# A Different Way of Thinking

## Working with Borderline Personality Disorder in Early Psychosis

Orygen
The National Centre of Excellence in Youth Mental Health

EPPIC
Early Psychosis Prevention and Intervention Centre

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# Introduction

Young people with early psychosis frequently have additional mental health issues that need to be addressed along with psychosis, as they can delay recovery from an episode of psychosis, complicate its treatment and may increase the risk of relapse. Personality disorder is one mental disorder that can co-occur with psychosis. Clinicians need to be able to recognise when a personality disorder is present and have strategies for dealing with the complexities presented.

Borderline personality disorder is the most prevalent personality disorder seen in clinical settings, including early psychosis services. This condition is characterised by instability in relationships, self-image, and emotional states and is accompanied by self-damaging impulsivity, often including deliberate self-harm. The presence of co-occurring BPD in early psychosis can make the treatment of early psychosis more difficult, and it is therefore important that clinicians and early psychosis services develop the skills and processes to help young people with this condition recover and achieve a good quality of life.

## About this manual

*A different way of thinking: working with borderline personality disorder in early psychosis* is one of a series of manuals produced as part of the EPPIC National Support Program (ENSP) to support the implementation of the Early Psychosis Prevention and Intervention Centre (EPPIC) Model in early psychosis services. The EPPIC Model of specialised early intervention in psychosis aims to provide early detection and developmentally appropriate, effective, evidence-based care for young people (aged 12–25 years) at risk of, or experiencing, a first episode of psychosis. It has been developed from over 20 years of experience within the clinical program at Orygen Youth Health and further informed by the National Advisory Council on Mental Health's Early Psychosis Feasibility Study (2011), which sought international consensus from early psychosis experts from around the world. Note that the EPPIC Model is informed by the Australian Clinical Guidelines for Early Psychosis (2010).[1]

'Early psychosis' refers to both first episode psychosis (FEP) and the pre-onset phase of ultra high risk (UHR) for psychosis, which is defined by meeting established criteria indicating risk of transition to psychosis (see the ENSP manual *The CAARMS: assessing young people at ultra high risk of psychosis*).

This manual is aimed at clinicians of all disciplines working in early psychosis services. Young people with co-occurring BPD and early psychosis represent a complex group, and it is essential that their treating team is comprised of at least two clinicians. Involvement of senior clinicians with experience with this group is recommended. In addition, a broader clinical team is helpful, as will be discussed, to support clinical work.

## How to use this manual

This manual is divided into three parts. The first aims to provide a background understanding of the nature of personality and personality disorder, in particular borderline personality disorder (BPD), and the rationale for early intervention with this group. The second outlines how early psychosis services may adapt the early intervention for psychosis approach so that they can provide appropriate care for young people with co-occurring BPD. The third includes suggestions to assist both clinicians and services to manage the clinical challenges that can stem from features of BPD, such as maintaining a therapeutic relationship and managing acute and chronic risk.

Clinicians may find it useful to refer to other manuals in the ENSP series that are particularly relevant for working with co-occurring BPD in early psychosis, including *What to do? A guide to crisis intervention and risk management in early psychosis, In this together: family work in early psychosis, Let me understand: assessment in early psychosis, A stitch in time: interventions for young people at ultra high risk of psychosis* and *A shared understanding: psychoeducation in early psychosis.*

# Background and rationale

# Background and rationale

## Personality disorder

### What is personality?

**Personality** is defined as a collection of characteristics or traits that describe relatively consistent patterns of relating, thinking, feeling and behaving that are pervasive across life domains and enduring over time. These characteristics or traits are those that make individuals both similar to others as human beings, and at the same time distinguish one person from another. They describe how individuals tend to perceive the world and therefore how they react, and relate to themselves and others and the world around them.

There are various descriptions of personality in the literature, the most common of which is the five-factor model.[2,3] This divides personality into five broad domains, or dimensions, of personality: 'neuroticism', 'extroversion', 'openness to experience', 'conscientiousness' and 'agreeableness'. Each of these five domains is made up of a cluster of more specific primary factors. For example, 'extroversion' includes 'gregariousness', 'assertiveness', 'excitement-seeking', 'warmth', 'activity', and 'positive emotions'.

Personality traits in the five-factor model are construed as dimensional, meaning each individual has more or less of a particular factor. For example, at one extreme, someone might be often very emotional, while at the other a person might seem very constrained and unemotional.

Research over the past two decades has demonstrated that personality is less stable than first thought. This is in contrast to previous assumptions in which personality was considered to be more or less fixed by early adulthood. It is now understood that while there may be periods in which our personality features are particularly malleable or flexible, change can occur across the whole lifespan.[4]

### What is personality disorder?

Personality disorder is the term used within the mental health field to describe longstanding difficulties in how an individual thinks and feels about themselves and others, and consequently how they behave in relation to other people. Personality disorder occurs when the characteristics (traits) that describe how we relate, think and behave are inflexible, inappropriate, and cause distress or impairment in social, occupational, or other areas of functioning.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines 'personality disorder' as an 'enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture'.[5] The pattern must be manifested in at least two of the following domains:

- cognition (ways of perceiving and interpreting ourselves and other people and events)
- affectivity (the range, intensity, lability and appropriateness of emotional responses)
- interpersonal functioning (our capacity to make and maintain relationships, resolve conflict and capacity for connection with others)
- impulse control (the ability to control urges and consider the consequences of our actions).

Maladaptive personality traits can foster vicious circles and perpetuate and intensify already present difficulties. Individuals with personality

disorder struggle to change, and continue to respond in maladaptive ways even when they receive feedback from the environment that their behaviour or responses are not achieving what they want them to. Personality disorders have their onset in adolescence or early adulthood, and to be diagnosed must not be better accounted for by another mental disorder or the effects of a substance or medical condition (such as head trauma).

The International Classification of Diseases (ICD-10) defines personality disorders as 'pervasive and clearly maladaptive' attitudes and behaviour that affect a number of areas of functioning.[6]

The prevalence of personality disorder in the general population is 4–15%. Personality disorder is associated with reduced life expectancy, due to increased risk of suicide, homicide, cardiovascular and respiratory disease and substance use.[6]

In addition, personality disorders are the most common disorders seen among people with a psychiatric disorder, with estimates suggesting around 50% of this population have a personality disorder.[6]

## Classification of personality disorders

The ICD and DSM both divide personality disorders into a number of categories based on disordered personality types or traits. Table 1 highlights the similarities and differences between the two classification systems.

Of note, the classification of personality disorders is undergoing a shift and is a subject of ongoing review. The categorical system in particular, used by the DSM, is not validated, and there is no consensus on definitions of each category.[7]

It has been asserted that normal and disordered personality features are continuous. For example,

TABLE 1. **COMPARISON OF THE DSM AND ICD CLASSIFICATIONS OF PERSONALITY DISORDER**

| | DSM | ICD |
|---|---|---|
| **Diagnostic criteria** | Behaviours or traits in recent and long-term functioning present since adolescence or early adulthood.<br><br>Personality disorder defined as group of behaviours or traits that cause subjective distress or functional impairment. | Variety of conditions reflective of a person's enduring pattern of inner experience (cognition and affect) and behaviour that diverge from what is culturally expected. |
| **Classification** | Three Clusters | Nine Types |
| | Cluster A:<br>• Paranoid<br>• Schizoid<br>• Schizotypal | Paranoid<br>Schizoid |
| | Cluster B:<br>• Antisocial<br>• Borderline<br>• Histrionic<br>• Narcissistic | Dissocial<br>Emotionally unstable:<br>• Impulsive type<br>• Borderline type<br>Histrionic |
| | Cluster C:<br>• Avoidant<br>• Dependent<br>• Obsessive-compulsive | Anxious (avoidant)<br>Dependent<br>Anankastic |

the personality trait of 'orderliness', would be expected to have a middle range that is considered normal, but anyone who expressed this characteristic at either extreme end of the dimension (i.e. being so obsessed by orderliness or so disorganised that it interfered with daily functioning), would be considered to be disordered in this trait. The evidence for a continuous or dimensional view of personality is increasing, but the diagnostic classification systems currently used are still fundamentally categorical, requiring clinicians to diagnose traits and personality disorders as present or not.

A proposed revision to the DSM-IV classification system was published in the recent DSM-5. This alternative model retains six (from the current 10) specific personality disorder diagnoses.[5,8] However, the lack of empirical evidence supporting the new DSM classification model resulted in it being placed in an appendix in the DSM-5 as an 'emerging measure and model', and the clusters and categories system remained unchanged in the DSM-5. Consequently, the only difference for personality disorders in the DSM-5 was the removal of the hierarchical Axis I (state disorders) and Axis II (trait disorders) system, so that personality disorders are now listed at the same level as other mental health problems in the manual.

However, a completely new classification of personality disorder is proposed for the forthcoming ICD-11 that emphasises the dimensional model, where personality disorder exists as part of a spectrum of personality from normal to severely disordered. The ICD-11 proposal has no specific categories, and personality disorder is only defined by severity, and if necessary, qualified by trait domains. This new ICD-11 classification is currently being field-tested by the World Health Organization.[6]

For more on the classification debate see Tyrer et al. 2015[6] and Krueger et al. 2012.[9]

## What is BPD?

Borderline personality disorder is characterised by marked instability across relationships, self-image and affect, and is accompanied by significant and self-damaging impulsivity. DSM-5 contains nine diagnostic criteria for BPD, and five or more must be present to make a diagnosis of full-threshold BPD (see Appendix 1).[5]

Although the aetiology of BPD is not completely understood, as with other mental health conditions, including psychosis, it is likely to involve a combination of biopsychosocial factors. Research suggests that biological factors (such as genetics, neuroanatomy and neurobiology), in addition to a person's experiences while growing up (such as trauma early in life, maladaptive parenting), are associated with BPD.[11] However, these factors are not specific to BPD and lead to increased risk for a range of mental health problems.[11]

BPD is the most prevalent personality disorder in clinical populations, and is associated with high morbidity and mortality across the lifespan. People with BPD also show severe and continuing functional disability across a broad range of domains, and have high rates of service utilisation and completed suicide.[12–16]

Despite this, a number of perceptions have contributed to people with BPD being excluded from services or receiving inappropriate and stigmatising interventions that lead to iatrogenic harm.[11] Many of the features that make up BPD can be challenging for clinicians, such as recurrent deliberate self-harm and suicidal behaviour, rapid shifts between idealising others and then devaluing them, unstable or labile moods, and inappropriate angry outbursts. This may lead to people with this condition being perceived as difficult or underserving of clinical care.

Additionally, in the past, BPD was considered to be 'untreatable'. However, there is now good evidence that BPD can be considered a treatable condition, even in adults with enduring and severe presentations. Over 25 randomised controlled trials demonstrate a range of effective, structured treatments that can reduce symptoms.[17] Although the outcomes at this point are modest, the greater challenge is that many people with BPD access little or no treatment, and those who do access care often receive only acute services or inconsistent care. Thus, a very small number are able to access and engage in more intensive specialised treatments for BPD.

Australian clinical guidelines for the management of BPD recommend structured, high-quality clinical care that includes non-specific mental health management, specific treatments for BPD and treatment for co-occurring mental illness.[17] Specialised treatment for BPD should be in the form of a structured psychological therapy that is specifically designed for BPD, with medical treatment used only for the treatment of co-occurring conditions where indicated or in a time-limited manner to manage acute crisis.[17]

## BPD in young people

Although there has been an enduring reluctance to diagnose BPD in people under the age of 18, there appears to be little justification for this. BPD can be considered a disorder of young people, as it has its highest prevalence in this age group and declines progressively over the lifespan (although, despite attenuation of clinical symptoms, with or without treatment, it appears that the functioning of people with BPD remains poor).[11] Furthermore, the majority of adult psychiatric morbidity, including personality problems, usually becomes evident in adolescence or early adulthood and there is longstanding agreement that personality disorders have their roots in childhood and adolescence.[18]

There is now evidence that BPD is a reliable and valid diagnosis in adolescence and it can be identified in day-to-day clinical practice.[11] Research has also shown that the stability of the diagnosis is similar in young people to that in adults and that there is no discontinuity from adolescence to adulthood.[19]

Australian data indicates that BPD may be present in 22% of young people in psychiatric outpatient settings. It is associated with a number of psychosocial problems, including mental state disorders, substance use, poorer psychosocial functioning, family breakdown, unwanted pregnancy, welfare dependency, and involvement with the youth justice system. Adolescent BPD is also a predictor of future BPD diagnosis, risk of other mental state disorders, interpersonal problems, distress and lowered quality of life.[11] Young people with BPD form a group with current and future high morbidity and mortality and particularly poor outcomes. However, BPD features in young people are flexible and malleable,[20] and have been found to respond to intervention.[19,21,22]

The case scenario 'Trudy' illustrates some of the difficulties that a young person with BPD may experience and how this can affect educational pathways and social functioning.

TRUDY

### CASE SCENARIO

**Trudy** is a 16 year-old high school student who has been referred for assessment by her GP after her parents complained that her behaviour was 'out of control'. She was described as a 'difficult child' from birth, with severe separation anxiety, unpredictable moods, frequent angry outbursts or tantrums, and has had significant difficulty making and retaining friendships. However, she was a bright and creative student who did well at school, and when things were calm, was a loving and lovable member of the family.

Since starting high school Trudy has been increasingly angry and argumentative with her parents, resulting in frequent shouting matches and some physical fighting. She has recently begun running away from home, going missing for several days at a time. She is also frequently in trouble at school due to her short temper, and yelling at teachers, and has been suspended twice in the previous year for this. She also has stormy relationships with peers at school.

She is constantly making new friends with whom she becomes obsessed, spends enormous amount of time with, and phones and texts many times each day. However, after a short period they fall out, usually after Trudy argues with the friend over whether the friendship is being appropriately reciprocated. She will then declare that she hates that friend and never wants to talk to them again. Her parents have discovered that she has been self-harming for the last 2 years by cutting and burning herself on her wrists and thighs, which she says she did because she felt so overwhelmed, needed to feel 'something' and deserves to be punished for being bad.

