PROJECT AIR
A PERSONALITY DISORDERS STRATEGY

14th International Conference on the Treatment of Personality Disorders:

Early Intervention

Online: Friday 6 November 2020

UNIVERSITY OF WOLLONGONG AUSTRALIA

ihmri illawarra health and medical research institute

NSW GOVERNMENT Health

Dear Conference Delegates

Welcome to our 14th International Conference on the Treatment of Personality Disorders ***Early Intervention***. 2020 has presented worldwide challenges we have not seen before, but we hope there is something positive for everyone in our conference this year – a first for us in that we don't get to welcome you in person.

This workbook is designed to help you with your participation at the conference - please follow this program throughout the day using the links provided. **All timings are AEDT**.

Because people will have differences in bandwidth and connectivity, we have designed the day with a number of activities - both online and offline. Please note that, whilst it is not mandatory to have camera and microphone access to join the training, feedback from past workshops has shown that the experience has been challenging for those without those tools.

The main platforms being used are zoom for the discussions and the presentations. It is a good idea to download zoom onto your device in advance. There are also connection options for phone/audio only, and skype for business.

When you are online, please mute your microphone. If possible, turning on your camera enhances your connection to the experience. When you want to ask a question, please use the chat function.

Some simple guides to this program:

- Links to join the morning sessions are listed on page 3;
- Links to join the afternoon sessions are listed on page 5;
- If you need to leave the session you can return any time by clicking on either the morning or afternoon session included in the program;
- Some recent publications from Project Air for pre or post conference reading begin at page 11;
- Posters profiled in the Lightening Talk session can be viewed here;
- Your feedback on the conference is important to us. A link to the end of day survey is included on page 6;
- For professionals seeking CPD hours, a link to a short quiz and CPD certificate is included on page 6; and
- Post-conference, a link will be circulated to all delegates to view presentations online. The presentations will remain online for one week after the conference.

We do hope you enjoy the day and look forward to seeing you there. At any time during the conference you can email info-projectair@uow.edu.au if you have any concerns.

8.45am	Conference room opens, connections, instructions for the day Topic: Conference A.M. Time: Nov 6, 2020 08:30 AM Canberra, Melbourne, Sydney **Join from PC, Mac, Linux, iOS or Android:** **https://uow-au.zoom.us/j/85010869703?pwd=TDZkMmt3N1RiVUNNd05ITGhQZmFGdz09** Password: 094631 Join from a video conferencing system or application: sip:85010869703@zoomcrc.com Join from iPhone one-tap (AU Toll): +61731853730,,85010869703# Australia +61861193900,,85010869703# Australia Join by phone: +61 7 3185 3730 Australia +61 8 6119 3900 Australia +61 8 7150 1149 Australia +61 2 8015 6011 Australia +61 3 7018 2005 Australia Meeting ID: 850 1086 9703 International numbers available: https://uow-au.zoom.us/u/kchFNWFTl7 Join using Microsoft Skype for Business: https://uow-au.zoom.us/skype/85010869703
9.00am	**Welcome and conference opening** Hon Bronnie Taylor MP Minister for Mental Health, Minister for Women, and Minister for Regional Youth **Professor Brin Grenyer** (Illawarra Health and Medical Research Institute) Setting the scene
9.10am	**Hareem Abbasi** (Sydney, Australia) Lived experience talk: *What I have learnt in my recovery journey*
9.30am	**Professor Carla Sharp** (USA) *This is me": How adolescence constitutes a sensitive developmental period for the development of personality pathology* (Slides at page 13)
10.30am	Morning break
11am	**A/Prof Paul Cammell, Judy O'Sullivan, Dr Cathy Ludbrook, Cathy McLeod Everett, Laura Cooke-O'Connor, and Dr Dianna Bartsch** (BPDco South Australia) *"So Far, So Good? Learnings from implementing a Statewide, Integrated, Stepped-Care Personality Disorder Service, one year in"*

12.00	**Lightening talks & poster presentation** 1 **Shane Thomas**: '*Youth Axis: an overview of the service principles, model and evaluation'* 2 **Paula Dagnino**: '*Profiles of Depression: Using machine learning to grasp heterogeneity'* 3 **Abby Dunn**: '*Parenting Experience of those with Borderline Personality Disorder: shared understanding in practitioner and parent perspectives'* 4 **Amy Bell**: *'Attachment and Dependency Challenges as seen by frontline workers of NPS short term program'* 5 **Karlen Barr**: '*Living with personality disorder and seeking mental health treatment: patients and family members reflect on their treatment'* 6 **Bethany Moore**: *'An attachment Perspective on Disordered Eating in Borderline Personality Disorder'* 7 **Nicholas Day**: *'Living with Pathological Narcissism'* 8 **Mekael Barnes**: *'Emotional Dysregulation and Shame in Borderline Personality Disorder Treatment'* 9 **Emily Matthews**: *'The Experience of Borderline Personality Disorder: A Core Conflictual Relationship Theme Study'* 10 **Kayla Steele**: '*Parenting stress and competence in borderline personality disorder is associated with mental health, trauma history, attachment and reflective capacity'* 11 **Candice Nicholls**: '*Should Physical Health be implemented into the Borderline Personality Disorder Aetiology?'* 12 **Charlotte van Schie**: *'Narcissistic traits in young people: Understanding the role of parenting and maltreatment'* **Note:** The posters profiled in this segment can be viewed here.

12.30pm	Lunch break (conference resumes at 1.00pm) Topic: Conference P.M. Time: Nov 6, 2020 12:30 PM Canberra, Melbourne, Sydney **Join from PC, Mac, Linux, iOS or Android:** **https://uow-au.zoom.us/j/87372286049?pwd=bk8rUFBFcDN2dlYvZ29mWDEzelhEUT09** Password: 757989 Join from a video conferencing system or application: sip:87372286049@zoomcrc.com Join from iPhone one-tap (AU Toll): +61370182005,,87372286049# Australia +61731853730,,87372286049# Australia Join by phone: +61 3 7018 2005 Australia +61 7 3185 3730 Australia +61 8 6119 3900 Australia +61 8 7150 1149 Australia +61 2 8015 6011 Australia Meeting ID: 873 7228 6049 International numbers available: https://uow-au.zoom.us/u/koIUU5rGa Join using Microsoft Skype for Business: https://uow-au.zoom.us/skype/87372286049
1pm	**Professor Andrew Chanen** (Melbourne, Australia) *A comparison of adolescent versus young adult outpatients with first-presentation borderline personality disorder: findings from the MOBY randomised controlled trial*
1.45pm	**Dr Jen Betts** (Melbourne, Australia) *A study comparing the experiences of family and friends of young people with borderline personality disorder features with family and friends of young people with other serious illnesses and general population adults*
2.10pm	**Dr Louise McCutcheon** (Melbourne, Australia) *Relational Clinical Care: an Evidence Based Approach to Treating Young People with Severe Personality Disorder*
2.35pm	**Gary Lamph** (UK) *The need for a Stepped Care Approach in the UK*
3.00pm	Short Break
3.15pm	***Learning from Lived Experience: Peer support as an early intervention for people living with borderline personality disorder.*** A structured discussion on the opportunities, challenges, innovations and future directions between Karlen Barr and Mahlie Jewell and attendees. Hosted by Charlotte van Schie
4.00pm	**Conference Close**

