals believe: personality is still developing, and therefore diagnosis cannot be made; personality disorder features in young people are transient or part of normal development; personality disorder is untreatable in young people; or that the DSM does not allow clinicians to diagnose personality disorder in people under 18. All these arguments are not supported by scientific evidence.(11,14,18,19)

Diagnosis in young people under 18 years should be supported by best practice biopsychosocial assessment, with information from family and others to corroborate, with careful consideration of alternative explanations for the presenting issues.

Previous editions of the DSM and ICD have never prevented the diagnosis of personality disorder in young people. The current editions of each now clearly and unambiguously support using the diagnosis of personality disorder in young people, thereby creating the opportunity for early intervention.(20,21) There are also now assessment tools validated for use in young people from approximately 12 years of age.

EXPERIENCES OF DIAGNOSIS

People with lived experience, researchers and mental health professionals in the field of personality disorder in young people, emphasise that diagnosis often feels like a relief, making sense of experiences previously bewildering to everyone. To support a positive experience of understanding diagnosis, young people and families must be supported through the process with genuine, candid, realistic, culturally sensitive and hopeful discussions, including discussions about treatment options and outcomes. This approach can reduce stigma, foster meaningful connections and trust, and lead to better outcomes. An early and shared diagnosis supports the start of timely intervention,(11) and allows care planning to be guided by the young person's and family's needs.

> "When the diagnosis was carefully explained to me, how it related to my behaviours and the things that had happened in my life, I thought oh yeah, that's definitely right. I felt relieved and could then start to make some changes which have been life-changing for me."

YOUNG PERSON EXPERIENCING PERSONALITY DISORDER

TREATMENT APPROACHES

A range of effective treatments exist for young people living with personality disorder. There is no evidence that any specific treatment is superior to another or that treatments must be lengthy and open-ended. Recent research in young people with personality disorder has supported an increased focus on episodic care, improving psychosocial functioning as a priority and has demonstrated that specialised individual therapy does not necessarily lead to better outcomes.(3,12)

> "Personality disorder isn't a hopeless condition. With empathy, support, hope and tenacity, we can live at the same time as managing illness."

YOUNG PERSON EXPERIENCING PERSONALITY DISORDER

EARLY INTERVENTION

Early intervention aims to address the high needs of young people experiencing personality disorder and reduce the risk of adverse long-term outcomes, including high mortality and morbidity. It encourages active involvement and collaboration with a young person, their family and the systems around them so that interventions are tailored to address their needs and goals. It focuses on:

- improving interpersonal functioning to help young people become more effective in getting their needs met;
- improving educational and vocational functioning;
- reducing mental ill-health and distress;
- enhancing health, wellbeing and safety; and
- reducing premature mortality.

The key elements of early intervention include:

- Early engagement of a young person and their family.
- Careful assessment of MH difficulties including personality disorder.
- Psychoeducation about personality disorder and treatment options.
- Development of a shared formulation with the young person and family that will guide treatment.
- Collaborative development of a care plan, including:
  - goal-setting, crisis planning (attention to risk and safety, using a harm minimisation approach) and family support;
  - integration of care for co-occurring physical and mental health conditions; and
  - practical support and problem solving.
- Time-limited episodes of care, paying attention to endings and transitions.

INTEGRATED CARE

Young people living with personality disorder have similar needs to those with other mental health conditions and require early access to an integrated mental health system that welcomes and respects them and adapts to their needs. To achieve this, early identification and timely treatment for personality disorder needs to be integrated into mainstream youth mental healthcare rather than siloed in specialist centres.(6)

Given the high prevalence of personality disorder and its short and long-term consequences, improving access to appropriate care to better meet the needs of young people experiencing personality disorder is a high priority.(3,6) High-quality clinical care has been demonstrated to be as effective as the specialised treatments. Integrating early intervention involves understanding the full range of difficulties a young person might experience, including any co-occurring mental health conditions, such as depression, anxiety or psychosis, as well as any other health issues, vocational or psychosocial difficulties. Goals need to be collaboratively negotiated with the young person, their family and the system as part of holistic and tailored treatment.(6,22)

RELATIONAL CLINICAL CARE

Challenges with relationships are part of the very nature of personality disorder. Using a relational model of personality disorder assists in understanding the young person's difficulties and helps to maintain a collaborative and effective relationship with the young person and family.