## The rationale for early intervention in BPD

Adolescence and early adulthood is a key developmental period, and disruption to this period due to severe and disabling mental health issues can cause wide ranging problems. In this context, there are a number of reasons that BPD in young people is an appropriate focus for prevention and early intervention:[11]

- It is associated with particularly poor outcomes later in life.
- It is associated with a high degree of functional impairment and service usage.
- It is common in clinical practice, as individuals with BPD are often help-seeking.
- It responds to intervention, even in people with an established disorder.
- It can be reliably diagnosed in its early stages.

Along with early intervention, indicated prevention is the 'best bet' for the prevention of BPD.[23] This approach targets individuals who display precursor (early) signs and symptoms of BPD: that is, people with some of the features of BPD. The evidence suggests that the strongest predictor of BPD in adulthood is the presence of BPD features in adolescence, over and above other precursor signs such as disruptive behaviour disorders or depressive symptoms.[24]

Rather than focusing on treating 'symptoms' of BPD, the aims of the early intervention approach are to alter life-course trajectory, reduce risk of poor outcomes (particularly the risk of iatrogenic harm) or avoid them altogether, and promote more adaptive help-seeking.[11]

# BPD and psychosis

## Prevalence

Estimates of BPD prevalence in the general population range between 0.7% and 2.7%. This figure rises to between 9.3% and 22.5% among people being treated in psychiatric settings, and as much as 40% in some inpatient settings. It is most prevalent in adolescence, after puberty, and gradually declines in prevalence every year afterwards.[11]

As BPD is the most frequently seen personality disorder in clinical practice,[19,25] it undoubtedly co-occurs with early psychosis.

There are very few studies that acknowledge and investigate this complex comorbidity in young people, possibly due to the complex and confusing debate about the nature and validity of psychotic symptoms in BPD that has plagued the field, discussed on page 13, and the fact that individuals with such comorbidities tend to be excluded from studies.

However, there has been increasing interest in co-occurring BPD and psychosis (schizophrenia) in adult populations in recent years, and a few studies provide information about prevalence. For example, Kingdon et al. (2010) found that 50% of adult BPD patients experience psychotic symptoms, particularly auditory verbal hallucinations, but paranoia was also common.[26] Yee et al. (2005) reported that 29% of their BPD sample had long-standing auditory hallucinations, and Gras et al. (2014) reported that 30% of patients with BPD reported auditory hallucinations.[27,28] Moran et al. (2003) found that 28% of their large sample of people with psychotic illnesses also had a co-occurring personality disorder diagnosis.[29]

Thus a significant proportion of people with BPD experience psychotic symptoms, and a significant proportion of people with psychotic illness also have a personality disorder, frequently BPD. This co-occurring condition is also seen in young people. Clinical experience from Orygen Youth Health Clinical Program in Melbourne, which has separate early intervention programs for early psychosis and BPD, informs us that psychotic symptoms are common in young people with BPD, and that BPD is present in a substantial minority of young people with early psychosis. Two small studies conducted at OYHCP also support this: Francey et al. (2006) found that approximately 20% of a FEP sample had co-occurring BPD, and Thompson et al. (2012) found that 17% of a small UHR sample had co-occurring BPD.[30,31]

It is therefore likely that clinicians working in early psychosis will need to treat young people who have co-occurring BPD. If they are to address this complex comorbidity and manage the challenges it may present, they need to understand the disorder and to be equipped with the required skills and strategies.

## Challenging misperceptions of BPD

Despite the prevalence of BPD among people with psychosis and its significant impact on outcomes, people with BPD who experience symptoms of psychosis are often not regarded as eligible for treatment within psychosis services. Two historical misperceptions seem to be responsible for this. The first is that BPD cannot or does not need to be treated by mental health services. Related to this is the belief that the symptoms of psychosis experienced by people with BPD are not 'true' psychotic symptoms, and that these too do not need to be treated in a psychiatric setting. However, as discussed below, neither of these beliefs are supported by the evidence, and they should not be used as reasons to exclude young people with BPD and psychosis.

### BPD responds to treatment and should be treated in a mental health setting

The nature of BPD, with core features of relational difficulties, impulsive aggression, recurrent self-harm and emotional instability, means that people with this disorder have traditionally been viewed as 'difficult' to treat, and indeed, they are often very challenging young people for clinicians to interact with.

People with BPD may be been seen as difficult or uncooperative and are often held responsible for their own undesirable behaviour, unlike people with other conditions such as depression or psychosis; this can lead to the belief that BPD is not a valid mental health problem, and thus, people with BPD are not deserving of treatment within mental health services.

Another longstanding clinical perception of BPD is that it does not respond to treatment, and is therefore not worth treating. However, this view is not supported by the most recent evidence.

Firstly, people can and do recover from BPD: the prevalence of BPD is highest in the youth age-group, and many people no longer have the features of the disorder in adulthood, demonstrating that people do recover.[12]

Secondly, it is unequivocally 'worth' treating people with BPD. The developmental trajectory of young people with BPD is likely to have been impacted by the disorder, and there is growing evidence that delays in treatment for young people with BPD can further disrupt developmental pathways. This risks multiple problems, including long-term vocational disability and iatrogenic harm.[32] Furthermore, symptomatic recovery does not equate with functional recovery. There is therefore a compelling case for the provision of appropriate mental health care to young people with BPD, to avoid delays in care and associated harms, and to enable them to achieve the highest possible level of functioning.

Australian guidelines now clearly state that BPD is a valid mental health problem and is deserving of care.[17]


**People with BPD often make up their symptoms to manipulate clinicians, and don't deserve to be treated in mental health services.**

**Not true.** BPD is a recognised and valid mental disorder that should be appropriately treated by skilled clinicians in mental health services.


# Psychotic symptoms experienced by people with BPD are not real psychotic symptoms.

**Not true.** Recent research demonstrates convincingly that there is no difference in quality, frequency or attribution between the psychotic symptoms experienced by people with co-occurring BPD and those without this diagnosis.

## BPD psychotic symptoms are no different to those experienced in other psychotic disorders

It has been recognised since the 1940s that people with BPD experience symptoms of psychosis; however, there has been a widely held idea that somehow psychotic symptoms experienced by people with BPD are different from those experienced by people with psychotic disorders. Psychotic symptoms in BPD have been given terms such as 'pseudohallucinations' or 'quasi-psychotic symptoms', which suggest doubts about the validity of these symptoms. They were also, until recently, believed to be brief ('micropsychotic episodes'), less severe and qualitatively different from those in 'true' psychotic disorders such as schizophrenia.[33]

In addition, auditory–verbal hallucinations in BPD are also widely assumed not to respond to treatment with antipsychotic medication,[34] although there has actually been no research into this question. This is another feature thought to distinguish them from 'true psychotic' symptoms and used as a reason to exclude people with BPD from treatment by psychosis services.

A further complication for people with BPD is that they often have a background of trauma, and their experience of psychotic symptoms is frequently attributed to post-traumatic stress disorder (PTSD), rather than a psychotic disorder; this means that often appropriate treatment for psychosis is not considered.

However, recent empirical studies have demonstrated convincingly that symptoms such as auditory hallucinations and delusions in BPD are essentially indistinguishable from those experienced by people with psychotic disorders such as schizophrenia,[34] and that there is no difference in quality, frequency or attribution of psychotic symptoms experienced by people with BPD.[26,33,35]

In light of this, the common exclusion of people with co-occurring BPD and psychosis from psychosis services is not justified and represents discrimination. Young people with early psychosis and co-occurring BPD must be included in early psychosis services, and services should incorporate best practice for treatment of BPD into their service.

It is equally vital that early psychosis services and clinical staff strive to build an understanding and acceptance of the fact that individuals with BPD (or indeed any other comorbidity) have a right to rapid and effective treatment for the full range of psychiatric conditions. If not, young people with these co-occurring conditions face the negative sequelae of untreated psychosis and BPD and the associated poorer outcomes.

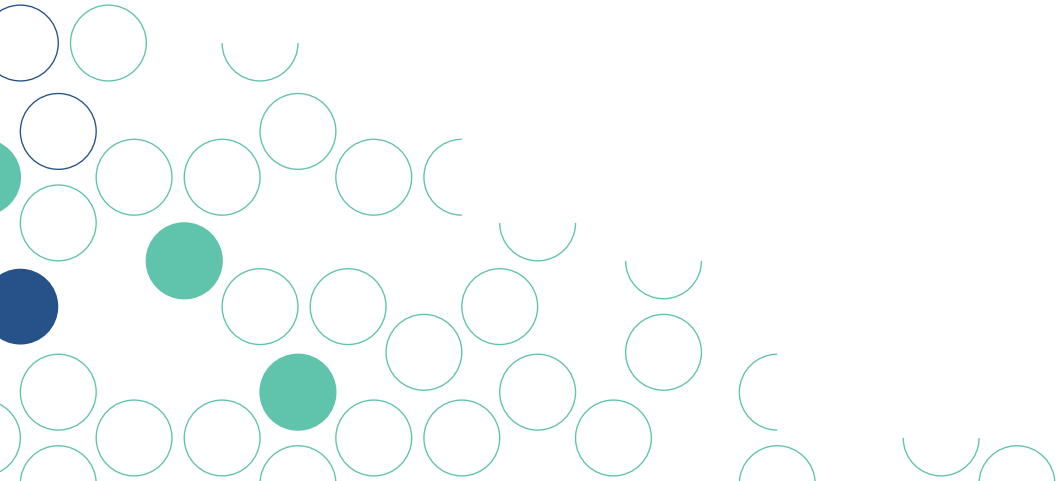
## BPD is not an exclusion to treatment in early psychosis services

The EPPIC Model promotes early psychosis services as accessible and responsive to **all** young people who present with symptoms of psychosis, including those with co-occurring conditions. As long as young people have been appropriately assessed and found to meet the service intake criteria (see the *EPPIC Model and Service Implementation* guide), they are entitled to receive the complete and comprehensive EPPIC service. Excluding any group or individual can cause unnecessary increases in a young person's duration of untreated psychosis (DUP), and risks a range of negative outcomes.

The EPPIC Model provides early intervention for psychosis based on the stress–vulnerability model of the onset of psychosis, and personality difficulties are appropriately viewed as vulnerabilities to be targeted for treatment to improve outcomes and reduce the risk of relapse.

Symptom profiles and diagnoses among young people change over time due to developmental processes, treatment responses and life events. It is therefore important to be inclusive in early psychosis services, to avoid discrimination against any particular presentations or diagnoses and to convey an attitude of optimism regarding recovery and future improved functioning for all young service users.

The case scenario of William illustrates the emergence of personality difficulties following the remission of acute psychotic symptoms.



WILLIAM

## CASE SCENARIO

**William** is 19 years old and has lived with his mother since his parents separated when he was 12 years old. William completed year 12 two years ago, and commenced studying law at university last year. However, he had to defer in second semester due to deterioration in his mental health. He stopped going out, wasn't sleeping well and was refusing to eat.

After hearing William talking to himself about someone watching him at night and telling him to hurt himself, his mother calls the local hospital. They advise her to bring William in for an assessment at their clinic.

On assessment, William is admitted to the inpatient unit after he tells the assessing team that he has bought a knife in case he needs to kill himself before his mother does.

He also reveals that he has experienced auditory hallucinations and visual hallucinations since he was 12, but they have become much more frequent in the last year. He hears derogatory voices ('you're fat, ugly, hopeless') and has visions of blood running down walls and a shadowy male figure in his room at night. He says that both signify that he is meant to kill himself. He also reports long-standing feelings of emptiness and intense fear that his mother will die in a car accident. He also thinks that people hate him and want to see him dead. He says the evidence for this is that people give him dirty looks on public transport and out in public.

William says that lately he has begun to think that his mother wants him to die as well and may be poisoning his food, which is why he had stopped eating the food she made. He has always worried that she does not want him, and feared that she would leave him like his father did.

William is treated on 2 mg risperidone and after 7 days in the inpatient unit he is discharged to the care of the community team and his mother. He has regular outpatient appointments with his case manager and his psychiatrist.

Over 6 weeks his intense psychotic symptoms resolve to the extent that he is only occasionally hearing vague mumblings, has no visual hallucinations and no longer thinks that his mother wants him dead. However, he continues to feel empty, to keep close tabs on his mother, and to ruminate about her potential death by accident.

As the treating team get to know William during his recovery from psychosis it becomes apparent that William has a history of very chaotic relationships since his early teens, and has developed strong feelings of attraction and dependency on multiple sexual partners, both male and female. He is confused about his sexual orientation and thinks he is probably bisexual. While most relationships start well, his poor anger control and tendency to rage in response to minor disagreements usually evolves into mutual physical abuse and abandonment by the partner. William says he is often disappointed when his extreme emotional reactions do not elicit care and concern from those around him.

# Early intervention in psychosis with co-occurring BPD

# Early intervention in psychosis with co-occurring BPD

## Overview

Although the principles of early intervention for BPD do not differ greatly from those for early psychosis, the added complexity of a young person having BPD features needs to be considered by services and clinicians when assessing, engaging and treating these young people in an early psychosis service. Despite these added complexities, however, it is important for clinicians to understand that they *can* manage people with co-occurring BPD. It requires the same skills as for treating psychosis, but with additional considerations.

This section compares early intervention models of care for BPD and psychosis and presents service-level considerations for treating young people with co-occurring BPD and psychosis. In addition, it discusses issues relating to assessment, engagement and components of treatment for co-occurring BPD.