End of conference survey:
https://www.surveymonkey.com/r/Conference6Nov2020

End of conference quiz and CPD certificate:
https://www.classmarker.com/online-test/start/?quiz=qhc5f966928be200

Presenters and abstracts

Hareem Abbasi, 22, is a Youth Health Consultant at Youthblock Youth Health Service and a part time student undertaking a course in community services. Hareem will discuss her lived experience with BPD and what it has been like to navigate the barriers within the health system and what she has learned from them, particularly from the perspective of a young person from Western Sydney**.**

Title: What I have learnt in my recovery journey

Professor Carla Sharp, Ph.D. is Professor and Director of Training for the Clinical Psychology doctoral program at the University of Houston, Texas USA. She is also Director of the Adolescent Diagnosis Assessment Prevention and Treatment Center and the Developmental Psychopathology Lab at UH. She holds adjunct positions at University of Texas, Baylor College of Medicine, University College London and the University of the Free State in South Africa, and is current President of the International Society for the Study of Personality Disorders. She has a longstanding interest in social cognition (mentalizing) as a cause and correlate of psychiatric disorder across the lifespan with a special focus on youth.

Carla has published over 250 peer reviewed publications, numerous chapters and books, including Social Cognition and Developmental Psychopathology (OUP), and Handbook of Borderline Personality Disorder in Children and Adolescents (Springer). A large proportion of her research uses Borderline Personality Disorder (and other personality pathology) to study where social-cognitive function goes awry. As such, she has significantly advanced scientific understanding of the phenomenology, causes and correlates of personality pathology in youth.

Title: This is me: How adolescence constitutes a sensitive developmental period for the development of personality pathology

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A/Prof Paul Cammell (Research Lead)**, Judy O'Sullivan** (Service Development Manager)**, Dr Cathy Ludbrook** (Clinical Lead)**, Cathy McLeod Everett** (Training Coordinator)**, Laura Cooke-O'Connor** (Advanced Clinician and Clinical Coordinator**), and Dr Dianna Bartsch** (Senior Research Officer): **BPD Co, South Australia**

Title: So Far, So Good? Learnings from implementing a Statewide, Integrated, Stepped-Care Personality Disorder Service, one year in

This presentation will briefly describe the history of advocacy for and design of BPD Co, and the process of implementation of its integrated, stepped model of care aimed at serving the 1.7 million people of South Australia. The discussion will involve descriptions of the design and implementation process, the clinical model, as well as the training and research frameworks for the service.

Professor Andrew Chanen is Director of Clinical Programs and Services and Head of Personality Disorder Research at Orygen in Melbourne, Australia. He is also a Professorial Fellow at the Centre for Youth Mental Health, University of Melbourne. Andrew's clinical, research and knowledge translation interests lie in prevention and early intervention for severe mental disorders, principally personality disorder, along with mood and psychotic disorders. He established and directs the Helping Young People Early (HYPE) prevention and early intervention program for severe personality disorder in young people.

Andrew currently receives grant funding from the National Health and Medical Research Council (NHMRC) and the Australian Research Council. He has over 140 scientific publications. He serves on several Editorial Boards and on a number of expert mental health groups. He is a Past President of the International Society for the Study of Personality Disorders (ISSPD) and the recipient of the 2017 Award for Distinguished Achievement in the Field of Severe Personality Disorders from the Borderline Personality Disorder Resource Centre and Personality Disorder Institute, New York.

Title: A comparison of adolescent versus young adult outpatients with first-presentation borderline personality disorder: findings from the MOBY randomised controlled trial

Background: The increasing focus on adolescent personality disorder has tended to ignore evidence of the developmental continuity of the period from puberty to young adulthood. The aims of this study are to: (1) describe the characteristics of a sample of young people with borderline personality disorder (BPD) who had no previous history of evidence-based treatment for the disorder; and (2) compare the characteristics of adolescents (15-17 years) and young adults (18-25 years).
Method: 139 care-seeking young people with BPD, newly enrolled in a randomised controlled trial (ACTRN12610000100099), completed a semi-structured interview and self-report measures assessing demographic, clinical, and functional characteristics. Adolescents (n=64) and young adults (n=75) were compared on these same variables using t-tests and chi-square tests.
Results: The entire sample of young people with BPD had a mean of 2.6 and 2.4 concurrent mental state and personality disorder diagnoses, respectively. Almost all (99.3%) participants had a history of self-harm and over a third (40.2%) were disengaged from vocational pursuits. The young adults had significantly greater difficulties in the areas of emotion regulation, substance use, vocational achievement/engagement, and antisocial personality disorder. The adolescents endorsed greater engagement with self-harm behaviours.
Discussion: Adolescents and young adults with early stage BPD both presented with severe problems, with more similarities than differences. This challenges the distinction between the two age groups and supports the concept of developmental continuity in personality disorders from puberty to the mid-20s.

Dr Jennifer Betts, BA(Hons), D.Psych(Clinical), is a Senior Research Fellow who coordinates Personality Disorder (HYPE) Research at Orygen and the Centre for Youth Mental Health, The University of Melbourne. She conducts innovative research in the field of early intervention for borderline personality disorder (BPD), specialising in the implementation of clinical trials evaluating psychosocial and pharmacological interventions for young people with BPD features and their family and friends. Jennifer has successfully coordinated four clinical trials to fruition in Australia and the United Kingdom, and is currently a coordinator of/investigator on four trials in Australia and The Netherlands.