Relational clinical care is a model of care that uses the understanding of a young person's relational difficulties (with themselves and others) and applies this understanding to working not only with the young person, but with the family, agency and within wider systems. It recognises that many of the difficult or unhelpful relational patterns a young person with personality disorder experiences can also manifest in how clinicians, services and other supports react and respond, particularly where risk and safety are concerned.

Relational care relies on the skills that mental health professionals are already using across the mental health system, from primary to tertiary-care settings. Using this model, the clinician's and team's role is to help the young person understand their relational difficulties and discover and practice more adaptive ways of responding. Establishing a shared relational understanding of how and why the young person has developed specific difficulties will assist everyone to work collaboratively together. Alongside this work, the clinician also provides practical support or clinical case management to support the young person to identify and work towards psychosocial goals. However, an important additional role is also to help others who support the young person (e.g. families, agencies and other parts of the healthcare system) to understand these relational patterns, and how they might be contributing to or reinforcing these, inadvertently making things worse or causing iatrogenic harm.

WHY IS RELATIONAL CLINICAL CARE HELPFUL IN WORKING WITH PERSONALITY DISORDER?

Given interpersonal challenges are central to personality disorder it is almost certain this will extend to relationships with mental health professionals. It is natural for mental health professionals to feel confused, frustrated or alarmed when observing patterns of self-harm or angry outbursts, or when young people become entangled in interpersonal difficulties.

Sometimes, clinicians can find themselves acting in ways that they would not normally entertain, such as becoming excessively directive, which may leave a young person feeling overly controlled, misunderstood or mistreated. This can lead to an exacerbation of the young person's difficulties, which then elicits further control and situations that can continue to spiral. Alternatively, clinicians may feel overwhelmed by a young person's situation and the challenges they are facing and might feel pulled towards rejecting the young person from the service. These are examples of how the relational patterns and difficulties that a young person experiences might arise in the therapeutic relationship.

Using a relational understanding of personality disorder helps the young person and mental health professional work on the difficulties in a collaborative way. The young person can learn to recognise these patterns and difficulties and with the support of the clinician, understand when and why they might happen. With this information and understanding, the young person is in a better position to develop more adaptive and functional ways of relating and responding. A relational understanding also helps the clinician to manage their own and others' expectations of what a young person might be able to change or achieve, can facilitate engagement, build trust, foster hope and support collaboration in the treatment plan.

Young people with personality disorder are likely to have experienced loss of trust or have been 'let down' by others, and as such establishing trust in a therapeutic relationship may be even more difficult. Mental health professionals can use the difficulties in engagement to discuss and demonstrate appropriate trust in relationships, with a focus on being realistic, clear, consistent and open about what they can and cannot offer the young person. This involves the clinician being open about their availability, and likely responses, especially when faced with behaviours they might find challenging. Demonstrating this through action, with a compassionate and empathic approach, is necessary to support the young person to make changes.

At times work with young people experiencing personality disorder can feel challenging, and inadvertently mental health professionals may find themselves responding in ways that may make things worse. Relational clinical care relies on supportive individual or group clinical supervision, to support the mental health clinician to reflect on the work with the young person, examine their roles in the relationship, and consider ways to support the young person to make change. Seeking formal and informal support from supervisors and colleagues to improve reflective capacity is essential to working effectively with young people experiencing personality disorder.