## Early intervention models for psychosis and BPD

### Differences in care

The two models of early intervention for psychosis and BPD in young people are very similar, especially in the underlying principles that guide the range of interventions provided. Both models emphasise easy access to services and early detection, a low threshold for skilled assessment, family work and family peer support, youth participation and youth peer support, home-based assessment and care, crisis support, access to youth-friendly inpatient care, a functional recovery program, a multidisciplinary team approach and direct clinical supervision. There are, however, a number of key differences between the two models of care, presented here.

#### Period of care and follow up

The early intervention model for psychosis provides treatment consistently and continuously for a minimum of 2 years, with an additional 3 years available for young people who have poor initial recovery. Treatment in early intervention services for BPD, by contrast, is usually episodic. Within a 2-year timeframe, it involves discrete episodes of care lasting 6–9 months, with 6 months of follow up offered and the opportunity to return for further episodes of care should the young person need them. Intervention consists of assertive case management, general psychiatric care, structured, time-limited psychotherapy, family work and psychosocial interventions.[36]

### Informed refusal of treatment

Whereas for young people with early psychosis it is not appropriate or recommended that they can easily opt out of psychosis treatment without a well-orchestrated alternative treatment plan, young people with BPD are encouraged to take responsibility for and make informed decisions about their treatment, including 'informed refusal' of treatment.

In the early intervention model for BPD, it is acknowledged that for many young people the features of BPD can make it hard for them to access and utilise treatments. Therefore, assertive efforts are made early on to engage young people and give them a positive experience of treatment. This allows for the concept of 'informed refusal', where a young person's decision to not accept therapy at a particular time can be respected, and young people who don't attend a service for BPD care despite concerted attempts at engagement can be discharged.

### Assertive follow-up

The phase-based approach to early psychosis intervention requires young people to be closely monitored and assertively followed up, especially during acute phases of illness. While this approach is likely to be quite appropriate in the early stages of treatment for BPD, especially in young people, most effective treatments for BPD aim to increasingly give the individual responsibility for their own participation in treatment.[37]

An assertive approach is not generally used for people with BPD unless the risk of suicide or harm to others is high. If this approach is thought appropriate for a young person with BPD, however, it should be done in a collaborative manner that explicitly focuses on increasingly handing over responsibility to the young person themselves. See also 'Managing chronic risk' on page 46.

## Merging the two early intervention models

The challenge when working with young people with co-occurring psychosis and BPD is merging the two approaches. Ideally, the process of comprehensive assessment, case formulation and treatment planning, with associated psychoeducation about both conditions, will lead to a situation in which a treatment contract appropriate to each young person's needs will be negotiated. This is likely to involve ongoing case management and symptom monitoring and a focus on functional recovery, which may include a negotiated, time-limited course of structured psychological therapy to address a young person's issues related specifically to BPD.

It is important to note that during the acute phase of an episode of psychosis, assessment and treatment of symptoms of psychosis take priority. There are several reasons for this. Firstly, it is necessary to assess the associated risks and manage the young person's safety. Secondly, the principle of timely intervention for early psychosis prioritises the need to reduce DUP. Thirdly, when someone is experiencing an acute episode of psychosis, it is impossible to be clear about which BPD traits will remain after state issues are treated.

As BPD can also require early intervention, the task of a clinician when treating both disorders is to prioritise what is needed at a particular point in time. It may well be that treatment of psychotic symptoms is required initially; however, personality difficulties may interfere with a young person's ability to engage with the service, so these may need to be addressed to enable early psychosis treatment to proceed. This is described in more detail in the section 'Managing clinical challenges' on page 39.

The early intervention model for psychosis specifies that cognitive–behavioural case management is provided to young people by their case manager (see Box 1). This is a close match to the approach recommended for early intervention in BPD. Recent evidence indicates that high quality, structured, generalist psychiatric treatments are effective in the treatment of BPD.[11,38] Thus, the early intervention approaches developed for early psychosis and BPD are very similar and compatible, both emphasising a formulation-driven approach to clinical work that emphasises functional gains to enable young people to achieve the life they would like to live (see also Box 4 on page 33).

**BOX 1 COGNITIVE–BEHAVIOURAL CASE MANAGEMENT**

Cognitive–behavioural case management provides cognitive–behavioural treatment within a therapeutic case management framework. The case manager is the central clinician who engages with the young person, and they remain involved throughout the young person's time with the service. They provide both service coordination and psychological therapy for early psychosis, as described in other manuals in this series. The dominant theoretical paradigm that underlies the psychological therapy is the cognitive–behavioural model.

Cognitive–behavioural case management has the twin components of case management and formulation-driven CBT, which are delivered in an integrated manner by the case manager.

The balance of the two activities varies according to the specific needs of the young person and the phase of psychosis – some young people have many case management needs, while others are more ready to engage in targeted and intensive CBT interventions.

## Service considerations

Given the complexity of working with this group of young people, services should have structures in place to support clinicians to manage these issues effectively. These structures acknowledge the issues clinicians can face both practically and emotionally when working with young people with co-occurring psychosis and BPD. A multidisciplinary team approach, frequent and regular supervision and access to specialist consultation are key service elements.

Working with co-occurring BPD and early psychosis requires a sophisticated understanding of both early intervention models and how they can be combined. All clinicians therefore, need to be able to consult with senior colleagues who have experience with young people with co-occurring BPD. In addition, the use of treatment and crisis management plans, team-based decision-making, 'clinically indicated risk-taking', and access to a risk review panel provides support for clinicians in the management of short-term risk and longer-term treatment planning (see also 'Service protocols for managing risk', on page 47).

In addition to support structures, a service culture that is accepting of young people with co-occurring conditions is crucial. The attitudes and experiences of clinicians may be stigmatising of young people with BPD;[40] consequently, the stigma associated with working with personality disorder needs to be openly acknowledged and addressed. Early psychosis service leaders should be open to working with people with personality disorders and see all co-occurring conditions as relevant to early psychosis treatment. In addition, they need to model appropriate attitudes and provide mentoring and training to support clinicians to work with young people with co-occurring BPD.

With this in mind, clinicians should be supported to develop skills in understanding the nature of personality disorders and personality pathology and managing the complexity and challenges associated with young people with co-occurring BPD in early psychosis. This includes recognition that there is now overwhelming evidence that psychotic symptoms experienced by people with BPD are real, distressing and warrant treatment and that recovery from personality disorders is achievable.[32]

# Assessment and engagement in co-occurring BPD

## Assessment of BPD

### Why diagnose BPD?

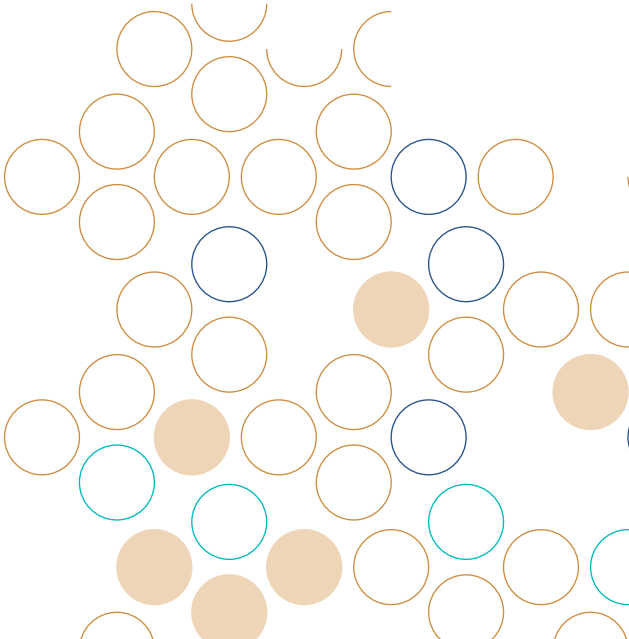
Clinicians can be reluctant to diagnose BPD in young people and in people with psychosis in particular. This means diagnosis is often delayed. However, early detection and a formal diagnosis are important for a number of reasons. Clinically, a delayed diagnosis leads to functional impairment and iatrogenic complications becoming entrenched, which limits the effectiveness of treatment, particularly regarding functional outcomes.[32] Another reason to formally diagnose BPD is to prevent misdiagnosis and inappropriate treatments. For example, if a young person is misdiagnosed with bipolar disorder II, rather than BPD, this might result in treatment with mood stabilisers, which have little efficacy in BPD, and are associated with considerable side effects.

From a service perspective, formally diagnosing BPD increases the recognition of personality disorders in general, and BPD in particular, among clinicians in an early psychosis service, which can help to combat the stigma and pessimism regarding personality disorders. In addition, a formal diagnosis is required to ensure eligibility for specialised services, meaning that specific treatment can be offered at an early stage.

A formal diagnosis can also help young people to understand and come to terms with their difficulties. Often people are relieved to get a diagnostic label that tells them that their condition or problems are understandable and treatable. Consequently, when diagnosing a young person with BPD, it is essential that this is accompanied by realistic and hopeful messages about prognosis. They can then be informed of the treatment options available to them and empowered to make their own choices.

Having a diagnosis also helps young people to connect with other people with the same condition and therefore feel more optimistic about their prognosis. A frequent concern of clinicians relates to young people with BPD developing mutually destructive relationships with other young people with BPD. However, the positive aspects of social support, particularly with peers with similar difficulties should not be undervalued. Such concern is usually not expressed about young people with psychotic symptoms, where peer support is promoted.

> ‘To be told that I had a diagnosis of BPD was nice, because I finally had a name to what I was feeling and I could research it, and it was good to know that I wasn’t the only one with it.’
>
> Young person,
> EPPIC, Orygen Youth Health Clinical Program



## Screening and assessment for BPD

Assessment of personality disorders can take some time, and is a task that requires skill and experience. The use of a simple screening procedure can assist by identifying people who are likely to be experiencing personality disorder features. This reduces the number of young people who need to receive the full diagnostic assessment for personality disorder.

There are a number of tools, such as the SCID-II PQ[40] (see Box 2), that can be used to screen for BPD. A positive screen for BPD (e.g. a SCID-II PQ screen score of 13 or more out of 15), indicates the need for further diagnostic assessment for BPD.

A comprehensive assessment allows for identification of the primary personality disorder and co-occurring disorders, estimates the severity of impairment, and engages the young person in treatment by providing the information needed for the development of a collaborative formulation that directs treatment.

For young people with co-occurring psychosis and BPD, an assessment should include careful assessment of psychotic symptoms to confirm that the young person meets the criteria for entry to the early psychosis service and ensure that psychotic symptoms are considered prominently in treatment planning. In relation to risk, it is especially important to consider the prominence and meaning given by the young person to positive psychotic symptoms. The omnipotence and believability of voices to the young person, especially command hallucinations, and paranoid ideation, need to be assessed and evaluated in relation to suicidality and risk to others. Once this has been completed, the assessment for BPD features can inform the formulation and treatment planning process.

In the assessment of personality disorders it is essential to distinguish 'mental state' disorders from 'trait' disorders, where the difficulties are due to pathological personality traits.[5]

### BOX 2 THE SCID-II PQ[40]

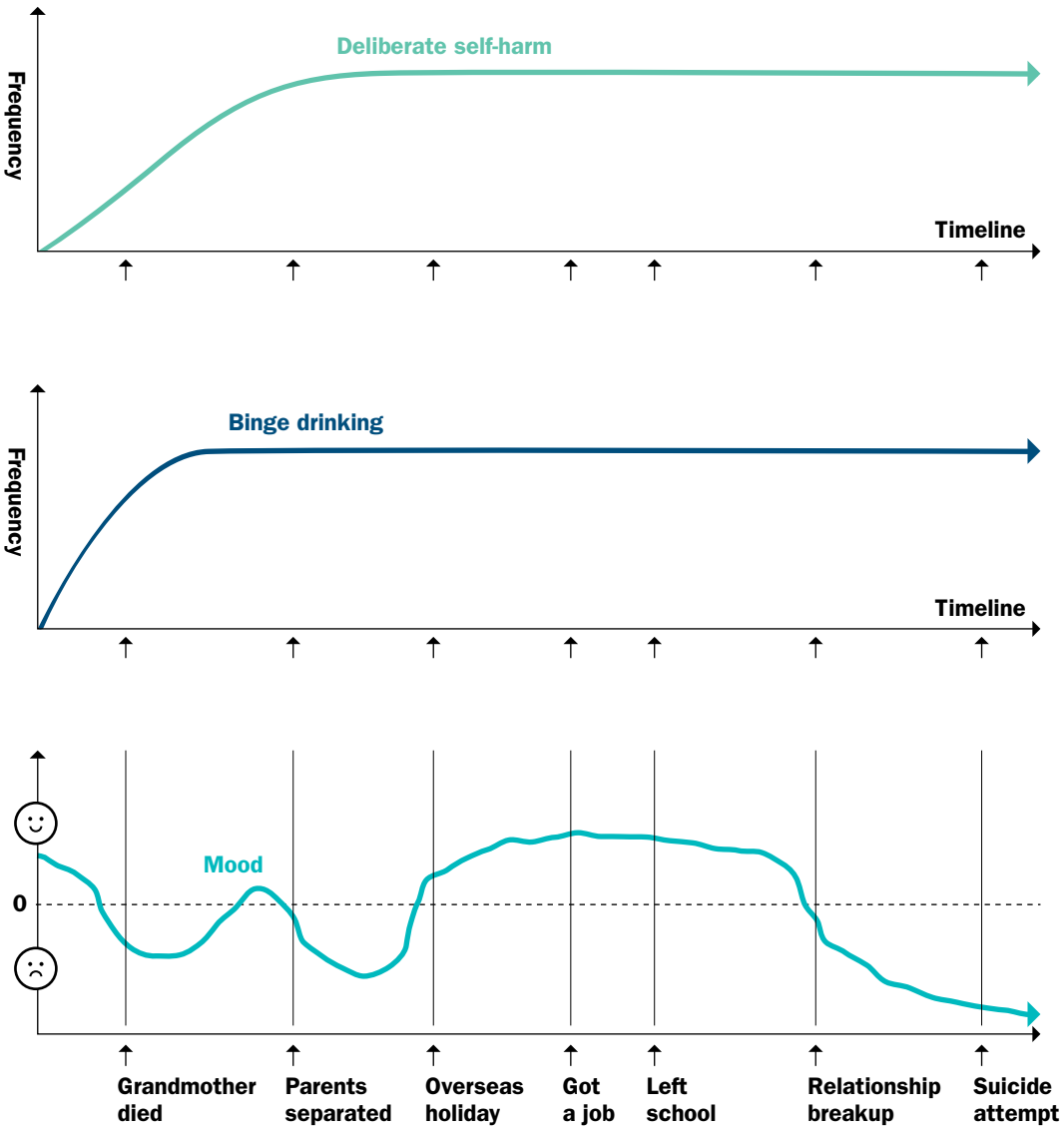
The BPD section of the SCID-II PQ instrument comprises 15 items, which are self-rated as true/false, and are based on the nine DSM-IV diagnostic criteria for BPD (some criteria have more than 1 item). The number of items rated as 'true' are summed. Depending on resources, the cut-off score can be set for further diagnostic assessment, such that sensitivity and specificity are balanced. At OYHCP, a screening study indicated that a score ≥ 13 indicated the likely presence of full-threshold BPD (5 or more BPD criteria), while a score of 11 or more indicated sub-threshold BPD as well (3 or more features).[41]

It is important to note that screening provides categorical data (i.e. information about behaviours or phenomena experienced at some point in the lifetime), and does not provide any information about intensity, severity or duration of these phenomena. Therefore, it does not distinguish between state-related phenomena and trait-related phenomena, and does not replace a thorough diagnostic assessment, which is necessary for a valid diagnosis of BPD.

