HYPE: A Cognitive Analytic Therapy-Based Prevention and Early Intervention Programme for Borderline Personality Disorder

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Introduction

Borderline personality disorder (BPD) is a leading candidate for developing empirically based prevention and early intervention programmes because it is common in clinical practice, it is among the most distressing and functionally disabling of all mental disorders, it is often associated with help-seeking, and it has been shown to respond to treatment, even in those with established disorder. Moreover, BPD can be reliably diagnosed in its early stages and it demarcates a group with high levels of current and future distress, morbidity and mortality, making intervention a clinically justified and humane response. Data also suggest considerable flexibility and malleability of BPD traits in youth, making this a key developmental period during which to intervene.

Accordingly, we have developed the Helping Young People Early (HYPE) programme, a comprehensive and integrated indicated prevention and early intervention programme for youth (15–25 years of age). HYPE includes both a service model and an individual therapy, and incorporates the principles of cognitive analytic therapy (CAT) into both components.

CAT is a time-limited, integrative psychotherapy that arose from a theoretical and practical integration of elements of psychoanalytic object relations theory and cognitive psychology, subsequently developing into an integrated model of development and psychopathology. CAT is practical and collaborative in style, with a particular focus upon understanding the individual's problematic self-management and interpersonal relationship patterns and the thoughts, feelings and behavioural responses that result from these patterns. A central feature in CAT is the joint (patient–therapist) creation of a shared understanding of the patient's difficulties and their developmental origins, using plain-language written and diagrammatic 'reformulations'. These form the basis for understanding self-management and relationship problems both within and outside therapy, assist the patient to recognise and revise their dysfunctional relationship patterns and assist the therapist to avoid or recover from collusion with such relationship patterns. CAT has particular advantages for early intervention in BPD, especially because its integrative and 'transdiagnostic' approach encompasses the myriad co-occurring problems, which are the norm in this patient group, within the overall treatment model.

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Prevention and Early Intervention Makes Sense

The long-term outcomes for adult American patients with established BPD are now well recognised. By 10 years, 85 % of adults with BPD 'remit' (no longer meet five or more DSM-IV BPD criteria) (Gunderson et al., 2011), rising to 99 % at 16 years (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012). This so-called remission tends to be stable but *recovery* is more elusive. When recovery is defined as 2 years of both remission of BPD symptoms and good social and vocational functioning (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010), only half of adult BPD patients will recover by 10 years. One third of those recovered will later 'relapse'.

It is now evident that BPD is associated with severe distress and persistent functional disability, which is at least as severe as that associated with major depression (Gunderson et al., 2011). There is also high family and carer burden (Hoffman, Buteau, Hooley, Fruzzetti, & Bruce, 2003) and high rates of continuing resource utilisation (Horz, Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010). Despite persistent help seeking, 8–10 % of adults with BPD will die by suicide (Paris & Zweig-Frank, 2001; Pompili, Girardi, Ruberto, & Tatarelli, 2005).

Notwithstanding the significant achievements of the past two decades of treatment research for adults with BPD (e.g. Bateman & Fonagy, 2009; Giesen-Bloo et al., 2006; Linehan et al., 2006), the overall outcomes from such interventions have been relatively modest. Moreover, many evidence-based interventions are complex and lengthy. Their implementation and availability are limited in most healthcare systems and they tend to be offered only to those patients who are 'motivated' to enter into treatment, leaving the majority of BPD patients untreated, undertreated or subject to unhelpful interventions with high a likelihood of iatrogenic harm and demoralisation (of patients and staff) (Mulder & Chanen, 2013).

These data support a *prima facie* case for developing prevention and early intervention programmes for BPD to complement established treatment services. These are intended to be made available earlier in the course of the disorder and offered to a wider variety of individuals and carers who access the health system. This chapter outlines the rationale for developing such programmes, and why combining *indicated prevention* and *early intervention* is currently the best alternative. It also describes the application of this theory to a frontline, 'real world' clinical setting in Melbourne, Australia where the HYPE programme has been operating for over a decade. HYPE is a comprehensive indicated prevention and early intervention programme that includes both a service model and an individual therapy, which incorporates the principles of CAT.