RESPONDING TO SELF-HARM AND RISK-TAKING BEHAVIOURS

While there are many reasons reported by young people for self-harm, the most common is to manage their overwhelming feelings.(23) It is also common for young people not to be sure why they engage in such behaviours and to try to hide their behaviour from others.(23) An important aim of early intervention is to enhance the young person's autonomy and self-reliance, as well as increasing their capacity to keep themselves safe and encouraging them to learn new, more adaptive ways to meet their needs. Understanding the function of this behaviour provides the basis for discussing change, however, when a young person is engaging in repetitive patterns of self-harm or suicidal behaviour it can be one of the most challenging issues for professionals, families and others.

Risk taking and impulsive behaviour associated with personality disorder can be dangerous, self-defeating and may elicit reactive, and sometimes, unhelpful responses in clinicians and other supports. However, many of these behaviours have short-term effects that the young person experiences as beneficial, even if the longer-term consequences might be harmful. Young people may not always view this behaviour as problematic, despite it often causing concern and distress for others.

Pragmatic harm minimisation, safety planning,(24) and learning to tolerate the discomfort of working with a young person who engages in self-harm are all important skills when working toward the common aim of helping the young person learn new ways of managing. Consistency and engagement are facilitated when everyone understands the function of the young person's behaviour, develops collaborative safety plans with them and their supports, and shares, where possible, these plans with others, such as other agencies, school staff or emergency services. Strategies to manage self-harm behaviours should aim to build general coping skills and improve communication. It is equally important to minimise distress and support the young person to maintain protective factors (for example, staying engaged in school) and reduce punitive responses, (such as being excluded from school following self-harm).

Even with safety plans in place, when risk increases many mental health professionals feel drawn to respond in more directive and restrictive ways usually in an effort to protect the young person's safety. Alternatively, some mental health professionals tend to ignore or underestimate the risks, falsely believing that the young person is not serious or is making empty threats. Unfortunately, both overly restrictive or dismissive responses can provoke young people to take bigger risks in an attempt to force others to take them seriously. Neither

response promotes collaborative engagement, improvement in communication, or encourages the young person to increase their capacity for self-management.(22)

Remaining non-judgemental, acknowledging what is effective, as well as jointly highlighting the adverse consequences of these behaviours can assist mental health professionals to explore this topic with the young person and their supports. Collaboratively exploring the function, aim or intention of the risk-taking behaviour with the young person supports them to begin reflecting on recurrent patterns of behaviour and to explore whether there are other ways of managing.

REMAINING REFLECTIVE AND GETTING SUPPORT

Remaining reflective as a mental health professional means taking time to critically reflect on your work, to learn and improve your practice. This will involve both putting yourself in the young person's shoes, as well as learning to identify your own responses. This reduces the likelihood of reacting immediately without considering whether your response is helpful or not. Supervision and/or reflective group practice can be especially important when you are feeling extremely concerned or frustrated about a young person's high-risk behaviour. Discussions with family and other clinical and non-clinical services should include the fact that self-harm cannot simply be switched off. No one is likely to give up their only way of managing feeling overwhelmed until they can find an equivalent or better way of managing their feelings.

FAMILY-INCLUSIVE CARE

Families can be key supports when engaged appropriately in treatment. Early family engagement, psychoeducation and practical assistance can benefit the young person's care. (25,26) Families of young people with personality disorder report high levels of burden, high levels of negative experiences related to their role, and high expressed emotion (critical comments). (27) Family members often experience their own mental health challenges, along with guilt and self-blame, wondering whether they might have contributed to the young person's difficulties.(28) They frequently report not knowing enough about personality disorder and feeling excluded from their loved one's care.(29,30) They might worry that they are not doing enough for the young person, whilst also experiencing burn-out, especially in the context of recurrent risk-taking behaviour.

> "My daughter would come out of an appointment in tears, and we did not know what had happened or how to help. I don't need to know everything but if we were involved from the start, it would have been easier to support her."
>
> **FAMILY MEMBER**

The relationship challenges that are central to personality disorder are often experienced more widely within families. Despite this, a young person's family can be their main support. Even when young people are no longer living with their family, most still hope for improved relationships with them.