To differentiate between state- and trait-based disorders, mental state disorders are diagnosed first. An efficient way to then determine trait-based disorders is to map these traits on a timeline alongside episodes of the mental state disorder (see Figure 1). This will help clinicians obtain a good history of any severe mental state symptoms, such as psychotic, manic, or severe depressive symptoms, at the same time. This is then followed by careful examination of the BPD features.
The major distinction is that state-related features (e.g. loss of appetite) will occur during episodes of major depression or psychosis, but not outside these episodes. In order to be considered trait-related, it would be expected that recurrent patterns of the phenomena would be observable or reportable outside the mental state episodes.

Clearly, pathological personality traits may be exacerbated by periodic mental state disorders, but in order to diagnose a personality disorder the traits must be present, at least to some degree, outside of these periods.

FIGURE 1. **A 'TRAIT' VS. 'STATE' TIMELINE**




A timeline can be used to differentiate between 'state'- and 'trait'-based disorders. In the example shown, binge drinking and self-harm can be considered trait-based, as they show a consistent frequency, outside of mental state episodes and life events.

## Diagnosis

To diagnose BPD in young people, the personality feature must have been consistently present over the previous 2 years at least, and there must be evidence of the problem outside of periods of mental state disorder.[36]

This 2-year period differs from the DSM-5 definition, which states that only a 12-month history is required for people under 18 years.[5] However, although it is conceivable that a young person might have state-related symptoms (such as depression or psychosis) for 12 months, such a time frame does not seem long enough to identify state-related phenomena that appear to be traits. Although the DSM does not say how long a history is required for people over 18 years, it is assumed to be a number of years (and other personality disorder assessment tools use 5 years). With the time periods varying so much, it is recommended that a more conservative and pragmatic approach is taken, and a mean time of 2 years is used for people between 15 and 25 years old.[36]

BPD is diagnosed using the DSM when an individual meets the threshold for at least five of the nine diagnostic criteria for BPD (see Appendix 1). These criteria cover the patterns of interpersonal relationships, self-image, impulsivity and affect over a period of time, usually commencing in early adulthood.[5]

In young people, however, it is useful to assess for the presence of any one of the BPD criteria, as research has shown poorer long term outcomes for individuals who have only one BPD criterion.[42] BPD features can also interfere with engagement and management of individuals. Early intervention services for BPD provide treatment to young people with sub-threshold BPD (less than five BPD criteria). This targeted indicated prevention approach is similar to service provision for young people identified as UHR for psychosis based on the staging model of psychosis.[43]

### Differential diagnosis

Most people do not fit neatly into the DSM-5 personality disorder diagnostic categories, and as such, personality disorder not otherwise specified (PD-NOS) is the most commonly diagnosed, rather than any one type of personality disorder.[44] Consequently, it is necessary to become familiar with the range of personality disorder, not just BPD, so that diagnoses can be made and appropriate interventions can be targeted to the personality difficulties.

There are a number of personality disorders that have features that clinicians may be challenged by, which might be incorrectly identified as BPD. For example, narcissistic personality disorder (NPD) features include grandiosity, need for admiration, a sense of entitlement, interpersonal exploitation, lack of empathy, and arrogant, haughty behaviours or attitudes. Individuals with antisocial personality disorder (ASPD) features may present as deceitful, lacking in remorse, and show disregard for, and may violate of the rights of others.

The careful and thorough diagnosis of personality disorder is important, so that BPD is not underdiagnosed, but also not overdiagnosed. Overdiagnosis can occur when clinicians rely on their ‘gut-feeling’, which is frequently related to feelings of irritation and frustration with a young person who repeatedly presents with challenging behaviours.[45]

'I was referred a young woman for treatment in our early intervention for BPD program. She had been difficult for the acute team to engage, only agreeing to talk to certain clinicians, "firing" others, refusing consent for contact with her family, referring to suicidal plans and deliberate self-harm, but refusing to discuss details to enable a thorough risk assessment.

'After an initial period of engagement, which allowed a more thorough diagnostic assessment to occur, it emerged that her primary personality disorder traits were narcissistic. Though she had some BPD traits, she was sub-threshold for full diagnosis and was formally diagnosed with mixed personality disorder. Her self-harm and suicidality, whilst assumed to be "proof" of BPD, was, in fact, confined to depressive episodes and so was state- rather than trait-driven. It reminded me of the importance of a thorough diagnostic assessment, and of not relying on your "gut" feeling.'

Senior clinician,
HYPE clinic, Orygen Youth Health Clinical Program

'I was really scared when I first went to EPPIC, and I missed a lot of appointments because I didn't like all the questions. Then my case manager came to see me at home a few times… and just sort of hung out with me. It was really good to see that she cared about me, and she explained why she had been asking so many questions, which was to work out how to help me get better.'

Young person,
EPPIC, Orygen Youth Health Clinical Program

SHARNI

## CASE SCENARIO

**Sharni** is a 21-year-old woman who demonstrates a range of personality disorder features across various personality disorders. She is bright and did well at school, but became unwell in her first year of university, when she began treatment within an early psychosis service for symptoms of paranoia and delusion.

Sharni's psychotic symptoms have settled; however, her case manager can now see more clearly that there are some longstanding personality issues that need to be worked on. He has begun to talk to Sharni about going back to her studies, suggesting she build up slowly to going back full time. However, Sharni is such a perfectionist that she cannot bear to consider not taking on a full time load. She is 'prickly' in sessions with her case manager and she discounts most of his suggestions, saying they wouldn't work or she has tried them already.

She seems to behave like this with her peers as well. Consequently, she has never really had close friends. She feels different from others, and appears to think she is better than them, yet somehow feels left out at the same time, and is therefore quite competitive.

Sharni has also developed a lot of rules about studying, and how she arranges things in her bedroom. She views others as disorganised 'morons', but she also struggles with longstanding anxiety – particularly social anxiety – and tends to avoid social situations. She says that it isn't that she can't interact with others, it is just that her usual way is to avoid any social interaction unless she can't get out of it.

Sharni demonstrates a range of narcissistic, obsessive–compulsive, and avoidant personality features.

## Engagement

There are number of challenges to engaging and treating young people with severe mental illness, including psychosis and BPD, that result from the developmental stage and features of the disorders. Most young people will have had little experience of attending health services, so they may not understand what is expected from them. In addition, the stigma about mental illness may reduce young people's willingness to attend services. Providing psychoeducation that is realistic and hopeful and using language that is clear and easily understood can help overcome these issues. In addition, clinicians should be open and honest as much as possible, avoid being judgmental by showing empathy and tolerance, whilst still showing concern for the person's safety. It is also helpful to prepare young people for questions about potentially distressing topics, such as letting the young person know that they will be asked some personal questions before asking about sexual matters. These issues are important when working with all young people in an early psychosis service.

Young people are also still developing their executive and regulatory skills, which means they may have difficulties with self-expression and discussing emotions and thoughts. This can be even harder for young people with BPD features who present with unstable emotions and identity disturbance.

Young people may also be late for, or miss appointments. In this situation, it is helpful to establish whether this is due to avoidance, immature organisational skills, or their symptoms. At times of crisis, for example during the acute phase of psychosis, personality features (e.g. unstable affect, inappropriate anger, risky impulsive behaviour, poor planning, self-harm and suicide threats, interpersonal/relational difficulties) can become more pronounced.

‘It was really sad that Amy’s parents did not seem to be able to help her get to appointments. She really wanted them to come with her and to show more understanding of the difficulties she was facing, but we couldn’t get them to come. In the end I had to arrange to see Amy each week at school as she couldn’t get to appointments. She really appreciated that I made the effort and saw her every week, despite the times when she could hardly talk because she was so upset. Thankfully she got better over time.’

Clinician,
EPPIC, Orygen Youth Health Clinical Program

Keep in mind that young people have varying levels of control over their life and may feel coerced into attending services by parents, guardians, teachers or other professionals. Conversely, sometimes families may be opposed to the young person’s attending a mental health service and may therefore not be supportive.

Clinicians should speak directly to the young person to gain an understanding of their situation, and treat young people as responsible and capable of making decisions.

It is important to recognise that maintaining a good working therapeutic relationship can require considerable effort on the part of the clinician, and this can be more challenging in BPD, where the very nature of the disorder involves interpersonal problems. Strong emotions and behaviour, such as anger, hostility, irregular attendance and disengagement, can all challenge clinicians.

PRACTICE TIP

Engagement can be enhanced by clarifying what the young person wants and balancing this with what you think is helpful. Try to find something you both agree that you can help the young person with.

Supervision and consultation with senior colleagues about a breakdown or tensions in the working relationship can assist with making difficult clinical decisions regarding management and resolution. Chronic and acute self-harm can also be particularly challenging for clinicians to manage, and may require flexible approaches and clinically-indicated risk-taking, where short-term risk to the young person is accepted in order to prevent long-term negative consequences. This will require consensus from senior management, a unified team approach, risk assessment and pre-negotiated responses where possible. These will be documented in a crisis plan (see ‘Service protocols for managing risk’ on page 47).

Strategies for managing the complexity and challenges related to working with young people with a BPD diagnosis, such as chronic suicidality and self-harm and hostile or threatening behaviour, are discussed in more detail in the section ‘Responding to clinical challenges in BPD and early psychosis’, on page 37.

## Interventions for co-occurring BPD in early psychosis

The following are key recommendations for working with young people with the dual problems of borderline personality disorder and early psychosis. These recommendations have been developed from over 20 years of clinical experience within the EPPIC program at Orygen Youth Health Clinical Program in Melbourne, and experience with many young people with this comorbidity. Simultaneously, an early intervention program for BPD has been established at Orygen (the Helping Young People Early, [HYPE] program),[36] and expertise developed in working with young people with BPD has been shared with EPPIC to assist with adapting the early intervention for psychosis model to treat the complex comorbid presentation of early psychosis plus BPD.

### Team-based approach

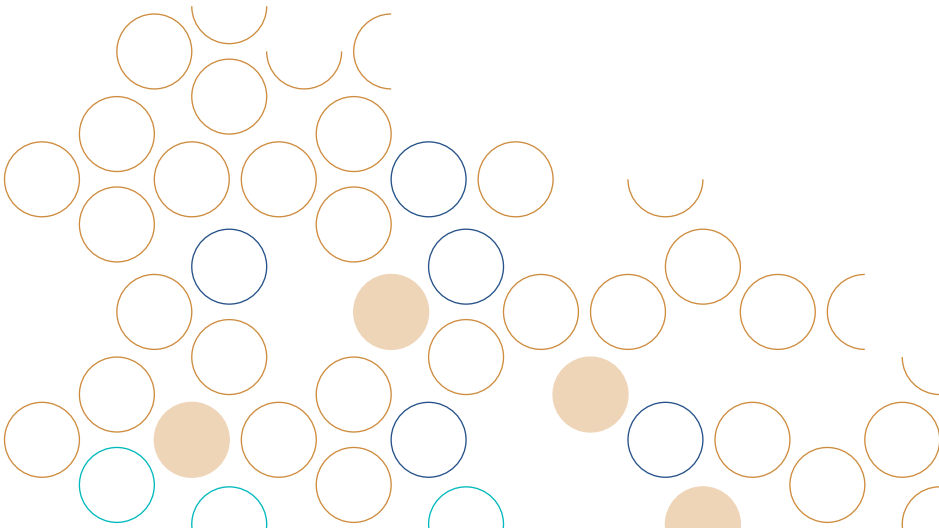
A team-based approach to treatment is especially important in complex cases, such as young people with co-occurring BPD and psychosis. The clinical team should consider the information derived from the comprehensive assessment to develop a case formulation in collaboration with the young person, followed by a treatment plan. The treatment plan sets out the short- and medium-term goals for treatment and lists any clear expectations of the young person and the treating team that have been negotiated.

The treatment plan may include a specific component about crisis management, or there may be a separate crisis plan. The crisis plan or safety plan lists coping strategies for the young person to use at times of high distress and/or elevated risk, and may include warning signs or triggers to be aware of, and the young person's preferred responses from significant others and service providers.

Regular review of the treatment and crisis plan is particularly important when managing more challenging and risky behaviour in young people, as service systems can inadvertently make things worse and contribute to the development of serious maladaptive patterns of engagement and help-seeking in this group.