BPD in Young People

Despite longstanding general agreement that personality disorders (PDs) have their roots in childhood and adolescence (APA, 1980), diagnosing PDs prior to age 18 years has been more controversial than diagnosing PDs in adults (Chanen & McCutcheon, 2008b), but this is no longer justified (National Collaborating Centre for Mental Health, 2009; National Health and Medical Research Council, 2012). BPD is increasingly seen as a lifespan developmental disorder (Tackett, Balsis, Oltmanns, & Krueger, 2009) that is similarly reliable and valid when applied to adolescents or adults (Chanen, Jovev, McCutcheon, Jackson, & McGorry, 2008; Miller, Muehlenkamp, & Jacobson, 2008), is not reducible to other diagnoses (Chanen, Jovev, & Jackson, 2007), and can be identified in day-to-day clinical practice (Chanen, Jovev, Djaja, et al., 2008).

In fact, BPD might be better considered as a disorder of younger people, with a rise in prevalence from puberty and a steady decline with each decade from young adulthood (Johnson et al., 2000; Samuels et al., 2002; Ullrich & Coid, 2009). Limited data suggest that BPD occurs in approximately 3 % of community-dwelling (Bernstein et al., 1993; Moran, Coffey, Mann, Carlin, & Patton, 2006) and up to 22 % of outpatient (Chanen et al., 2004; Chanen, Jovev, Djaja, et al., 2008) adolescents and young adults.

BPD (or dimensional representations of BPD) in young people demarcates a group with high morbidity and a particularly poor outcome. BPD uniquely and independently predicts current psychopathology, general functioning, peer relationships, self-care and family and relationship functioning (Chanen et al., 2007). It also uniquely predicts poor outcomes up to two decades into the future, such as a future BPD diagnosis, increased risk for other mental disorders (especially substance use and mood disorders), interpersonal problems, distress and reduced quality of life (Cohen, Crawford, Johnson, & Kasen, 2005; Crawford et al., 2008; Winograd, Cohen, & Chen, 2008).

A Practical Strategy for Prevention and Early Intervention

The above data suggest that BPD is a leading candidate for developing empirically based prevention and early intervention programmes because it is common in clinical practice, it is among the most distressing and functionally disabling of all mental disorders, it is often associated with help-seeking (cf. schizotypal or antisocial personality disorders, (Tyrer, Mitchard, Methuen, & Ranger, 2003)), and it has been shown to respond to treatment, even in those with established disorder. Moreover, BPD can be reliably diagnosed in its early stages and it demarcates a group with high levels of current and future morbidity and mortality. Data also suggest considerable flexibility and malleability of BPD traits in youth (Lenzenweger & Castro, 2005), making this a key developmental period during which to intervene, and adolescent BPD features have been shown to respond to intervention (Chanen, Jackson, et al., 2008, 2009; Schuppert et al., 2009, 2012).

Aims of Prevention and Early Intervention

Prevention and early intervention for BPD should primarily aim to alter the life-course trajectory of young people with borderline personality pathology by attenuating or averting associated adverse outcomes and promoting more adaptive developmental pathways. It should not be narrowly focused upon the diagnostic and symptomatic features of BPD, as these naturally attenuate over time.

Antisocial personality disorder (ASPD) provides a useful model for such purposes. There is a remarkable amount of information about childhood-onset and adolescent-onset conduct disorder (CD) and the developmental pathways leading to ASPD, along with associated outcomes such as substance abuse, mental disorders and poor physical health (Moffitt et al., 2008). These data logically give rise to potential 'universal' (whole population), 'selective' (asymptomatic but with risk factors) and 'indicated' (symptomatic but not 'case level' disorder) preventive interventions (Mrazek & Haggerty, 1994), along with early intervention for the established phenotype (Weisz, Hawley, & Doss, 2004; Woolfenden, Williams, & Peat, 2002).

Although the time course and form of early manifestations of BPD are likely to differ from ASPD, the two disorders have substantial phenotypic overlap and similar objectives might be realised for BPD through identifying appropriate risk factors and antecedents for intervention.

What Form Should Intervention Take?

Risk Factors: Implications for Universal and Selective Prevention

We have reviewed the findings from prospective longitudinal studies of community samples and studies of young people with borderline pathology elsewhere (Chanen & Kaess, 2012). These suggest a variety of genetic, neurobiological, psychopathological and environmental risk factors for BPD. However, a fundamental drawback of these data is that their specificity for BPD appears to be limited (Chanen & Kaess, 2012), making these findings less than informative for the purposes of prevention.