Title: A study comparing the experiences of family and friends of young people with borderline personality disorder features with family and friends of young people with other serious illnesses and general population adults

Background: Family and friends ('carers') of adults with borderline personality disorder (BPD) and carers of young people (YP) with other serious illnesses experience significant adversity but research on the experiences of caring for a YP with BPD features is sparse. This study aimed to: (i) describe the experiences of carers of YP with BPD features; (ii) compare them with published data assessing carers of YP with other serious illnesses and with adults from the general population.
Method: Eighty-two carers (M age = 44.74, SD = 12.86) of 54 outpatient YP (M age = 18.76, SD = 3.02) who met 3 to 9 DSM-IV BPD criteria completed self-report measures on distress, experiences of caregiving, coping, and expressed emotion. Independent-samples t-tests were employed to compare scores with those reported by convenience comparison groups of general population adults or carers of YP with eating disorders, cancer, or psychosis.
Results: Carers of YP with BPD features reported significantly elevated levels of distress, negative caregiving experiences, and expressed emotion, as well as maladaptive coping strategies, compared with general population adults or carers of YP with other serious illnesses.
Discussion: Carers of YP with BPD features experience elevated levels of adversity compared with their peers in the general adult population. This adversity is similar to, or greater than, that reported by carers of YP with other severe illnesses. Research is needed to clarify factors underlying adverse caregiving experiences and to develop and evaluate interventions to support carers of YP with BPD features.

Dr Louise McCutcheon is a clinical psychologist and joint founder of the award-winning, evidence-based Helping Young People Early (HYPE) program, an early intervention program for borderline personality disorder in young people at Orygen. She coordinated the HYPE clinical program for 12 years and has been an investigator on many of the research projects conducted in the program, including a number of RCTs funded by NHMRC. She co-developed the psychologically informed approach for working with BPD called Relational Clinical Care and has been teaching this approach to mental health clinicians since 2003. In her current role as coordinator of the Orygen Clinical training service, she overseas training provided across the Victorian youth mental health sector. Her particular area of interest is in working with mental health services across Australia and internationally to develop evidence-based early intervention programs for young people with BPD. She developed the HYPE service development program and established the first Cognitive Analytic Therapy (CAT) training program in Australasia in 2003. She is a qualified cognitive analytic therapist, supervisor and trainer and oversees the current CAT training programs in Australia. She is the current chair of the International CAT Association (ICATA) and was the founding chair of ANZACAT.

Title: Relational Clinical Care: an Evidence Based Approach to Treating Young People with Severe Personality Disorder

Background: Early detection and intervention are now an accepted part of good practice guidelines for BPD, including those in Australia (NHMRC, 2013). The evidence in adults and particularly in young people indicates that simple, structured approaches can have almost as good outcomes as the specialist therapies developed for BPD (Chanen et al, 2008). Despite this, many clinicians who do not work in specialist Personality Disorder teams or have specialist psychotherapy training, do not feel confident to work with young people with BPD. As a result, many young people with PD features are denied access to care.
Method: This presentation will describe an evidence-based model, Relational Clinical Care, designed specifically for young people presenting with sub-syndromal and full threshold BPD and associated problems.
Results: This model, developed in the Helping Young People Early (HYPE) program in Melbourne, uses psychologically informed clinical case management and psychiatric care to deliver time-limited, practical interventions that can improve outcomes for young people.
Discussion: This relational approach emphasizes collaboration and the development of a joint formulation with the young person that guides goal setting, risk-management, family work and psychiatric care, assisting clinicians and services to avoid unhelpful responses to challenges that can lead to iatrogenic harm. The approach is easy to teach, and training has been delivered across a variety of settings, including primary care, such as headspace, as well as in tertiary mental health.

Gary Lamph is a Senior Research Fellow at the University of Central Lancashire; Registered Mental Health Nurse; BABCP accredited Cognitive Behavioural Psychotherapist. He won the UK National Nursing Times Award in Mental Health in 2011 for leading on the development of a 'Multi-Agency Personality Disorder Strategy' and complete a National Institute of Health Research funded Clinical Doctoral Research Fellowship 'Enhancing Understanding of the Experience of People with Common Mental Health Disorders and Co-morbid Personality Disorder Traits who Present to Primary Care IAPT Services' in 2017. He is Programme Director for the Offender Personality Disorder Higher Education Programme at UCLan and is interested in whole system approaches for personality disorder.

Title: The need for a Stepped Care Approach in the UK

There are a lack of stepped care approaches to support adults with personality disorder in the UK. Most treatments are provided to those with highest severity and risk in specialist services. In England an initiative called 'Improving Access to Psychological Therapies' (IAPT) provides timely and accessible psychological treatment to the general population, with the aim of providing the lowest dose of psychological treatment to achieve a health benefit. Whilst IAPT is effective in the treatment of anxiety and depression, it has more recently been identified that people with co-morbid personality disorder present in high numbers, go unidentified and hence receive sub-optimal treatment and have poorer outcomes. Within this presentation we will outline some of the key findings from an NIHR funded PhD fellowship which explored the

qualitative perspectives of IAPT therapists and patients, which have led to recommendations for practice and future research plans to address the deficits.

Karlen Barr is a PhD (Clinical Psychology) candidate in the School of Psychology at the University of Wollongong and a research assistant at the Project Air Strategy for Personality Disorders. Her research focuses on evaluating peer support for borderline personality disorder through the perspectives of consumers, carers, peer workers, and mental health professionals. She is active in clinical practice as a provisional psychologist at Northfields Psychology Clinic.

Mahlie Jewell is a qualified mental health professional, peer mentor and DBT facilitator with a lived experience of BPD. Mahlie worked within the NGO sector for over 15 years and now works independently within a social justice framework. Mahlie created the Lived Experience DBT Art Group, using art practice and a peer-led strengths-based approach to support people to find their life worth living. She is currently completing a Master's degree in Art Therapy.

Learning from Lived Experience: Peer support as an early intervention for young people living with borderline personality disorder. A structured discussion on the opportunities, challenges, innovations and future directions.