Another advantage of a team-based approach to managing complex and often high-risk young people is that it provides a structure for regular support for clinicians. The team structure ensures that appropriate supervision is available and utilised, and facilitates regular clinical review meetings so that risk and responsibility for young people can be shared by the team.

> 'I find clinical review meetings really helpful, because they allow me to present my young person in a comprehensive way and to get suggestions from the multidisciplinary team on how to handle current challenges.'
>
> Clinician,
> EPPIC, Orygen Youth Health Clinical Program



## A phase-based approach to treatment

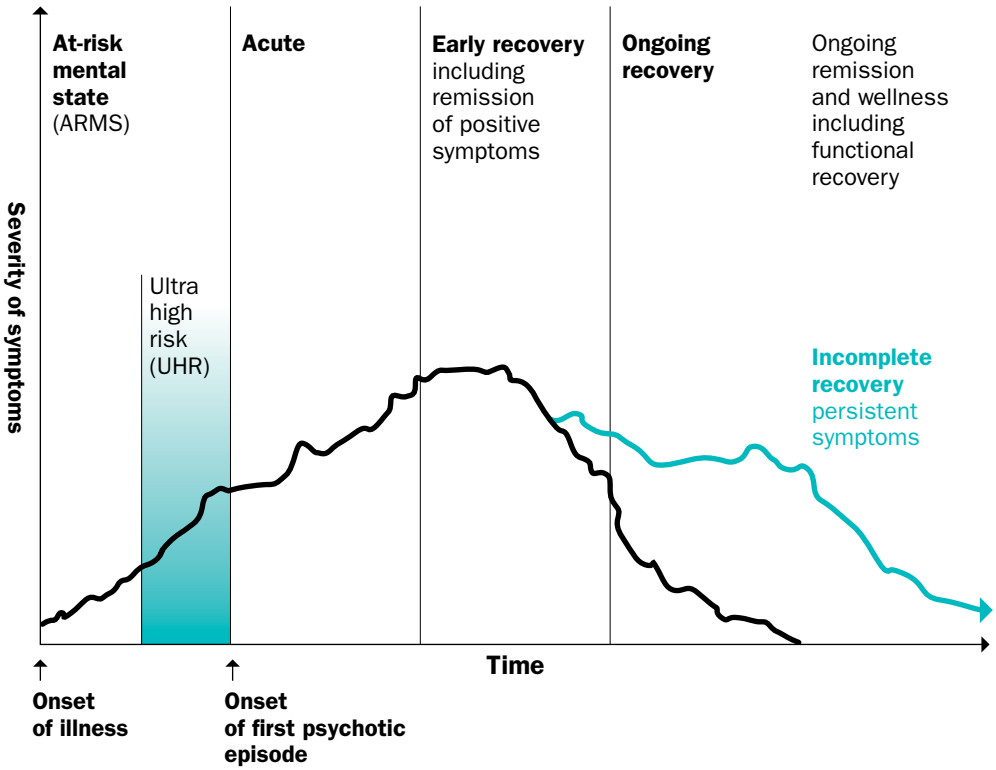
A phase-based approach to treatment is core to early psychosis work (see Figure 2). Young people within an early psychosis service will have already met the threshold criteria for UHR or first episode psychosis. Decisions to focus treatment on personality features will therefore be based on a young person's case formulation and phase of psychosis.

In the **UHR** phase, treatment goals are developed through collaborative case formulation and goal-setting aimed at reducing distress and risk of transition to psychosis (see ENSP manual *A stitch in time: interventions for young people at ultra high risk of psychosis*). Where BPD features are present, these are likely to be identified as targets for treatment by the young person or others. Applying the stress–vulnerability model of onset of psychosis would support targeting BPD features to reduce risk of transition to psychosis.

During the **acute** phase of an episode of psychosis, psychotic symptoms must be the priority for treatment, and young people with co-occurring BPD should be treated no differently than those without. BPD features may need to be addressed if it interferes with the provision of adequate treatment for acute psychosis.

During **recovery** phases, BPD and other comorbidities may become treatment priorities against a background of comprehensive case management for early psychosis.

FIGURE 2. **THE PHASES MODEL OF PSYCHOSIS**



## Components of treatment for co-occurring BPD in early psychosis

### Case formulation and treatment planning

As with all early psychosis treatment, comprehensive assessment comes first and leads to the development of the case formulation which in turn leads to the treatment plan. For comorbid cases, the case formulation will encompass both psychosis and personality disorder issues and is used to generate treatment goals (listed on the treatment plan), which are best phrased in terms of functional outcomes. For many people with BPD, their goals for treatment involve managing their emotions, finding purpose in life, and building better relationships.

A study of recovery in BPD found that people's goals were to feel better about themselves, have a purpose in life, manage emotions and minimise distressing symptoms.[46] Such goals are likely to be relevant to all young people recovering from serious mental illness, including people with co-occurring BPD and early psychosis. The important thing is that the formulation and treatment plan is collaboratively developed with the young person and thus contains meaningful goals.

### Case management

Case management for early psychosis has evolved over many years at the EPPIC service and is described in detail in a handbook.[47] Australian clinical guidelines for the general management of both BPD and early psychosis both advocate good clinical care and early intervention with young people, which form essential guidelines for case management.[1,48] Common tasks identified by both sets of guidelines are to:

- confirm diagnoses
- provide psychoeducation
- assist the young person to engage with the service
- develop a treatment plan based on comprehensive and ongoing biopsychosocial assessment
- provide assertive follow-up when required
- convey hope and optimism about recovery
- assess and manage risk
- involve families and significant others
- manage crises
- plan for discharge and manage it appropriately.

When co-occurring BPD has been identified, additional focus is required to:

- gain trust and manage emotions
- set boundaries
- manage transitions and endings.

The vulnerabilities and interpersonal sensitivities that people with BPD bring to treatment, often due to a history of stigma and rejection in response to their difficult behaviour, mean that clinicians usually need to work hard to develop trust and respect within the case management relationship. This process is assisted by clinicians being consistent, reliable and respectful and always maintaining empathy and a caring attitude. It is important to remain calm, even in a time of crisis, to communicate clearly and to take seriously the young person's description of their experience. The young person needs to feel that they are being listened to, are receiving empathic responses and are not being judged.

> 'An example of how my case manager helped me is one time when I stopped taking my medication for a few days and started to get voices and paranoia. I told my case manager what was happening, and she contacted me every day for five days, and saw me twice, just to make sure I was OK and back taking my medication. She was really just there for me.'
>
> Young person,
> EPPIC, Orygen Youth Health Clinical Program

The nature of BPD means that young people with these features are likely to be very sensitive to feeling rejected or abandoned. Boundaries, transitions and endings are best managed with open and constant communication, giving plenty of notice of any changes or specific service parameters, and minimising or at least assisting the young person to manage changes in their care (e.g. a change of case manager) whenever possible.

While all of the above are components of best clinical practice generally, it is important to recognise that when working with individuals with BPD, it is easy to feel 'pulled off-course' and to leave out aspects of the normal approach to good clinical care. This can be because of the constant crises and high acute and chronic risk, or threats and hostility, strong emotions and avoidance or disengagement. The team-based approach is helpful in countering any diversion from the usual treatment approach.

**PRACTICE TIP**

Don't get 'pulled off course' from providing good clinical care. Remember to make the most of the whole treating team, including supervision, clinical reviews and just general support.

## Psychoeducation

The provision of psychoeducation is a central and crucial task of case management for early psychosis and underpins the collaboration required between the young person and the treating team as they work towards recovery. To collaborate in their own care, young people need to fully understand the nature of the disorder they are recovering from, its treatment options, the associated risks, and the possible prognosis or outcomes.

Principles and topics of psychoeducation for early psychosis are described in detail in the ENSP manual *A shared understanding: psychoeducation in early psychosis.* Additional psychoeducation that addresses the specific co-occurring condition of BPD in young people with psychosis is presented here.

Psychoeducation for co-occurring BPD in early psychosis aims to assist the young person to gain a thorough understanding of the additional diagnosis of borderline personality disorder and all that this implies. See Appendix 2 for a factsheet to use with young people to help explain what BPD is.

Although it can be difficult to make clear distinctions, it is important that young people with both psychosis and BPD understand both diagnoses and which symptoms and treatments are associated with each condition. They are likely to come across these diagnostic labels in different places and times in their lives and need to feel empowered to deal with any stigma and misinformation that arises. At the same time, it is helpful for young people to understand that there are limits to current levels of scientific knowledge about mental illnesses and that diagnostic systems and labels are not perfect. This is an important rationale for each young person's treatment being individually tailored based on the comprehensive and collaboratively derived case formulation, and this should be explained to each young person.

Some topics of psychoeducation for young people with BPD and their families are shown in Box 3.

### Delivering psychoeducation

Clinicians often worry about how they will talk about the BPD in helpful ways. This can be discussed with peers, in supervision and with colleagues, with helpful phrases being developed and adopted across teams.

Some helpful points are:

- Psychoeducation should be tailored to each young person.
- Material that is given to the young person, family members, workers and others should use consistent language and simple terms.
- Discussion and questions should be encouraged, and this needs to be an evolving and dynamic conversation that is revisited over time, as a young person progresses through treatment, and their understanding and what is relevant for them changes.

### Addressing stigma

Young people and their families should be warned that there are a variety of different points of view about BPD on the internet and in other media, much of which tends to be negative. It is important to let them know that most of what has been developed is aimed at a smaller group of adults who have had BPD for many years. The larger group of young people with BPD include many who will not go on to have enduring and complex BPD for decades. It is hoped that early intervention can help these young people onto a healthier developmental trajectory, thus reducing the severity or functional disability for them down the track.

## BOX 3 TOPICS FOR PSYCHOEDUCATION REGARDING BPD

### Causes

There appear to be a range of pathways leading to development of BPD, including genetic vulnerability, experiences (many people with BPD have experienced hardship and sometimes trauma and abuse) and the interpretation of these for the individual (some people seem to be able to recover from trauma or adversity without significant difficulty, while for others these experiences are difficult to recover from and go on affecting them for long periods of time, shaping how they see the world and themselves and others in it).

### Blame: it is no one's 'fault'

This is not the same as saying that people perhaps didn't hurt others, or abuse them, or that traumatic things didn't happen, because of course they did for some. It is important not to trivialise or dismiss the traumatic and harmful things that have happened to people with BPD. The message is more about intentions. On the whole, parents don't intend to cause their children harm. They even sometimes do bad or unhelpful things for good reasons (e.g. trying to help). There are also some people who do intend harm and often when we are talking about people who abuse children we need to acknowledge that this was wrong, but that doesn't mean everyone can't be trusted. The challenge is to learn who to trust.

The message needs to be that everyone can improve, that parents and family members can learn better ways to communicate and care for each other and that most are doing the best they can. Taking a blaming stance usually stops us from learning better coping or communication skills.

### Optimistic attitude towards prognosis

BPD is something that can be treated and the outcomes vary. Some people continue to have problems for longer and some respond more quickly – we can't tell what an individual's response will be but the focus of treatment is on coping and learning better ways of living.

### Treatment

Treatment for BPD in early psychosis is individually tailored and based on the young person's goals. It will focus on reducing distressing symptoms, increasing purpose, improving the young person's functioning in life, and reducing risks. The BPD component of treatment is usually psychosocial rather than medical and comprises skilled and consistent case management and psychological therapy. Sometimes medications and inpatient treatment are used for specifically defined problems.

NAZRA

## CASE SCENARIO

Nazra has been attending an early psychosis service for a few months, and now that her symptoms of psychosis have begun to subside, her treating team has begun to consider her features of BPD. Her case manager raises the topic of BPD in their next session.

**Case manager:** So Nazra, you've been coming to the service for a few months now and we've been treating your psychosis, which we have discussed as being called a 'first episode of psychosis'.

**Nazra:** Yeah.

**CM:** It's great that those symptoms have been getting much better. We've been discussing lately that you seem to have some other issues that have been around for a long time, and seem to be a bit of a pattern for you. I'm wondering if you'd like to discuss how we understand these long-standing problems and the diagnostic label that is used to describe them?

**Nazra:** Yeah, I've worried for a long time that I don't seem to be normal in the way I get on with other people and how I feel about myself. And I get so emotional all the time. Like, it was good to find out there's a name for my problems with hearing voices and feeling paranoid, so if there's is a thing about my other problems, I'd like to know.

**CM:** Okay, that's good. So if we think about your situation, am I right in thinking that the main longstanding issues that have worried you are problems with your relationships with other people, and having difficulty with emotions?

**Nazra:** Yeah, plus feeling like I don't have a personality, I don't really know who I am or who I want to be.

**CM:** This factsheet is about borderline personality disorder, or BPD, in young people, and I think this is very relevant for you. As you can see, the problems that happen with BPD are things you've described – unstable emotions, relationship problems and problems with sense of self. Personality disorder is a term used to describe longstanding patterns of behaviour that are unhelpful for the person and which prevent them from getting on well with their life – ways of coping that don't seem to work and yet persist despite this. From what you've told me about your experiences, I think they fall under this category of borderline personality disorder. Have you heard of this before? What is your reaction to hearing this?

**Nazra:** Well, someone I met in the waiting room said that they had BPD, but I didn't know what that meant. Now I can check it out, and it's a relief to hear that it's not just that I'm weird or bad. It's good to hear that there are other people like me, with the same types of problems. So how do you think you can help me?

**CM:** Well, it might be helpful for us to keep discussing this as we work together, so that you get the most appropriate treatment for your issues. I can give you some websites with helpful information that we can talk through too, which will help you understand better what we mean by BPD and how to best assist you.

## Structured psychological therapy

There is sound, although limited, evidence that structured psychological therapy can be effective in treating BPD.[48] However, when psychological therapy is offered for BPD, it must be a therapy specifically adapted or developed for BPD and delivered by therapists with adequate training and supervision. In addition, any specialised psychotherapy for BPD will need to be specifically adapted for young people. In reality, only a small number of people with BPD will actually access a specialised psychotherapy for BPD. There are many reasons for this, including that specialist programs and training is expensive and many of the treatments are quite long and intensive.