Stand-alone universal (whole population) prevention of BPD is not currently feasible because

BPD is not sufficiently prevalent to justify whole population approaches and it is unclear exactly what form or 'dose' of intervention would be appropriate. Similarly, selective prevention (targeting those with risk factors for BPD) is currently impractical because many of the risk factors for BPD (particularly environmental factors) more commonly lead to, or are associated with, outcomes other than BPD (i.e. multifinality; Cicchetti & Toth, 2009). This should not diminish the importance of intervention for some risk factors (e.g. child abuse and neglect) as primary objectives because they are undesirable, immoral or unlawful. However, many factors (e.g. poverty and inequality) require a major social and political change and are unlikely to have a major impact on BPD prevention in the near future. Also, it is difficult to design studies with adequate statistical power to demonstrate the efficacy or effectiveness of universal and selective prevention (Cuijpers, 2003). Some of these problems would be overcome if current universal and selective programmes (e.g. parent training programmes) were to measure multiple syndromes as outcomes, and the above data constitute a strong case for including BPD as one of these syndromes.

Precursor Signs and Symptoms: Implications for Indicated Prevention

Prospective longitudinal data indicate that certain temperamental characteristics and early onset mental state or behavioural problems that are analogous to characteristics of BPD are precursors to the emergence of the BPD phenotype but do not predict its onset with certainty. These include attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, substance use, depression and deliberate self-harm (DSH), along with the actual features of BPD. However, it is technically imprecise to refer to many of these phenomena as 'risk factors' (Kraemer et al., 1997), as these same phenomena are later used to define PD. Eaton, Badawi, and Melton (1995) refer to the signs and symptoms from a diagnostic cluster that precede a disorder but do not predict its onset with certainty as *precursor signs and symptoms*.

Maternal reports of childhood temperament are related to BPD in adolescence or adulthood, up to 30 years later (Carlson, Egeland, & Sroufe, 2009; Crawford, Cohen, Chen, Anglin, & Ehrensaft, 2009). Substance use disorders during adolescence, particularly alcohol use disorders, also specifically predict young adult BPD (Rohde, Lewinsohn, Kahler, Seeley, & Brown, 2001; Thatcher, Cornelius, & Clark, 2005) and there are strong prospective data that disturbances in attention, emotional regulation and behaviour, especially the disruptive behaviour disorders (CD, ODD, ADHD) in childhood or adolescence are independent predictors of young adult BPD (Burke & Stepp, 2012; Carlson et al., 2009; Stepp, Burke, Hipwell, & Loeber, 2012). Moreover, one study suggests that for adolescent BPD symptoms, difficulties with emotion regulation and relationships might precede problems with impulse control (Stepp et al., 2012).

DSH is a core feature of BPD (Leichsenring, Leibing, Kruse, New, & Leweke, 2011) and retrospective reports from adults with BPD indicate childhood-onset of DSH in more than 30 % and adolescent-onset in another 30 % (Zanarini et al., 2006). However, DSH is surprisingly under-researched as a potential precursor to BPD. Although DSH is relatively common among adolescents and young adults (Nock, 2010) and is associated with a range of clinical syndromes, there is evidence that repetitive DSH, which is less frequent, might differ from occasional DSH (Brunner et al., 2007). BPD can be diagnosed in the majority of female adolescent inpatients with DSH (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006) and the likelihood of meeting the diagnosis of BPD is greater in adolescents endorsing both DSH and suicide attempts compared with individuals reporting DSH or suicide attempts alone (Muehlenkamp, Ertelt, Miller, & Claes, 2011). Also, the number of BPD criteria met is predictive of whether or

not an adolescent has engaged in DSH or attempted suicide (Jacobson, Muehlenkamp, Miller, & Turner, 2008).

There is now clear evidence that dimensional representations of BPD features have similar stability in adolescence and adulthood (Chanen, Jovev, McCutcheon, et al., 2008). Evidence is emerging that the underlying dimensions of BPD features (conceptualised as impulsivity, negative affectivity and interpersonal aggression) are also stable in children (Crick, Murray-Close, & Woods, 2005; Stepp, Pilkonis, Hipwell, Loeber, & Stouthamer-Loeber, 2010). Only one study has specifically measured childhood or adolescent PD features as a predictor of later PD over multiple assessments from childhood to adulthood (Cohen et al., 2005). PD symptoms in childhood or adolescence were the strongest long-term predictors, over and above disruptive behaviour disorders and depressive symptoms (Bernstein, Cohen, Skodol, Bezirganian, & Brook, 1996; Cohen, 1996; Cohen et al., 2005; Kasen, Cohen, Skodol, Johnson, & Brook, 1999), of later DSM-IV cluster A, B or C PD. Overall, the data support a normative increase in BPD traits after puberty, perhaps bringing the problems associated with BPD to clinical attention. As this wanes in early adulthood, partly due to maturational or socialisation processes (Cohen et al., 2005), a group is revealed that is increasingly deviant compared with their peers (Crawford et al., 2005) and that might more closely resemble the 'adult' BPD phenotype. This suggests that young people displaying BPD features are a major group from which the adult BPD phenotype arises.