New fact sheets from Project Air

You've been diagnosed with BDP – What now?
https://www.projectairstrategy.org/content/groups/public/@web/@project-air/documents/doc/uow260274.pdf

Myths and Facts about Borderline Personality Disorder
https://www.projectairstrategy.org/content/groups/public/@web/@project-air/documents/doc/uow264451.pdf

Talking respectfully about Personality Disorder
https://www.projectairstrategy.org/content/groups/public/@web/@project-air/documents/doc/uow263246.pdf

Guide for first responders and health professionals in the hospital setting: Providing support for people living with personality disorders
https://www.projectairstrategy.org/content/groups/public/@web/@project-air/documents/doc/uow260272.pdf

Providing compassionate, recovery-oriented care: guide for mental health professionals
https://www.projectairstrategy.org/content/groups/public/@web/@project-air/documents/doc/uow260273.pdf

Giving a diagnosis of personality disorder: A guide for mental health professionals
https://www.projectairstrategy.org/content/groups/public/@web/@project-air/documents/doc/uow260276.pdf

Recent publications from Project Air

Barr, K.R., Jewell, M., Townsend, M.L. et al. Living with personality disorder and seeking mental health treatment: patients and family members reflect on their experiences. Borderline Personality Disorder and Emotion Dysregulation 7, 21 (2020). https://doi.org/10.1186/s40479-020-00136-4

Barr, K.R., Townsend, M.L. & Grenyer, B.F.S. Using peer workers with lived experience to support the treatment of borderline personality disorder: a qualitative study of consumer, carer and clinician perspectives. Borderline Personality Disorder and Emotion Dysregulation 7, 20 (2020). https://doi.org/10.1186/s40479-020-00135-5

Crowe, R., Townsend, M.L., Miller, C.E. et al. Incidence, Severity and Responses to Reportable Student Self-Harm and Suicidal Behaviours in Schools: A One-Year Population-Based Study. School Mental Health (2020). https://link.springer.com/article/10.1007/s12310-020-09390-x

Day, N.J.S., Townsend, M.L. & Grenyer, B.F.S. Living with pathological narcissism: a qualitative study. Borderline Personality Disorder and Emotion Dysregulation 7, 19 (2020). https://doi.org/10.1186/s40479-020-00132-8

Patriarca E, Brusadelli E, Grenyer BFS. (2020) A bridge between person-based versus symptom-based nosology: A clinical case study using the Psychodiagnostic Chart-2. Psychoanalytic Psychology. https://doi.org/10.1037/pap0000308

Miller CE, Townsend ML, Day NJS, Grenyer BFS (2020) Measuring the shadows: A systematic review of chronic emptiness in borderline personality disorder. PLoS ONE 15(7): e0233970. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0233970

Abramov, G., Miellet, S., Kautz, J., Grenyer, B. F., & Deane, F. P. (2020). The paradoxical decline and growth of trust as a function of borderline personality disorder trait count: Using discontinuous growth modelling to examine trust dynamics in response to violation and repair. PloS ONE, 15(7), e0236170. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0236170

Ng, F., Townsend, M. L., Jewell, M., Marceau, E. M., and Grenyer, B. F. S. (2020) Priorities for service improvement in personality disorder in Australia: Perspectives of consumers, carers and clinicians. Personality and Mental Health, https://doi.org/10.1002/pmh.1485.

King, R., Grenyer, B., Gurtman, C. & Younan, R. (2020). A clinician's quick guide to evidence-based approaches: Narcissistic personality disorder. Clinical Psychologist, 24 (1), 91-95.

Van Schie, C.C., Jarman, H.L., Huxley, E. & Grenyer B.F.S. (2020). Narcissistic traits in young people: understanding the role of parenting and maltreatment. Borderline Personality Disorder and Emotion Dysregulation 7, 10 https://doi.org/10.1186/s40479-020-00125-7

Steele, K.R., Townsend, M.L. & Grenyer, B.F.S. (2020) Parenting stress and competence in borderline personality disorder is associated with mental health, trauma history, attachment and reflective capacity. Borderline Personality Disorder and Emotion Dysregulation 7, 8. https://doi.org/10.1186/s40479-020-00124-8

Huxley, E., Lewis, K. L., Coates, A. D., Borg, W. M., Miller, C. E., Townsend, M. L., & Grenyer, B. F. S. (2019). Evaluation of a brief intervention within a stepped care whole of service model for personality disorder. BMC Psychiatry, 19(1), 1-12. https://doi.org/10.1186/s12888-019-2308-z

Van Schie, CC, Chiu, C-D, Rombouts, SARB, Heiser, WJ, Elzinga, BM. When I relive a positive me: Vivid autobiographical memories facilitate autonoetic brain activation and enhance mood. Hum Brain Mapp. 2019; 40: 4859– 4871. https://doi.org/10.1002/hbm.24742

Steele, K. R., Townsend, M. L., & Grenyer, B. F. (2019). Parenting and personality disorder: An overview and meta-synthesis of systematic reviews. PloS one, 14(10), e0223038. https://doi.org/10.1371/journal.pone.0223038

Pigot, M., Miller, C. E., Brockman, R., & Grenyer, B. F. (2019). Barriers and facilitators to the implementation of a stepped care intervention for personality disorder in mental health services. Personality and mental health, 13(4), https://doi.org/10.1002/pmh.1467

Ng, F. Y., Townsend, M. L., Miller, C. E., Jewell, M., & Grenyer, B. F.S (2019). The lived experience of recovery in borderline personality disorder: a qualitative study. Borderline personality disorder and emotion dysregulation, 6(1), 10. https://doi.org/10.1186/s40479-019-0107-2

Grenyer, B. F., Bailey, R. C., Lewis, K. L., Matthias, M., Garretty, T., & Bickerton, A. (2019). A randomized controlled trial of group psychoeducation for carers of persons with borderline personality disorder. Journal of personality disorders, 33(2), 214-228. https://guilfordjournals.com/doi/abs/10.1521/pedi_2018_32_340

Vardy, Y., Day, N. J. S., & Grenyer, B. F. (2019). Development and validation of an experience of time alone scale for borderline personality disorder. PloS one, 14(5), e0217350. https://doi.org/10.1371/journal.pone.0217350

Hegarty, B. D., Gusset, M., Marceau, E. M., & Grenyer, B. F. S. (2019). Early treatment response in psychotherapy for depression and personality disorder: Links with core conflictual relationship themes. Psychotherapy Research. https://doi.org/10.1080/10503307.2019.1609114

Lewis, K.L., Fanaian, M., Kotze, B. & Grenyer, B.F.S. (2019). Mental health presentations to acute psychiatric services: Three-year study of prevalence and readmission risk for personality disorders compared with psychotic, affective, substance or other disorders. British Journal of Psychiatry Open, 5, e1, 1-7. https://doi.org/10.1192/bjo.2018.72

Ng FYY, Carter P, Bourke ME, Grenyer BFS (2019) What do individuals with Borderline Personality Disorder want from treatment? A study of self-generated treatment and recovery goals. Journal of Psychiatric Practice. 25, 148-155. DOI: 10.1097/PRA.0000000000000369