Eleven different varieties of structured psychological therapy have data supporting their effectiveness for people with BPD, including CBT, which is the therapy usually recommended for psychosis. There is limited evidence to support the choice of one specialised therapy for BPD over another, as all of them seem to produce similar outcomes.[48] This is despite these treatments being based on very different theoretical orientations (e.g. psychodynamic, behavioural and cognitive models).

It has also become apparent from recent work that 'structured high-quality' care performs almost as well as specialised therapies for BPD.[37,38] It therefore appears that structures that support clinicians to deliver high-quality treatment are likely to be more important than the delivery of any particular brand of psychotherapy.

There is very little evidence to guide whether specialised therapy should be used in young people with co-occurring BPD in early psychosis. There has only been one small pilot randomised controlled trial (RCT) testing the use of a BPD intervention in addition to standard treatment for FEP. This pilot study found the treatment appeared to be acceptable and safe and showed an encouraging pattern of improvement in outcome measures.[49]

Emerging evidence has suggested that the range of specialised treatments available currently for BPD do not sufficiently target functional recovery goals, and that poor functioning often remains long after symptomatic recovery has been achieved. These sorts of goals can be a focus of case management without the need for a specialised psychotherapy (see Box 4).

### BOX 4 NOTE ON FUNCTIONAL RECOVERY GOALS FOR YOUNG PEOPLE WITH BPD

Obtaining the best possible level of functioning is an appropriate goal for young people with co-occurring BPD and early psychosis.

Young people with early psychosis are usually assumed to have been functioning well prior to the onset of the episode of psychosis, after which they experience a decline in functioning. Therefore, the aim for functional recovery is to assist the young person to return to their premorbid level of functioning.

However, the presence of longstanding personality dysfunction may mean that the person has never achieved a good level of psychosocial functioning. Therefore, a more appropriate goal for young people with BPD might be to achieve a higher or more appropriate level of functioning than has previously been reached.

'When a young person has BPD as well as early psychosis, their psychosocial functioning can be really poor – they have few friends and there seems to often be problems in the family. They have often dropped out of school very early and have not found a job or a direction to head in. They are often leading a chaotic life, with unstable housing and financial problems too.'

Senior clinician,
EPPIC, Orygen Youth Health Clinical Program

## Pharmacotherapy

It is now generally accepted that medications are not helpful for the treatment of BPD, *per se,* and so are not recommended. However, a range of medications may be prescribed for treatment of co-occurring conditions, such as psychosis or mood disorders.[48] Low-dose second generation antipsychotic medication is recommended in treatment guidelines for early psychosis and will be part of the treatment regimen where psychosis is prominent (refer to the ENSP manual *Medical management in early psychosis: a guide for medical practitioners*).

It is important to recognise that providing access to potentially lethal medications can be dangerous, especially for those with co-occurring BPD and a history of taking overdoses. Suggestions for limiting the risks associated with medication use by young people at risk of overdosing should be discussed by the treating team and with the young person and their family. Initially it can be helpful to limit the supply of medications (e.g. weekly dispensing) and enlist assistance from family members or significant others to keep the young person safe. This can be set up as a routine practice 'until we get to know each other better', with an explicit plan to increasingly hand over responsibility to the young person for managing their own medication as their mental state settles. This practice can also be reinstated if necessary during times of crisis.

Care should also be taken to avoid polypharmacy in young people with co-occurring BPD. There is a risk that young people will be prescribed antipsychotic medication to treat BPD features, or to alleviate distress, despite there being no clear indication for this. Furthermore, once the symptoms prove unresponsive, they may be prescribed additional medication, leading to polypharmacy and the risk of side effects.

It is essential to establish an open and collaborative relationship with the young person, their family and significant others about the use of medication and the way it is prescribed. For example, being explicit about the needs of the clinicians (to prescribe safely) and the needs of the young person (to demonstrate they are trustworthy, or to take charge of their own care) is important in developing a shared understanding of the issue.

PRACTICE TIP

Responsible self-management by the young person of medications and other aspects of health should be the aim of treatment in the longer term. This aim should be explicitly discussed when possible with any young person who is not able to demonstrate this capacity initially.

## Family involvement

As with all early psychosis work, it is important to include families or other supports of young people with co-occurring BPD in all aspects of their care. Many young people are still living with their family when they enter treatment for early psychosis, and most have some form of contact with family. Families are crucial collaborators in the provision of recovery-focused care, and they also have their own needs, including understanding the mental health problems that their young person is facing and dealing with stigma resulting from their young person's condition. Families therefore need to be provided with accurate and complete psychoeducation about all of the mental health conditions that their young person has been diagnosed with, and the treatments recommended for each of them. Questions are likely to be asked about the cause of mental illness, and it is important to recognise that families can be very sensitive to feeling blamed for their young person's illness. Accurate and honest information and discussion should help the family to accept that they are not to blame, that there are many factors implicated as causal in mental illnesses and that ultimately the complete explanation remains a mystery.

Families of young people with co-occurring BPD and early psychosis face additional challenges. The complex nature of co-occurring BPD in early psychosis means that the family may have experienced extremely stressful events and need education and support to collaborate effectively with the treatment team in supporting the recovery of their young person. The following are some particular areas that families may need support in coping with.

### Understanding diagnosis

Families will vary in their reaction to the diagnoses that they learn from the treating team. Some will be more concerned about the psychosis diagnosis, while others may feel alarmed by the BPD diagnosis, as it is less familiar. Frequently, families have not heard of BPD, and this can be either reassuring (it's not that bad if it is not well publicised) or threatening (it must mean that something worse will develop).

It is important to take time to understand families' perceptions of the diagnosis, their principal concerns about it and what they see as its implications. This will also involve assessing the impact of stigma on families' reactions and redressing any negative expectations of outcomes for these conditions that they may have.

> 'I had such mixed feelings when I heard that Jessica had BPD as well as first episode psychosis. I was relieved that there was a name and an explanation for all the problems we've been having for so long, but I also thought, how are we going to cope with this as well?'
>
> Family member,
> EPPIC, Orygen Youth Health Clinical Program

### Addressing stigma

It is important to inform families that both BPD and psychosis have had negative images in the past, in terms of dangerousness, recovery potential and causality. Families need to know that there continues to be false information and bad examples portrayed in the media and on the internet, and that they need to take care that the information they obtain is appropriate. Particularly for BPD, care needs to be taken to access accurate information as the condition has only recently been recognised as a serious, valid and treatable condition that occurs in young people.

### Managing risky behaviour

Families may need or request special help with managing risky or bad behaviour in the young person. It can be helpful to encourage families to openly discuss risk of suicide and deliberate self-harm and the reasons that might underlie such behaviours. If families can be helped to see that such behaviour is the young person's attempt to cope with difficult emotions, they may be able to assist the young person to develop other ways of coping.

It may be beneficial for the family to validate and name the young person's emotional reactions, and to disclose their own, as a way of generating discussions about feelings and coping. However, mental health conditions cannot be an excuse for bad behaviour; families need to be supported to set and adhere to reasonable limits for behaviour within their family including by their young person receiving treatment for mental illness. Effective, respectful and non-critical communication within the family is an appropriate focus for family intervention in this group.

### Discussing recovery

Families often feel confused by clinicians' messages about recovery from BPD. They are often hoping it will be straightforward, like it is with physical illness. It is appropriate that clinicians are optimistic, but they must also be measured about their expectations for the young person's recovery. Some people may recover rapidly, while others might take many years. Furthermore, what constitutes 'recovery' can be different for each individual. Exploring what the family members are hoping for in the young person's recovery is therefore important.

Clinicians need to spend some time explaining these issues and the complexities of treatment and recovery with families. They will also need to return to them over time.

### Supporting the family

The difficulties experienced by young people with co-occurring BPD in early psychosis have often have a long history, and this can have impacted on family relationships and stamina. There can have been years of struggle with many difficulties, which has resulted in families responding in extreme ways. Families need to be supported and can be encouraged to reconsider what a reasonable response to extreme behaviour might be, and to change unhelpful patterns that have developed over time.

Where difficult family relationships are part of the clinical picture, there will usually be a need for a dedicated and experienced family worker to be involved, consistent with the EPPIC approach. As some parents have experienced their own difficulties, whether specialist family intervention is available or not, aiming to help families feel reassured enough to respond in 'reasonable' or 'sensible' ways, or to learn how to do this if they have not been able to do this well in the past, is extremely important.

See the ENSP manual *In this together: family work in early psychosis* for more about working with families in early psychosis.

'[A diagnosis of BPD] helped me to understand why Jess had behaved the way she did. It was a relief to know it was a mental illness. I still worried I had caused it, but talking to the clinicians did also help me to feel better and not so alone in dealing with it all.'

Family member,
EPPIC, Orygen Youth Health Clinical Program

# Responding to clinical challenges in BPD and early psychosis

# Responding to clinical challenge in BPD and early psychosis

## Introduction

This section aims to help clinicians recognise the difficulties of BPD that can affect the way in which young people engage with care and the ways that clinicians offer care. It focuses on understanding better what these challenges are in order to develop appropriate strategies for responding to them, with the goal being that the young person's care is not compromised, and that the care provided can assist the young person to effectively manage his or her difficulties. It includes a section on managing acute risk of deliberate self-harm and chronic risk of deliberate self-harm and suicide. See also the ENSP manual *What to do? A guide to crisis intervention and risk management in early psychosis.*

## How features of BPD affect the therapeutic relationship

Care provided by clinicians often assumes that young people can engage effectively in treatment and the relationships of which it is comprised. This assumption may not always be accurate in people with BPD.

In general, the core characteristics of personality disorder can make it difficult for people with personality disorder to seek out, accept, and use care appropriately. The functional inflexibility of personality disorder is typified by the tendency to rigidly apply the same behavioural responses to diverse situations; care and treatment therefore often require developing a capacity to respond differently and more appropriately to the vagaries of life experience. Self-defeating behaviour patterns can restrict the capacity of the person with personality disorder in their attempts to learn from past mistakes or experience and to respond in ways that do not worsen the situation. Unstable functioning in the face of stress, and the instability of mood, thinking and behaviour this represents, can impair the young person's motivation to seek out care and engage consistently with it.

Features of personality disorder specific to BPD can also influence how easily people with BPD engage effectively with care, and how easy it may be for clinicians to care for this group. The emotional world of people with BPD can be sufficiently tumultuous that chaos rather than order is the rule, which can make the practicalities of attending scheduled appointments far more challenging. Relationship instability and desperate fears of abandonment can also influence young people's capacity to engage in and reflect upon the therapeutic relationship.

As such, some of the difficulties core to BPD pose problems for young people in accessing care at all, and in receiving consistent, effective care. For example, young people who have experienced adversity and trauma are likely to find it difficult to engage in treatment and trust that it will be free from abuse. They may also have had limited exposure to attempts to label and understand emotions and thoughts.

Key relational challenges for people with BPD, such as frantic efforts to avoid abandonment and relationship instability, can make it difficult for a young person and therapist to collaborate for change. Other features of BPD, such as inappropriate outbursts of anger, can play out in the relationship between clinicians and young people. Problematic behaviour, such as risky impulsivity and deliberate self-harm, can also work against treatment by making matters worse for the young person and for creating an anxiety in clinicians that can leave them feeling paralysed.

It should be borne in mind that features of other personality disorders, which can co-occur with BPD, may also interfere with the provision and receipt of effective care, including, for example, the aggression of antisocial personality disorder, the avoidance of avoidant personality disorder, or the contempt of narcissistic personality disorder.

These difficulties can make clinical work more difficult and stressful, both for clinicians and young people. While some clinicians enjoy this work and developing their skills further, others can feel increasingly hopeless, helpless, and incompetent in their attempts to help. It is likely that this mirrors similar experiences of the young person in the face of their significant distress, and can lead both services and young people to doubt the utility of treatment for BPD and to disengage from care, either by being reluctant to provide services (on the part of clinicians) or to treatment dropout (on the part of young people).

By gaining a better understanding of what might be underlying the difficulties for the person with BPD, clinicians are likely to be able to take a helpful stance with the young person. It is important to take the time to understand what young people want their lives to look like, and then to help them to set realistic goals to work towards. This will also help clinicians in formulating strategies together with the young person to respond to his or her difficulties. This is in turn is likely to result in clinicians who feel positively skilled and more effective in the management and treatment of BPD.

As with all mental illnesses, young people may be aware of the stigma that can surround having a psychiatric problem and receiving help for it. This may be particularly pronounced for those with BPD who may have experienced more stigma from others for their BPD than their psychotic symptoms; this BPD-focused stigma can, regrettably, be present in mental health professionals.

**PRACTICE TIP**

Allowing yourself to feel victimised, exploited or deliberately targeted by a young person is unlikely to help you assist them; trying to recognise that the young person is doing their best with what resources and skills they have can help you to instead take a more compassionate view in the face of difficulties or intense interactions.

## Managing clinical challenges

When young people with BPD engage in behaviours that are perceived as problematic by clinicians, it is unlikely they are doing so to be difficult, manipulative, or hard to treat. Rather, they are responding to difficult experiences in the best way they know how, usually with strategies that have historically worked for them, at least in some way. However, the failure to learn from experience that is endemic to personality disorder then influences the extent to which the young person can recognise that these strategies are ultimately unhelpful and so revise them.

For example, negative emotional experience can be so overwhelming for people with BPD that any alternative might appear more attractive. While this makes sense in the short term, the strategies used to alleviate difficult emotions may themselves cause problems by confirming how unbearable these experiences are and the necessity to avoid them. They may also create their own considerable problems (e.g. a secondary substance use disorder that becomes severe). It is therefore important that clinicians and young people understand that what is now a ‘problem’ was previously a solution to what was perhaps an even more desperate problem. This can create understanding and compassion on the part of both the young person and clinician.