In short, signs and symptoms appear from childhood through to adolescence that resemble aspects of the BPD phenotype and presage its later appearance in adolescence or emerging adulthood. Certain early temperamental and personality features, internalising and externalising psychopathology and specific BPD criteria are all candidate precursor signs and symptoms. However, more work needs to be done to gain a better understanding of the role these factors play in the developmental pathways to BPD and to increase their specificity for BPD.

The data reviewed above suggest that 'indicated prevention' (Chanen, Jovev, McCutcheon, et al., 2008) is currently the 'best bet' for prevention of BPD. This targets individuals displaying precursor (i.e. early) signs and symptoms of BPD. Although the BPD phenotype is not robustly identifiable in children, its underlying dimensions can be measured, appear to be relatively stable and could be directly targeted. Moreover, typical child and adolescent psychopathology (e.g. disruptive behaviour disorders, DSH, substance use, depressive disorders) might additionally be regarded as targets for indicated prevention of BPD, rather than separate domains of psychopathology that might then be renamed in adulthood. Two programmes have been developed that directly target sub-syndromal borderline pathology in adolescents (Chanen, Jackson, et al., 2008; Chanen, McCutcheon, et al., 2009; Schuppert et al., 2009), while concurrently targeting syndromal BPD.

Early Detection and Intervention

Early detection and intervention for BPD is now justified and practical in adolescence and emerging adulthood (Chanen, Jovev, Djaja, et al., 2008; National Collaborating Centre for Mental Health, 2009; National Health and Medical Research Council, 2012) and consequently, we have developed and researched a novel early intervention programme (Chanen, Jackson, et al., 2008; Chanen, McCutcheon, et al., 2009). This programme should be differentiated from conventional BPD treatment programmes that are applied to individuals who have established, complex and severe BPD but who happen to be less than 18 years old. Treatment for this latter group should already be considered part of routine clinical practice in adolescent mental health (National Collaborating Centre for Mental Health, 2009; National Health and Medical Research Council, 2012).

The HYPE Programme: Indicated Prevention and Early Intervention for BPD Using Cognitive Analytic Therapy

Cognitive Analytic Therapy

CAT is the core of the HYPE therapeutic model and is the *lingua franca* of the team. CAT is a time-limited, integrative psychotherapy that has been developed in the United Kingdom over the past 30 years (Ryle & Kerr, 2002). CAT arose from a theoretical and practical integration of elements of psychoanalytic object relations theory and cognitive psychology, developing into an integrated model of development and psychopathology. Key features of the CAT model of development and psychopathology are outlined in Fig. 23.1.

The self is seen in CAT to be characterised by an 'internalised' repertoire of relationship patterns, acquired throughout early and subsequent development. When development is suboptimal (as in the development of personality disorders) and early caregiving interactions are less nurturing or even destructive, these relationship patterns will be internalised and used or re-enacted inappropriately and/or inflexibly.

CAT is practical and collaborative in style, with a particular focus upon understanding the individual's problematic relationship and self-management patterns and the thoughts, feelings and behavioural responses that result from these patterns. A central feature in CAT is the joint (patient–therapist) creation of a shared understanding of the patient's difficulties and their developmental origins, by means of plain-language written and diagrammatic 'reformulations'. These form the basis for understanding relationship problems both outside and within therapy and assist the patient to recognise and revise their dysfunctional relationship and self-management patterns. Because of its collaborative style and strong relational focus, CAT has been increasingly used with more complex and relational types of disorder, especially BPD (Ryle, 2004), where it has a specific model and treatment approach (Ryle, 1997a).

CAT has particular advantages for early intervention in BPD. Its integrative and 'trans-diagnostic' approach encompasses co-occurring problems (e.g. other personality pathology, mental state and substance use disorders) within the overall treatment model, rather than seeking separate interventions. Also, CAT sees 'psychological mindedness' as a goal of therapy, rather than a prerequisite. Youth, especially those with BPD, rarely present as 'therapy ready' in any traditional sense and they often have limited and/or adverse experiences of mental health services or therapy. Finally, while CAT is essentially a talking-based therapy, the model can be modified for use with less verbal patients or those with intellectual/learning difficulties and can also encompass a range of other (e.g. behavioural) approaches.