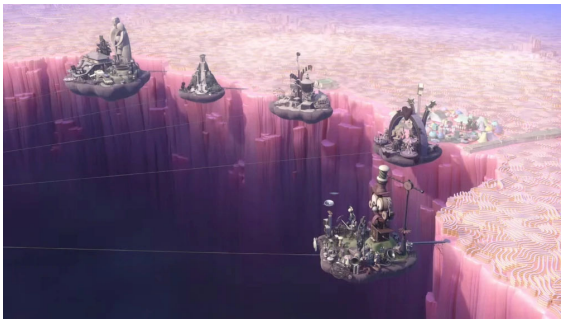
Day, N. J. S., Bourke, M. E., Townsend, M.L., Grenyer, B.F. S. (2019). Pathological narcissism: A study of burden on partners and family. Journal of Personality Disorders. Vol 33, 1-15. https://doi.org/10.1521/pedi_2019_33_413

"This is me"

How adolescence constitutes a sensitive period for the development of personality pathology

Carla Sharp, Ph.D.
csharp2@uh.edu

Artwork by Randomlovers



Scientific understanding

- Personality-psychopathology spectrum approach
- Development of DSM-5 Section II defined personality disorder
- Development of maladaptive self and interpersonal function

Personality-psychopathology spectrum approach

DSM-5 AMPD

Criterion A Level of Personality Function (0-4) Maladaptive self and interpersonal function	Criterion B Maladaptive trait function 5 trait domains 25 trait facets *The Big Five	Borderline personality disorder
Identity	Negative affectivity (neuroticism)	Difficulties in 2 Criterion A features
Self direction	Detachment (>< extraversion)	Difficulties in 4 trait facets (at least one must be risk taking, impulsivity, hostility
Empathy	Antagonism (disagreeableness)	
Intimacy	Disinhibition (>< conscientiousness)	
	Psychoticism (openness)	

ICD-11

Impairment in self and interpersonal functioning Level of severity Mild, moderate, severe	**Optional Trait domain qualifiers 5 trait domains	Borderline pattern
Self (identity, selfworth, capacity for self-direction)	Negative affectivity (neuroticism)	1. Abandonment fears 2. Unstable/intense relationships 3. Identity disturbance 4. Impulsive behaviors 5. Recurrent self-harm 6. Emotional instability 7. Chronic feelings of emptiness 8. Inappropriate intense anger 9. Transcient psychotic-like features
Interpersonal (e.g. developing and maintaining close and mutually satisfying relationships, understanding others' perspectives, managing conflict in relationships)	Detachment (>< extraversion)	
Impairments in self-and/or interpersonal functioning manifest in maladaptive patterns of cognition, emotional experience and expression and behavior	Dissociality (disagreeableness)	
	Disinhibition (>< conscientiousness)	
	Anankastia	

DSM-5 AMPD

Criterion A Level of Personality Function (0-4) Maladaptive self and interpersonal function	Criterion B Maladaptive trait function 5 trait domains 25 trait facets * The Big Five	Borderline personality disorder
Identity	Negative affectivity (neuroticism)	Difficulties in 2 Criterion A features
Self direction	Detachment (>< extraversion)	Difficulties in 4 trait facets (at least one must be risk taking, impulsivity, hostility
Empathy	Antagonism (disagreeableness)	
Intimacy	Disinhibition (>< conscientiousness)	
	Psychoticism (openness)	

Temperament-personality

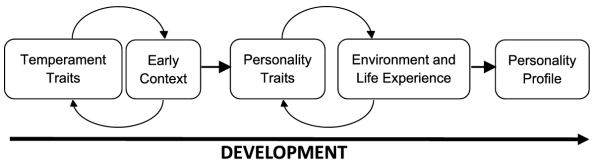


Fig. 1. Mechanisms of change from temperament to personality development.

Anaya & Perez-Edgar (2019)

Temperament-personality

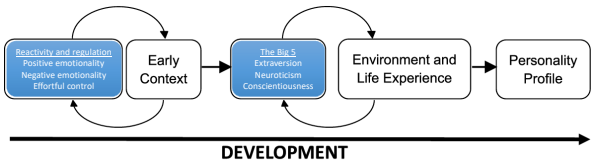


Fig. 1. Mechanisms of change from temperament to personality development.

Anaya & Perez-Edgar (2019)

Personality-psychopathology spectrum approach

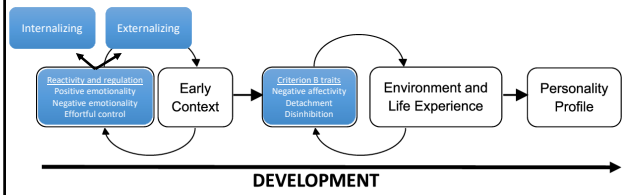
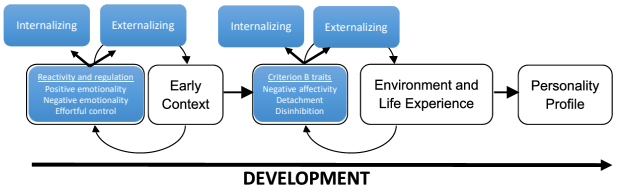


Fig. 1. Mechanisms of change from temperament to personality development.

DeClercq et al. (2009)
Shiner & Tackett (2014)
Tackett (2006)

Personality-psychopathology spectrum approach



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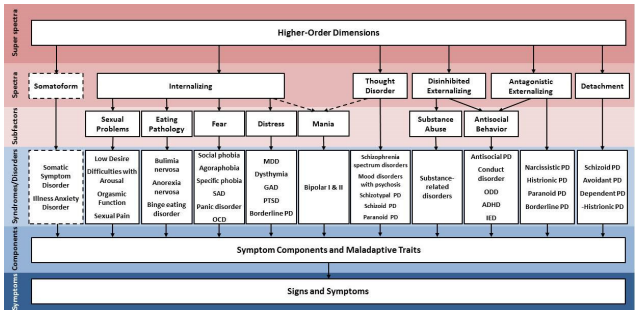
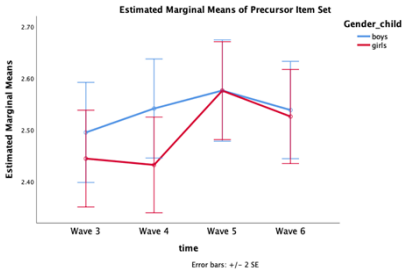


Kotov et al. (2017)



DeClercq et al. (under review)

Table 3. *Rank-order stability for the DIPSI dimensions across 1 and 2 years*

	Time 1			
	DIS	INS	ITR	COM
Time 2				
Disagreeableness	**.71*****	.42***	.40***	.09
Emotional instability	.45***	**.71*****	.62***	.29***
Introversion	.31***	.51***	**.69*****	.16**
Compulsivity	.16**	.27***	.29***	**.72*****
Time 3				
Disagreeableness	**.68*****	.46***	.41***	.09
Emotional instability	.49***	**.65*****	.55***	.14*
Introversion	.34***	.47***	**.64*****	.12*
Compulsivity	.24***	.25***	.24***	**.67*****

Note: DIPSI, Dimensional Personality Symptom Item Pool (De Clercq et al., 2003); DIS, disagreeableness; INS, emotional instability; ITR, introversion; COM, compulsivity; $N = 307$.
$^{*}p \leq .05$. $^{**}p \leq .01$. $^{***}p \leq .001$.