Engaging families early in care is important so they can continue to effectively support the young person. A family-inclusive approach focuses on understanding how family members experience the young person and their difficulties, as well as focusing on family strengths, difficulties and needs.(30) Early areas of intervention might include providing psychoeducation, reducing conflict and stress, and improving communication and relational skills. Providing direct and practical support, such as links to financial supports, are often indicated and can assist families to better support the young person. It is important for clinicians to regularly involve families in the young person's care and treatment planning, and where indicated, to support families to access external supports.

Practice tips

- Use a curious, non-judgmental approach to understand the young person's experiences.
- Develop a shared formulation with the young person (and family/supports) to help guide treatment and care.
- Validate the young person's distress while exploring more effective ways of coping.
  - Involve and support families early, providing psychoeducation and practical assistance.
  - Focus on improving self-esteem and work towards engaging the young person in meaningful activities.
  - Build relational skills and improve communication.
- Integrate personality disorder care with treatment of co-occurring conditions.
- Regularly review treatment and progress with the young person and family/supports to ensure that treatment remains effective and satisfactory.
- Seek supervision and support to manage challenges in the therapeutic relationship.

TAKE HOME MESSAGES

Personality disorder is a mental health condition that is common in clinical settings and can be reliably diagnosed in young people from the age of 12 onwards. It is a developmental disorder whereby young people experience difficulty managing life's challenges, which manifests as enduring difficulties in their relationship to self and others. Young people experiencing personality disorder are often trying their best to manage life's challenges but may be ill-equipped or haven't developed adaptive ways of coping.

A relational understanding of personality disorder supports the provision of good clinical care that is compassionate, validating and collaborative. Early intervention is essential so that young people with personality disorder can learn to effectively manage their difficulties, and to minimise the impacts on other areas of their lives. Involving families in care also helps the young person and their family to make sense of their experiences and develop more effective means of managing life's challenges.

RELATED RESOURCES

More information on how to have conversations with young people about personality disorder is available in these resources:

- Videos. Personality disorder and young people.
- Factsheet – Supporting young people experiencing personality disorder.
- Factsheet – Supporting the families of young people experiencing personality disorder.

FURTHER INFORMATION

- Australian BPD Foundation. www.bpdfoundation.org.au
- National Education Alliance for Borderline Personality Disorder Australia (NEABPD-Australia). www.bpdaustralia.org
- Project Air. www.uow.edu.au/project-air
- Spectrum. Specialising in Personality Disorders and Complex Trauma. www.spectrumbpd.com.au

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CONTRIBUTORS

- Professor Andrew Chanen, Chief of Clinical Practice, Head, Personality Disorder Research, Orygen and Professorial Fellow, Centre for Youth Mental Health, The University of Melbourne.
- Caroline Crlenjak, Workforce Development and Partnerships lead, Knowledge Translation, Orygen.
- Sian Lloyd, Director Workforce Development and Service Implementation, Knowledge Translation, Orygen.
- Associate Professor Louise McCutcheon, Principal Psychology Educator and Senior Program Manager, Helping Young People Early (HYPE) Service Development, Orygen Specialist Program.
- Zoe Nikakis, Project Officer, Knowledge Translation, Orygen.
- Sophie Ratcliff, Clinical Educator, Knowledge Translation, Orygen.
- Desirée Smith, Registered Nurse, Team Leader Workforce Development, Knowledge Translation, Orygen.

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- Ben McKechnie, Clinical Psychologist, Clinical Stream Leader, Helping Young People Early (HYPE), Orygen Specialist Program.
- Joan Veltkamp, Registered Nurse, Eastern Health.
- Helping Young People Early (HYPE) clinicians, Orygen Specialist Program.
- Anonymous, family member.
- Anonymous, young person experiencing personality disorder.
- Lived experience consultant, who has recovered from personality disorder.
- Susan, Senior Family/Carer Consultant, Orygen.

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