Routinely, 16 CAT sessions (plus whatever case management is required) are offered to each patient, with four post-therapy follow-up sessions (at 1, 2, 4 and 6 months) to monitor progress and risk. This is negotiable to a lesser amount, especially for those who are ambivalent about treatment, but can be extended up to 24 sessions, if needed.

The CAT Approach to BPD

Key features of the CAT model of therapy for BPD are outlined in Fig. 23.2.

CAT adopts a dimensional approach to the conceptualisation of degrees of damage to and dysfunction of the self. From a CAT perspective, BPD is seen as a severe and complex disorder frequently characterised by considerable comorbidity. The self is understood as operating in states ranging from normal multiplicity through to those of overt dissociation (Ryle & Fawkes, 2007; Ryle & Kerr, 2002). Lesser degrees of damage to the self are characterised by the presence of mildly dysfunctional or maladaptive reciprocal role procedures for coping, located within a more integrated self that is capable of self-reflection, empathic interactions with others and an advanced capacity for executive function. However, more severe degrees of damage are characterised by failure of integration of the structures of the self (notably, its repertoire of reciprocal roles and reciprocal role procedures), and by lack of self-

- The model is predicated on a fundamentally relational and social concept of self; this implies that individual psychopathology cannot be considered apart from the sociocultural context in which it arose and within which it is currently located.
- In the context of individual genetic and temperamental variation, early socially meaningful experience is internalised as a repertoire of reciprocal roles.
- A reciprocal role is a complex of implicit relational memory that includes affect and perception and is characterised by both child-derived and parent/culture-derived poles; a role may be associated with a clear dialogical 'voice'.
- Enactment of a reciprocal role always anticipates or attempts to elicit a reciprocal reaction from a historic or current other.
- Reciprocal roles and their recurrent procedural enactments determine both subsequent interpersonal interactions and also internal dialogue and self-management.
- All mental activity, whether conscious or unconscious, is rooted in and highly determined by our repertoire of reciprocal roles.
- Human psychopathology is rooted in and highly determined by a repertoire of maladaptive or unhealthy reciprocal roles.
- More severe and complex damage to the self may occur as a result of chronic developmental trauma/deprivation, resulting in dissociation and disruption of the repertoire of reciprocal roles and consequent impairment of self-reflective and executive function. These phenomena are accounted for in the 'multiple self-states model' of borderline personality disorder.

Fig. 23.1 Key features of the cognitive analytic therapy model of development and psychopathology

reflective capacity and problems associated with a lack of a coherent and continuous sense of identity (Kerr, 2005; Ryle, 1997b, 2004). Such a disorder is also typically characterised by extreme psychological distress that might manifest as a stress-related dissociation into different self-states as well as extreme coping procedures. Dissociation is also conceived of as the principle mechanism through which developmentally abusive, traumatic and depriving interpersonal experiences have a deleterious effect on the developing self. The damage is considered to occur in the context of likely neurobiological vulnerability through, for example, impaired impulse control and/or proclivity to dissociation in the face of (psychological) trauma (Ryle & Kerr, 2002).

This conceptualisation addresses and largely accounts for the range of psychopathology encountered in BPD, in particular the tendency under pressure to switch suddenly and apparently unpredictably between different self-states, with their associated differing reciprocal roles and reciprocal role procedures (Pollock, Broadbent, Clarke, Dorrian, & Ryle, 2001). These switches between self-states represent some of the most problematic and challenging enactments encountered in working in any capacity with people with BPD, often causing such patients to be seen as 'difficult' or 'hard to help'—at least in the absence of a coherent model accounting for these interactions. Another advantage of the CAT model in this context is its explicit and

- Proactive and collaborative ('doing with') style, stressing the active participation of the patient/client.
- Aims at non-judgemental description of, and insight into origins and nature of, psychopathology conceived as procedural enactments of reciprocal roles and associated dialogical voices, and of a tendency under stress to dissociate into different self-states.
- Aims to offer a new form of non-collusive relationship with a benign, thoughtful other that the patient/client can internalise in the form of new reciprocal roles and that enables the exploration of new perceptions of self and new ways of interacting with others; this is conceived of in terms of recognition and revision of maladaptive reciprocal role procedures.
- Therapy is aided by the early collaborative construction of written and diagrammatic reformulations (conceived of as psychological tools) by the end of the initial phase of therapy. These serve as 'route maps' for therapy and also as explicit narrative and validating testimonies.
- Therapy subsequently focuses on revision of maladaptive reciprocal role procedures and associated perceptions, affects and voices as they are evident in internal self-to-self dialogue and self-management, through enactments in the outside world, and also as manifest in the therapy relationship (as transference and countertransference).
- Further techniques may facilitate this ranging from challenging of dialogical voices to behavioural experiments, mindfulness exercises, 'empty chair' work or active processing of traumatic memories.
- The focus from the beginning is on a time limit (whether in individual therapy or CAT-informed approaches in other settings); 'ending well' is seen as an important part of therapy (experience of new reciprocal roles), and as a means of addressing issues surrounding loss and of avoiding protracted and collusive relationships.
- Social rehabilitation is an important although often neglected aspect of therapy.