DeClercq et al. (2009). D&P

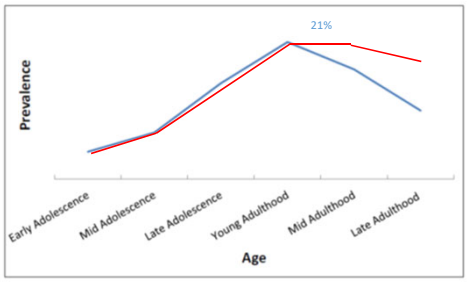
Development of DSM-5 Section II defined personality disorder

DSM-5 Section II

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
2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization 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)
5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
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

N = 800
T1 = age 9
T2 = 14
T3 = 16
T4 = 22



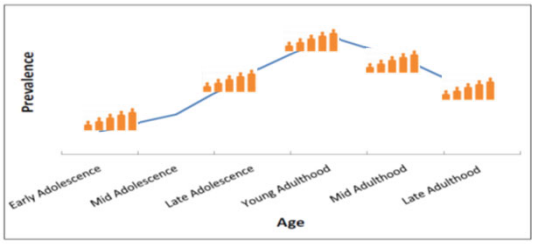
Cohen et al. (2005) *JPD*

Measure	Internal consistency	Inter-rater reliability	Factor structure	Construct validity
CI-BPD				
Zanarini (2003)	.81	.65-.93	Not reported	
Sharp et al. (2012)	.80	.89	Unidimensional	Associates with PAI-BOR, clinician diagnosis, BPFS-C, BPFS-P, internalizing and externalizing problems
Michonski et al. (2013)	.78	Not reported	Unidimensional	N/A
PAI-A BOR				
Morey (2007)	.85-.87	N/A	Four-factor	Associated with range of other BPD relevant pathology
BPFS-C				
Crick et al. (2005)	.76	N/A	Not reported	Associates with relational aggression, cognitive sensitivity, emotional sensitivity, friend exclusivity over time
Chang et al. (2011)	.88	N/A	Not reported	Sensitivity .85 Specificity .84
BPFS-P				
Sharp et al. (2013)	.90	N/A	Not reported	Correlates with BPFS-C, internalizing and externalizing problems
BPFC-11				
Sharp et al. (2014)	.85	N/A	Unidimensional	Sensitivity .740 Specificity .714

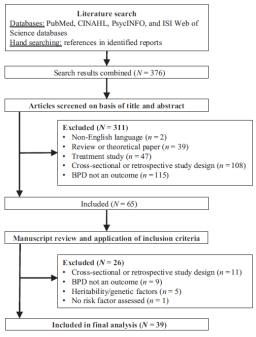
Sharp & Fonagy (2015) *JCPP*

Prevalence rates

- Clinical
  - 11% in outpatients (Chanen et al., 2004).
  - 33% (Ha et al., 2014) in inpatients.
  - 43-49% (Levi et al., 1999) in inpatients.
- Community
  - 3% in the UK (Zanarini et al., 2011)
  - 1% in the USA (Lewinsohn et al., 1997)
  - 2% in China (Leung et al., 2009),
  - cumulative prevalence rate of 3% (Johnson et al., 2008)



Rank-order stability for PD symptoms in the range of .40-.65 (Bornavola et al., 2013)



- Int/ext precedes BPD, but not the other way round
- Co-development of BPD features, int, ext

Stepp et al. (2016) *PD:TRT*

BPD can be differentiated from internalizing and externalizing psychopathology

- Course:
  - CIC: Cluster B more stable than internalizing and externalizing.
  - DeClercq et al (2009): Externalizing symptoms show steeper and continued decline beyond that of personality traits → developmental maturation processes/"grow out" of externalizing behaviors.

Incremental value of BPD over and above internalizing and externalizing psychopathology

Sharp et al (2012)

- 156 consecutive admissions (55.1% female; age = 15.47; *SD* = 1.41).
- A diagnosis of MDD or BPD independently increased the odds for thinking about death by nearly 2.5 times, MDD, *B* = −.91; *SE* = .36; Wald statistic (*1*) = 6.56; *p* = .01, *OR* = 2.48; BPD, *B* = −.88; *SE* = .44; Wald statistic (*1*) = 4.02; *df* = 1, *p* < .05, *OR* =2.42,
- The addition of BPD to the model robustly improved correct classification of those wishing to die from 29% to 41%.

Chanen et al (2006)

- BPD significantly predicted general psychopathology as measured by the Youth Self-Report (YSR; Achenbach, 1991) and the Young Adult Self-Report (YASR; Achenbach, 1997), functioning, peer relationships, self-care, and family and relationship functioning, above and beyond other PD's or Axis I disorders.

Acka, Wall & Sharp (2020)

- 33% of those with BPD have ADHD; 45% of those with ADHD have BPD
- Those diagnosed with both have higher levels of severity for self harm, suicidal ideation and general symptoms.
- Yet, BPD still incremented ADHD in predicting outcomes.

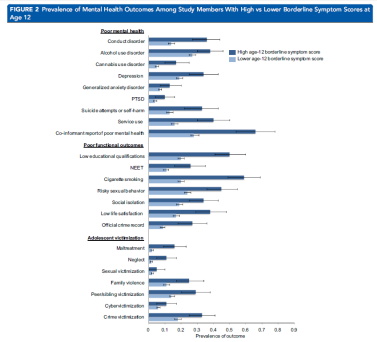


FIGURE 2 Prevalence of Mental Health Outcomes Among Study Members With High vs Lower Borderline Symptom Scores at Age 12

Wertz et al. (2020) *JAACAP*

E-Risk Longitudinal Twin Study
2,232 British twin children
Age 12 mothers rated borderline symptoms