The following is a guide for clinicians to help young people consider alternative behaviours that allow them to respond more effectively to difficult experiences.

## Identify the 'problem'

An early step in treatment is to identify as 'problems' behaviours that influence a young person's capacity to engage with care, including, for example, late or poor attendance, constant discussions relating to risk, irritability or hostility. This should be done collaboratively, taking into account the young person's goals for treatment (see Box 5). While clinicians may regard these behaviours as problems, young people may not until the implications for their capacity to engage with treatment and work towards their goals are identified.

### BOX 5 COLLABORATION AND GOALS FOR TREATMENT

Collaboration is the foundation on which an understanding of the young person's difficulties and working towards change is based. A particularly important element of this is understanding who the young person is beyond their current difficulties and, in particular, what they want from life. This allows the development of understanding about the mixed feelings the young person may have about some of their problems, and can prompt them to reflect on further possibility of change.

Without identifying change as a goal, young people may be less inclined to collaborate, and clinicians risk being regarded as yet another adult who is telling them what to do without understanding the problem. Clear and shared therapeutic goals also provide a context within which clinicians can address and collaboratively problem-solve with young people any difficult behaviours that get in the way of planned treatment.

## Identify the goal of the behaviour

An important part of the process is to clarify what underlies these behaviours. While the assumption can usefully be that they are attempts to solve larger problems, it is important to assess individual reasons for behaviour (i.e. what it aims to do and, in particular, how it helps the young person cope) and create a shared understanding of these, while acknowledging that many reasons may underlie the same behaviour. For example, missing appointments or running late could represent avoidance of the treatment and the distressing emotions it can trigger, or it may reflect immature organisational skills or interpersonal chaos, such as homelessness. Likewise, a number of factors may underlie deliberate self-harm (see Box 6 on page 44 for more information).

A non-judging, curious stance allows clinicians to effectively assess these reasons and avoid the criticism that young people have likely experienced in the past regarding these behaviours. Maintaining a compassionate position, rather than responding punitively, will increase the likelihood of young people continuing to seek care.

An example of exploring reasons for particular behaviours in this way might include questions such as:

- 'It's likely that smashing things has in the past worked for you, otherwise you wouldn't do it – thinking about the situation in which it occurred, how do you think it might have worked for you?'
- 'What do you think you wanted to be different?'
- 'What were you hoping for, for yourself or for others, in the moment that you smashed the TV?'

In young people with both BPD and psychosis, it is also important to establish the extent to which some of their behaviours are driven by symptoms of psychosis. For example, suicidality or deliberate self-harm may be a response to unbearable feelings of shame or rejection, or to auditory hallucinations or persecutory delusions. This formulation of the drivers of behaviours is likely to influence the treatment provided (see 'Assessment and engagement in co-occurring BPD' on page 20).

MARIA

**CASE SCENARIO**

**Maria** is a 20-year-old female who was transferred to an inpatient unit after being medically cleared by a general hospital, after she overdosed on 75 aspirin and severely slashed her wrist. Although she has always excelled at school, she has never established any meaningful friendships and describes herself as empty, without a personality, and always alone.

Assessment reveals that Maria has been self-harming on an almost daily basis since she was 13, when she first noticed wild fluctuations in her moods across most days, and found that she felt calm when cutting herself. She says that she gets very excited when planning things and can be very happy, but reacts with extreme anger if she feels slighted or let down by people, and feels sad and lonely the majority of the time. She has been arrested three times for physically assaulting people and she is currently completing a community based order following a conviction for assault.

Since 15, Maria has been drinking heavily and she has been using methamphetamine since 16. She has been trading sex for drugs and money, has been raped once, and beaten up several times in this context. She describes auditory hallucinations of a female voice saying that she is bad and ugly and does not deserve to be successful, also since aged 13, but with periods of up to 6 months when they did not occur; however, they have been continuously experienced for the last 2 years.

'Yes I've harmed myself. I did it for a number of reasons. To relieve the tension of extreme emotion. I might have been suicidal, and that was the only way I could really cope, especially when I was alone. I also did it to punish myself.'

Young person,
HYPE Clinic,
Orygen Youth Health Clinical Program

## Clarify whether the behaviour achieves the goal

A subsequent step is to clarify the extent to which the behaviour meets the desired goal, i.e., how well the behaviour designed to solve a larger problem actually solves it or, alternatively, cements it further or makes it worse. These steps can allow further exploration of whether other attempts to solve the problem have been effective or ineffective and, if the latter, why. Cost–benefit analysis or motivational interviewing can sometimes help to model understanding of these behaviours, allowing exploration of reasons for it without condoning it, and of the extent to which the behaviour has pros and cons, including in meeting the underlying goal.[50,51]

## Discuss alternative ways to meet the goal of the behaviour

Identifying (a) what the problematic behaviour is, (b) what needs are met by it, and (c) how it gets in the way of meeting those needs (or in fact reinforces the problem) can create an opportunity to discuss alternative ways of meeting the stated needs that do not impact on the young person's achieving what they want from their life. There may be many strategies that can achieve the one need or goal. An example of alternative strategies for deliberate self-harm, arrived at through this method, is shown in Table 2.

TABLE 2. **IDENTIFYING ALTERNATIVE STRATEGIES TO DELIBERATE SELF-HARM**

| The needs attempted to be met by the problem | Does the problem actually meet the needs? | Alternatives to the problem to meet the needs |
|---|---|---|
| To punish myself | Punishing myself gets in the way of leading the life I want to live | Consider how to adopt a more compassionate approach towards myself |
| To have control over my body when it feels others are always controlling me | I feel separate, but others become more controlling when I self-harm | Brainstorm other ways of feeling autonomous from others (e.g. communicating with them my need to be autonomous) |
| To manage overwhelming feelings | I feel relief from feelings in the short-term but it confirms my inability to cope with feelings and makes me feel more helpless and hopeless | Brainstorm other ways of managing overwhelming feelings (e.g. understanding what triggers them and allowing them to pass, using other strategies) |

The crucial part of this process is to be collaborative with the young person in exploring the problem. Stepping in with strategies without understanding the function of previous behaviour such as deliberate self-harm or avoidance is likely to be perceived as controlling and rejecting.

It is also vital to have reasonable expectations of the young person's capacity to try out alternative ways of coping – this does, however, require a level of tolerance of uncertainty and motivation that can be difficult to sustain. A young person's previous patterns of managing difficulty are often well known and entrenched, and there are likely to be a number of missteps along the way to change. Clinicians need to be very mindful of this process as well.

## Supporting clinicians in offering care for young people with BPD

As clinicians, we are affected by the interactions we have with the young people we are treating. Some clinicians may find some of the difficulties associated with BPD particularly challenging to work with, and different people will find different difficulties challenging and will react in different ways when feeling challenged. For example, some clinicians are especially distressed by self-harming behaviour (although almost all find it challenging), while others find the direct expression of aggression (such as yelling, kicking chairs or other actions) most difficult to deal with. Others will find implied aggression (threats, contempt and dismissiveness) most difficult. Clinicians therefore need to be mindful of what they may find most difficult, to ensure that they react appropriately in those situations.

Alongside using a compassionate approach as a foundation for work with young people, having self-awareness regarding what behaviours or patterns might be particularly triggering for clinicians is vital. This awareness allows appropriate self-care via personal and professional support mechanisms (e.g. supervision) and ensures that reactions to situations that are difficult are reflective rather than reactive – guided by good clinical care, rather than emotional responses.

If a clinician is finding a young person's chronic risk and ongoing self-harm difficult to work with, this issue should be discussed within supervision, clinical review, and with others who may be involved with treatment (doctor, case-manager, others involved – family worker or group program clinicians, inpatient staff or after hours crisis staff). The discussion has the goals of allowing the clinician to gain support in his or her role, ensuring the care of the young person is shared, and supporting the team to operate in a coordinated way. It should cover the formulation, the interplay between psychosis and personality disorder and what is driving the self-harm, strategic risk management and collaborative strategies to reduce deliberate self-harm.

It is also helpful if clinicians are comfortable with the range of interpersonal challenges that can arise

in the therapeutic relationship. This means that it is incumbent on each clinical service organisation to provide appropriate support, consultation and professional development opportunities to enable staff to develop skills to manage interpersonal challenges, so they can function well and continue to develop in their work roles.

# Assessing and managing risk

## Assessing risk

Young people with BPD often present increased risk to themselves, due to the deliberate self-harm and/or suicidal behaviour that are core features of BPD. They may also present with elevated risk to others, either secondary to BPD or, more commonly, to other personality disorders such as antisocial personality disorder.

General principles of risk and crisis assessment and management in psychiatric care apply to young people with BPD as they do with any other disorder. People with BPD may be chronically at risk; unfortunately, this chronicity, together with frequency that young people may report risk, can sometimes lead clinicians to fail to fully and thoroughly assess risk, and therefore to underestimate it.[52]

The assessment of risk in young people can be particularly complex given intention may shift more rapidly and knowledge of lethality may be poorer, leading to higher rates of accidental injury. Each presentation must be assessed in its own right, and deliberate self-harm and suicidal behaviour and ideation should always be taken seriously and assessed thoroughly. As in any disorder, the assessment phase usefully identifies acuity or chronicity of risk, patterns of risk and triggers to any change in risk. As clinicians get to know a particular young person, the growing understanding of that person and the function of self-harm or risks can then inform assessments of risk. Importantly, this assessment phase should include the development of a shared understanding of risk-related activity; this then informs treatment goals and specific crisis and risk management plans.

Assessing risk and working towards change with young people who are poorly engaged and do not disclose information about risk, either unprompted or invited, can be challenging. Collateral information should be collected where possible, for example from the young person's friends or family, and at times this might be all that can be relied on. It is important to acknowledge the possibility of a high acute risk 'worst case scenario'. Open communication is important, and it may be necessary to explain to young people, and their families, the rationale for a decision to deviate from usual collaborative care when risk requires it.[19]

Management of risk in young people in particular, and perhaps especially so with BPD, requires an understanding that young people with psychiatric conditions are keen to be autonomous and may resent any challenge to this. Stepping in too early (e.g. with psychotropic drugs or inpatient admission) in the face of risk can be as problematic as intervening too late, as it can prevent young people from developing their own skills in managing crises and reduce their belief that they may be able to manage without these measures.

However, this needs to be balanced with the fact that, for a range of reasons, young people with BPD may at times have difficulty in exercising autonomy safely.[52]

Encouraging autonomy can also unintentionally be interpreted as invalidating or dismissing, which can itself escalate risk. A key task in discussions relating to managing risk is to be transparent with young people and their support networks about these dilemmas, and to ask them to be as involved as far as possible in decisions about how much risk is tolerable and how best to manage it; preferably both at times of crisis and outside of these.

Organisations are increasingly favouring the use of formal risk assessments, without stressing the need to work with each young person on the reasons for their self-harm or suicidal behaviour. However, regular risk assessment alone is often not sufficient to change behaviour. It is unlikely to help in the absence of a more meaningful understanding and collaborative plan with the young person to work towards a more meaningful and satisfactory life. Indeed, frequent risk assessment may get in the way of goal-directed therapy by becoming a proxy for treatment of BPD or other disorders.[53]

## Managing deliberate self-harm

Deliberate self-harm can be particularly challenging for clinicians and services to manage. It is possible that clinicians may assume that deliberate self-harm, particularly repeated, or repeated threats to engage in deliberate self-harm or suicide attempts, are ways to 'get attention' or to control and manipulate others. This may leave clinicians feeling resentful, controlled or victimised, and can lead to dismissive or punitive reactions as a result.

> 'Cutting myself is not for getting attention; it's a release. It helps with the anguish, it's a way of expressing distress.'
>
> Young person,
> EPPIC, Orygen Youth Health Clinical Program

However, as noted, these are normally goal-directed behaviours that aim to meet particular needs in a context in which the young person has not had the opportunity to learn more appropriate and effective coping strategies. Management of the risks posed by this kind of behaviour therefore needs to focus on understanding the reasons behind deliberate self-harm and other behaviours (see Box 6). For example, we all have a need to be noticed and to feel in charge of our lives. If young people are attempting to meet this need by deliberate self-harm or suicidal behaviour, while it is possible that this behaviour does initially elicit care, if repeated it can lead to frustration, criticism or rejection from care providers and secondary shame in the young person. Recognising this can be a powerful motivator for change.[50] This can also be one of the goals for treatment with a young person.

**BOX 6 POSSIBLE REASONS FOR DELIBERATE SELF-HARM[54]**

| |
|---|
| To manage feelings, particularly negative affect and/or overwhelming feelings |
| To punish oneself |
| To create exhilaration or excitement |
| To replace or avoid the urge to suicide |
| To identify oneself as separate from others or to assert one's autonomy |
| To end an episode of dissociation or derealisation |
| To seek help from, influence or control others |
| In response to command hallucinations or fixed delusions |

## Managing acute risk of deliberate self-harm

It is important to recognise that young people may not see deliberate self-harm as a problem. Therefore, an important early step in managing acute risk of deliberate self-harm is for clinicians to be clear that they are concerned for a young person's wellbeing and are aiming to reduce deliberate self-harm or suicidal behaviour, while acknowledging that this may not be a current aim of the young person, given he or she may struggle to identify other mechanisms which may meet their needs.

Psychoeducation about the risks associated with deliberate self-harm (e.g. wound infection, potential lethality of overdose) is vital, but should not coach young people in harming themselves more dangerously. Pressing for abstinence might be unrealistic, so a better strategy is likely to be to aim for gradual change that focuses on 'harm minimisation'.