Easily jealous
Falls for new friends intensely, expects too much too quickly
Changes friends constantly, loves them one day and hates the next
Fears they will be rejected or abandoned
Feels others are out to get him/her
Acts overly seductive or sexy, flirts a lot
Attracted to unsuitable romantic partners
Emotions spiral out of control, has extremes of rage, despair, excitement
Cannot think when upset, becomes irrational
Unable to soothe or comfort self
Lacks stable image of self, changes goals/values
Expresses emotions in an exaggerated dramatic way
Irritable, touchy, or quick to "fly off the handle"
Angry and hostile
Engages in self-harm behavior

TABLE 3 Borderline Symptoms (Measured on a Continuous Scale) of 12-Year-Olds Predict Poor Outcomes at Age 18

Age 18 outcome	Model 1[a]	Model 2[b]	Model 3[c]
Personality	β (95% CI)	β (95% CI)	β (95% CI)
Openness to experience	−.08 (−0.13, −0.03)	−.02 (−0.08, 0.04)	.00 (−0.10, 0.11)
Conscientiousness	−.16 (−0.21, −0.12)	−.09 (−.14, −.03)	.02 (−.11, .14)
Extraversion	.06 (0.02, 0.11)	.13 (0.07, 0.18)	.02 (−0.11, 0.14)
Agreeableness	−.28 (−0.32, −0.23)	−.17 (−0.22, −0.11)	−.08 (−0.17, 0.03)
Neuroticism	.23 (0.19, 0.28)	.19 (0.13, 0.25)	n.09 (−0.03, 0.22)
Poor mental health	IRR (95% CI)	IRR (95% CI)	IRR (95% CI)
Conduct disorder	1.41 (1.31, 1.51)	1.17 (1.05, 1.31)	1.02 (0.81, 1.29)
Alcohol use disorder	1.12 (1.05, 1.19)	1.08 (0.99, 1.17)	0.99 (0.81, 1.22)
Cannabis use disorder	1.44 (1.24, 1.66)	1.09 (0.89, 1.32)	1.04 (0.73, 1.49)
Depression	1.18 (1.09, 1.28)	1.09 (0.99, 1.20)	0.95 (0.79, 1.15)
Generalized anxiety disorder	1.13 (0.97, 1.31)	1.02 (0.83, 1.23)	1.32 (0.90, 1.92)
Posttraumatic stress disorder	1.26 (1.05, 1.52)	1.15 (0.90, 1.47)	1.61 (0.86, 2.99)
Suicide attempts or self-harm	1.38 (1.27, 1.50)	1.26 (1.13, 1.40)	1.10 (0.89, 1.35)
Service use	1.31 (1.21, 1.41)	1.26 (1.14, 1.40)	1.18 (0.99, 1.40)
Coinformant report of poor mental health	1.36 (1.29, 1.44)	1.21 (1.12, 1.31)	1.00 (0.87, 1.14)
Poor functioning	IRR (95% CI)	IRR (95% CI)	IRR (95% CI)
Low educational qualifications	1.40 (1.32, 1.49)	1.18 (1.08, 1.28)	1.13 (0.93, 1.38)
NEET status	1.35 (1.21, 1.50)	0.99 (0.86, 1.13)	1.12 (0.74, 1.68)
Cigarette smoking	1.40 (1.33, 1.49)	1.19 (1.09, 1.30)	1.00 (0.89, 1.11)
Risky sexual behavior	1.29 (1.22, 1.37)	1.17 (1.07, 1.26)	0.93 (0.78, 1.11)
Social isolation	1.23 (1.14, 1.33)	1.07 (0.97, 1.18)	1.14 (0.95, 1.37)
Low life satisfaction	1.27 (1.17, 1.36)	1.06 (0.96, 1.17)	1.14 (0.95, 1.37)
Official crime record	1.54 (1.40, 1.69)	1.19 (1.03, 1.36)	1.02 (0.84, 1.26)
Adolescent victimization	IRR (95% CI)	IRR (95% CI)	IRR (95% CI)
Maltreatment	1.89 (1.61, 2.22)	1.47 (1.09, 1.98)	1.18 (0.95, 1.46)
Neglect	1.84 (1.56, 2.17)	1.63 (1.23, 2.16)	1.10 (0.61, 1.98)
Sexual victimization	1.45 (1.22, 1.72)	1.00 (0.77, 1.29)	1.30 (0.80, 2.10)
Family violence	1.30 (1.18, 1.44)	1.14 (1.00, 1.31)	0.85 (0.66, 1.11)
Peer victimization	1.28 (1.17, 1.39)	1.17 (1.05, 1.31)	1.07 (0.87, 1.31)
Cyber-victimization	1.32 (1.16, 1.50)	1.27 (1.07, 1.51)	1.15 (0.73, 1.80)
Crime victimization	1.25 (1.16, 1.34)	1.16 (1.05, 1.29)	1.01 (0.84, 1.22)

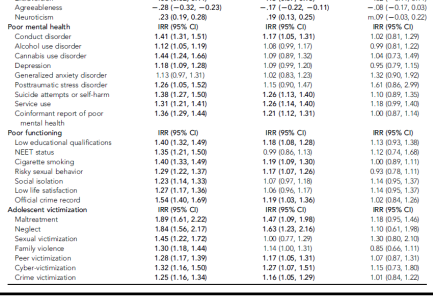


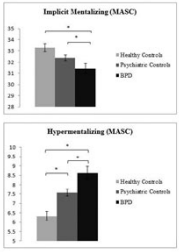
Figure 2. The final path model including associations between adolescent BPD and subsequent psychopathologies.

Winsper et al. (2019) *Austr NZL Jnl Psych*

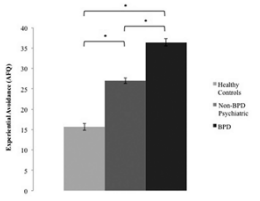
ALSPAC study
6,091 UK birth cohort study
CI-BPD age 11/12
Follow-up: 18 and 22/23 years

Independent developmental pathways linked to hypomania and psychotic symptoms were not likely attributable to symptom overlap between outcomes, as we simultaneously controlled for all associations between each of the psychopathological outcome assessments.

Correlates

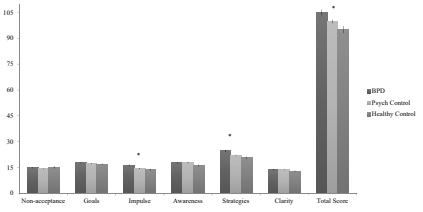


Penner et al. (2019) *JPD*



Jones et al. (2019) *Cog Beh Th*

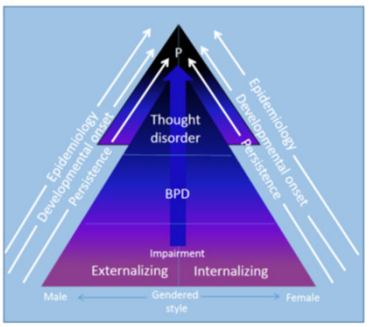
Correlates

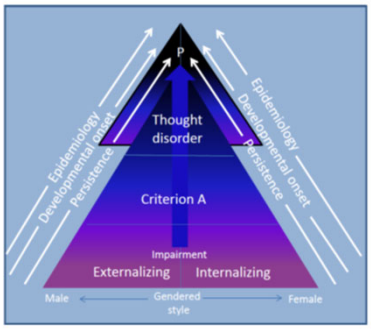


Ibrahim et al (2017) *BPD/ED*

Summary

- Syndrome does not onset until adolescence.
- Differentiation from internalizing and externalizing psychopathology in terms of correlates, course, incremental prediction.
- But also significant overlap.
- But why does it onset in adolescence? Traits alone do not seem adequate to explain the onset of personality disorder in adolescence.





Sharp & Wall (2017) *Current Dir Psychology*
Sharp, et al. (2018) *Psych Clin North America*
Sharp (2020) *Psychopathology*
Sharp, Kerr & Chanen (in press) *APA textbook*

Development of maladaptive self and interpersonal function

DSM-5 AMPD

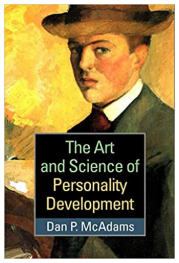
Criterion A Level of Personality Function (0-4) Maladaptive self and interpersonal function	Criterion B Maladaptive trait function 5 trait domains 25 trait facets *The Big Five	Borderline personality disorder
Identity	Negative affectivity (neuroticism)	Difficulties in 2 Criterion A features
Self direction	Detachment (>< extraversion)	Difficulties in 4 trait facets (at least one must be risk taking, impulsivity, hostility
Empathy	Antagonism (disagreeableness)	
Intimacy	Disinhibition (>< conscientiousness)	
	Psychoticism (openness)	

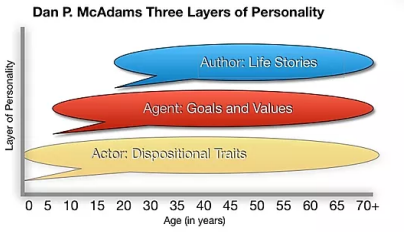
Definition of Criterion A/LPF

- LPF is best defined as the intrinsic aspects of personality functioning that, if disordered, characterizes a general adaptive failure or delayed development of the intrapsychic system needed to understand and manage the self in affectively charged attachment and/or interpersonal contexts necessary for adult role function
- The core of personality pathology and common (general) to all manifestations (flavors) of personality disorder
- Captured by borderline criteria (Sharp et al., 2015)

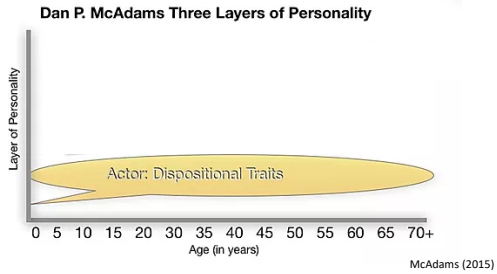
Personality originally defined: intrapsychic system needed to understand and manage the self

- William James (1892/1963)
  - "I": an intuitive, emotionally experienced sense of self (self as subject)
  - "Me": a result of self-reflective process leading to an integrated awareness and knowledge about oneself (self as object)
- Freud (1923):
  - Ego = "Ich" = "I"
  - Id = "Es" = "it"
- Mead (1934):
  - the social world (an audience, real or imagined) facilitates self-regulation, invoking the idea that humans can look upon themselves from the outside in to regulate the self

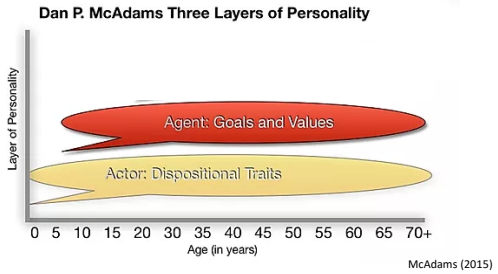




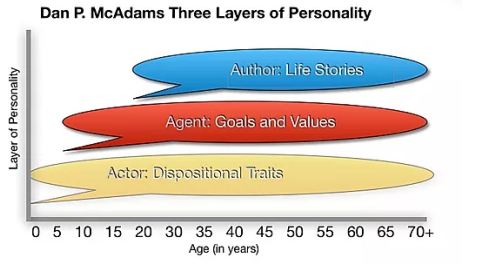
McAdams (2015)



McAdams (2015)



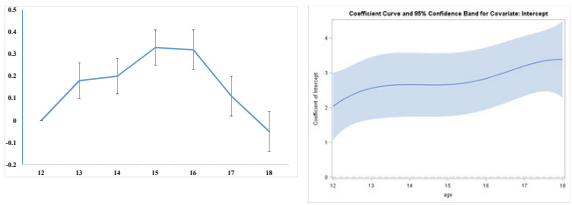
McAdams (2015)



McAdams (2015)

Emerging empirical basis for the developmental model

- Reflective capacity associates with BPD in adolescents (Penner et al., 2019; Sharp et al., 2011; Somma et al., 2019; Ha et al., 2013; Sharp et al., 2019).
- Reflective capacity predicts increase in BPD traits over a one-year follow up period in adolescents (Sharp et al., 2014).
- Improvement in reflective capacity associated with reduction in BPD traits in adolescents (Sharp et al., 2013).
- BPD traits associate with identity diffusion and lower narrative coherence in adolescents (Lind et al., 2019a).
- Narrative coherence associate with reflective capacity in adolescents (Lind et al., 2019b)



Sharp et al. (under review)

Summary

- Humans contribute to an active and continuous process of reflection and interpretation of themselves and others.
- The capacity for this reflective process onsets in adult form in adolescence and facilitates consolidation of identity and adult role function (love and work).
- If disrupted, personality pathology (Criterion A dysfunction) ensues.
- Criterion A can account for the onset of BPD in adolescence, while Criterion B provides a useful descriptive account of continuous aspects of personality function over time.
- While Criterion B maladaptive traits provide important descriptive nuance to manifestations of personality pathology, maladaptive Criterion A function is conditional to the diagnosis of personality disorder.
- Target of treatment:
  - Scaffolding of identity development in adolescents
  - Enhancing reflective (mentalizing) capacity

Many thanks!