It is important for clinicians to be alert to changes in chronic levels of risk, when risk becomes more acute. Changes in life circumstances and levels of psychosocial support, onset of other mental health problems, or broader unexplained changes in risk levels or lethality of deliberate self-harm or suicide attempts require assertive assessment (particularly with reference to risk history and corroboration from others where possible) and appropriate team-based and service wide clinical response.[50,55]

## Responding to crises in young people with BPD[48,56]

### During a crisis

- Respond to the crisis promptly, whether reported by the person or by a family member or carer.
- Listen to the person – use an interviewing style that validates the person's experience and shows that you believe the person's distress is real. Let the person 'vent' – this can relieve tension.
- Be supportive, non-judgemental, and show empathy and concern. Express concern if the person mentions suicidal thoughts or other risks to their safety.
- Assess the person's risk. Check if there is any change in the pattern of self-harm and suicidality that could indicate high immediate risk. Check for repeated traumatic experiences or new adverse life events.
- Assess psychiatric status and rule out co-occurring mental illness.
- Stay calm and avoid expressing shock or anger.
- Focus on the here and now.
- Take a problem-solving approach.
- Plan for the person's safety in collaboration with them. Do not assume that you know best about how to help them during a crisis. Ask the person to say if they want help and to explain what kind of help they would like. Provide practical help.
- Clearly explain your role and the roles of other staff members.
- Communicate with and involve the person's family, partner or significant others, and involve in the management plan if appropriate.
- Offer support to the person's family, partner or significant others; they may need to debrief too.
- Refer the person to other services, as appropriate, and make a follow-up appointment.
- Consider the benefits of offering brief admission to an acute psychiatric inpatient facility if the person has presented to an emergency department and is at significant immediate risk of harm, or if the person has a co-occurring mental illness (e.g. depression or substance use disorder).
- Where possible, liaise with other clinicians/ teams/hospitals involved in the person's care. These should be identified in the person's management plan and crisis plan (if available).

### After a crisis

- Follow up by discussing all safety issues, including their effect on you, within the context of scheduled appointments.
- Actively interpret the factors that might have helped provide relief (e.g. the perception of being cared for).
- Explain that it is not feasible to depend on the mental health service or GP to be available at all times. Help the person use a problem-solving approach to identify practical alternatives in a crisis.
- Help the person deal with their anger whenever it becomes apparent.

## Responding to injury

In situations in which the young person has harmed him- or herself, the initial responses need to be tailored to the seriousness of the injury.

- If the injury needs a medical response, this should be attended to first. Self-harm can sometimes be fatal and should always be taken seriously.
- Try not to appear overwhelmed by the injury, but at the same time do not ignore or shut off your own emotional response. If you do, you may be perceived as uncaring, which threatens engagement.
- Even if the person does not appear to be distressed, it may be helpful to acknowledge that they may feel very upset, 'stirred up' or dissociated.
- If you need to touch the person to treat an injury, first explain what you are doing and why.
- Ask whether there is a friend or someone they would like to have with them while receiving physical treatment.

## Managing chronic risk in BPD

Many people with BPD live with persistent thoughts of suicide or deliberate self-harm. As noted earlier, these are unlikely to shift quickly; given deliberate self-harm or suicidal behaviour often attempts to meet a particular need, it may be unlikely to reduce until alternative, less harmful strategies to meet these needs are tested.

Box 7 outlines general principles for working with chronic risk. Collaboration on the change that might be useful – including feeling more capable in the face of overwhelming emotions and trying out less harmful ways of dealing with them – is vital.

**BOX 7 PRINCIPLES FOR WORKING WITH CHRONIC RISK**

Collaborate with the young person at every opportunity.

Identify goals for a more meaningful life and reference treatment tasks to these.

Give the young person as much control as possible and avoid power struggles, while working within ethical and legal requirements.

Ensure risk is assessed without using risk assessment as a proxy for treatment.

Consult with other clinicians and senior staff about the level of risk that can be tolerated and what can usefully happen if risk is too high; discuss this also with the young person and support networks.

Adopt a clear and open communication style, including about more restrictive care when it may be indicated.


**CASE SCENARIO** (CONTINUED FROM PAGE 41)

**Maria** was referred to an early psychosis service during her admission and began attending outpatients. Initially she attended erratically and required numerous home visits. However, with persistence, understanding, and empathy for her situation, her case manager was able to build a relationship with her, and Maria began to attend most of her appointments which were available to her at the same regular time each week. She was treated with antipsychotic medication, and her auditory hallucinations reduced considerably.

Her self-harm and substance use continued, but over time Maria agreed to begin to consider other ways to address her distress and to develop goals for a future that did not include these behaviours and which she hoped would lead to greater satisfaction with her life. They agreed that managing difficult feelings and developing a life plan would be the focus of their sessions for three months and then reviewed.

Maria agreed that her case manager would check each week that her overall risk to herself had not worsened, but that the self-harm and substance use would not be the main focus of their sessions.

## Service protocols for managing risk

As with all early psychosis work, a treatment team and a larger consulting team is required to provide multidisciplinary care for young people with co-occurring BPD, and to share responsibility for the management of clinical risk. Services need to be structured so that young people can be allocated to the care of a minimum of two clinicians (case manager and doctor) who work closely together to formulate the case and provide treatment. These individual clinicians need skilled supervision and other support, such as team-based decision-making, to enable them to develop and sustain themselves in this difficult work. There also needs to be regular review and input from a larger, experienced clinical team as a quality assurance mechanism, and there should be an understanding that clinical risk is a responsibility shared by the whole service as well as the treating team.

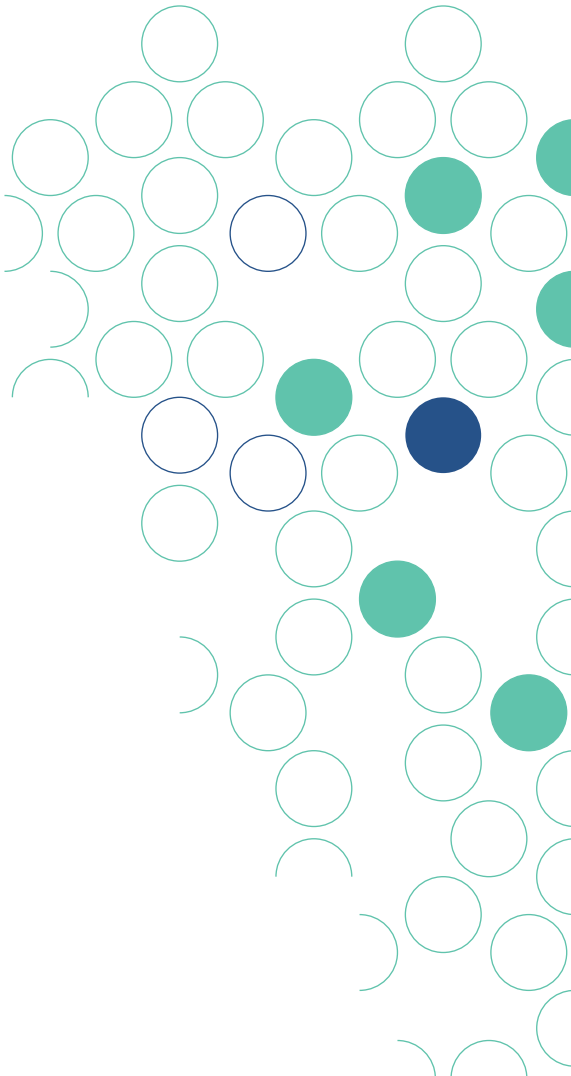
For extremely high-risk young people, a mechanism for reviewing and approving crisis plans at the most senior level of the organisation is required. The requirement for senior staff approval acknowledges that there are situations in which high risk continues despite skilled and prolonged efforts by clinicians, that this is recognised by the service, that the best possible crisis plan is in place, and that an unwanted outcome may still eventuate.

There are occasions when increasingly restrictive responses to risks appear to be making things worse. For example, frequent inpatient admission might be thought to be reducing the short-term risk of suicide, but overall it might be increasing the longer-term risk if the young person feels less confident in his/her own ability to cope with stress and living. Clinically indicated risk-taking is sometimes necessary (e.g. to discharge a young person from an inpatient unit), acknowledging that reducing risk in the medium- to long-term may require tolerating an increase in risk in the short-term. The rationale for such a plan should be well documented and should be signed off at the highest level. It should be regularly reviewed and should be conducted in an open way with as much collaboration with the young person and their social supports as possible.

The service needs to support the implementation of crisis plans across different components of the service, and at times, with other services. There may be plans that stipulate when, if, and for how long inpatient services or home-based outreach can be involved with particular young people, based on the case formulation, treatment goals and careful evaluation of the risk and benefit of previous use of these service components. It may also be necessary at times to negotiate particular protocols with emergency services regarding their response to specific young people. The service needs to provide and support clear procedures for documenting risk assessment, crisis plans, and senior staff approval of these, when necessary. For more information about service structures to respond to risk and crises in young people, please refer to the ENSP manual *What to do? A guide to crisis intervention and risk management in early psychosis.*

It is essential to involve family members and significant others in planning for and managing acute and chronic risk situations. Families, friends, and other social supports, where appropriate, should be involved in devising crisis plans and may be included as key support people in the plan.

Services also need to consider support for staff following critical incidents and have well-defined procedures for ensuring that the needs of other young people service users, families and staff are monitored and addressed following any incidents.



## Summary

Co-occurring BPD in early psychosis presents challenges to clinicians and services in how to provide appropriate care for young people with significant and often complex needs. A significant proportion of people with BPD experience psychotic symptoms and a significant proportion of people with psychotic illness also have a personality disorder, frequently BPD. This comorbidity is also seen in young people and thus it is important to adapt the EPPIC model to provide treatment for this group as all young people with early psychosis, regardless of comorbidities, are able to access treatment within the EPPIC model.

Recent research on BPD has supported early intervention for this disorder since, as with early psychosis, it has been shown to have an early onset, to be treatable, and to lead to poor functional outcomes if left untreated. Similarly, the principles and components of early intervention for BPD are essentially the same as for early psychosis and so the two approaches can be combined effectively, but with some additional considerations to cope with BPD features. These considerations have been outlined in this manual, along with suggestions to assist clinicians to deal with the acute and chronic risk that often accompanies BPD.

# Appendices

# Appendix 1: DSM-5 diagnostic criteria for BPD

**A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:**

1. Frantic efforts to avoid real or imagined abandonment. (**Note**: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Information Sheet

# Borderline personality disorder and young people

This information sheet explains what borderline personality disorder (also known as BPD) is. If you have any questions or comments after reading this, please discuss this with your case manager or doctor.

## What is borderline personality disorder?

**BPD is a term used to describe a pattern of problems that usually start in adolescence or early adulthood and affect most areas of life, causing the person significant distress over a number of years. It is possible to have many of these problems or only a few. They include:**

### Unstable emotions

People with BPD usually say that their emotions (feelings) often change suddenly. One minute they feel OK, the next they feel very sad or angry or anxious. This is often confusing for the person with BPD, and for other people. People with BPD often describe trouble controlling their temper and can feel angry very easily, resulting in fights or verbal or physical outbursts.

### Problems with identity, self-image and thinking

People with BPD often describe feeling that they don't know who they really are, or that their sense of who they are is unstable. Sometimes this is described as a disturbing feeling of being empty or 'hollow' inside. When stressed, people with BPD sometimes describe unusual experiences, such as feeling like suddenly everything is no longer real or like they are in a dream, or they might become overwhelmed by their suspicion of other people. These experiences usually go away when they are no longer stressed.

### Relationship problems

People with BPD often experience difficulties managing their relationships with others. Their relationships are often intense but stormy, with lots of break-ups and reunions. They can suddenly shift from feeling like others are 'perfect' to feeling angry, betrayed and let down. Some people with BPD describe a sense of panic when a relationship ends, or even just at the thought that it might end. This can lead them to behave in desperate ways to stop people from leaving them.

### Behaviour

People with BPD usually say they act before thinking through the consequences of their actions. This is called impulsive behaviour. As a result, they often end up doing things that they later regret, or take risks that are likely to lead to harmful consequences. Commonly, this involves spending money that they don't really have, unplanned or uncontrollable drug and alcohol use or taking risks with sexual behaviour. A common and serious form of impulsive behaviour in BPD involves repeated thoughts of suicide or repeated acts of deliberate self-harm, such as self-cutting or self-poisoning ('overdosing'). This is often done during periods of intense distress, sadness, anger or irritability. Often, people say they use these methods to manage their feelings, but like other forms of impulsive behaviour, they often regret it later.

### What causes BPD?

Scientific research tells us that personality characteristics are shaped by the interaction of the genes we are born with and the environment in which we grow up. Painful experiences, such as loss, abuse or other traumatic events, are common in BPD, but there is no single 'cause' of BPD. It is likely that a combination of factors leads to BPD and that this combination differs for each individual.

### How common is BPD?

BPD occurs in approximately 3% of young people in the community. It is more common in females than males and also more common in young people than older people.

### Isn't this just 'normal adolescence'?

While any one of the problems described above might be familiar to young people, it is the number and severity of the problems that make BPD a mental health problem. BPD improves over time. However, young people who have some or all of the features of BPD have an increased risk of serious problems that can continue into adulthood. These include persistent BPD, drug and alcohol problems, depression, relationship problems and suicide.

For further information regarding mental health and information in other languages visit:

**www.betterhealth.vic.gov.au**

**www.sane.org.au**

**www.healthdirect.gov.au**

**www.borderlinepersonalitydisorder.com**

**www.bpddemystified.com**

**www.reachout.com.au**

## What can treatment do?

Specialised mental health treatment for BPD is effective. There is now scientific research showing that early intervention for BPD is also effective. The early intervention approach to BPD aims to help young people with some or many of the features of BPD before problems become established. It is also usual for people with BPD to have other mental health, social, educational or work problems at the same time and these problems also need to be addressed.

Adapted from Orygen Youth Health Clinical Program. More factsheets can be found at **www.oyh.org.au**

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## NOTES

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