Fig. 23.2 Key features of the cognitive analytic model of therapy for borderline personality disorder

robust relational framework, which can help make sense of the frequently challenging relational dynamics, both individual and systemic, which represent a core feature of these disorders. The model can provide a *lingua franca* for teams and, ideally, to others involved in the care of the individual with BPD, which enables considered responses rather than 'knee-jerk' reactions to be made to 'difficult' and challenging patient behaviours (reciprocal role enactments) through use of tools such as an extended 'contextual' reformulation, even if formal therapy as such is not being offered to the patient. This can reduce staff stress, team splitting and burn out (Caruso et al., 2013; Thompson et al., 2008), and in turn improve the delivery of patient care.

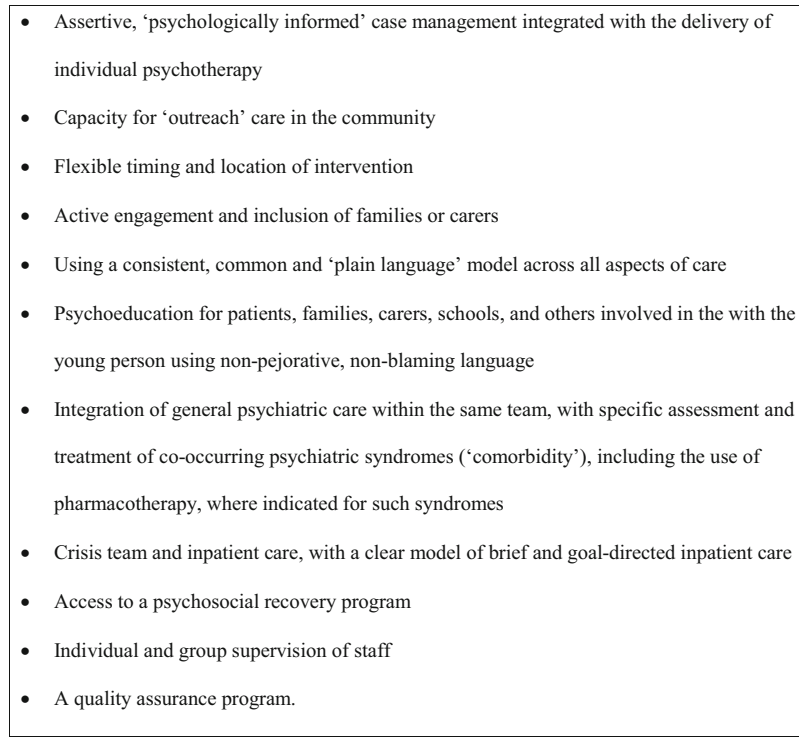

Fig. 23.3 Key elements of a team-based, integrated early intervention for BPD

Principles of Indicated Prevention and Early Intervention for BPD

There is such a great emphasis in the treatment literature for BPD on providing individual psychotherapy that it leads to the misleading conclusion that lengthy individual therapy is both necessary and sufficient for the treatment of all individuals with BPD. Little prominence is given to the service delivery models that support the provision of individual therapy for BPD (Mulder & Chanen, 2013), the emerging evidence that 'high quality care' for BPD might be as effective as 'branded' psychotherapies (Bateman & Fonagy, 2009; Chanen, Jackson, et al., 2008; McMain et al., 2009) or that intermittent care might be worthy of empirical investigation (Paris, 2007).

The HYPE model addresses these issues by defining a model of service delivery separately from the practice of individual psychotherapy, while using a common language and tools for the integration of both components. It also uses time-limited, intermittent treatment as its primary mode of intervention. The key features of this model are listed in Fig. 23.3 and elaborated in the following sections.

A Dimensional View of BPD

An indicated prevention and early intervention programme for BPD needs to adopt a dimensional view of BPD and to recognise its heterogeneity and 'comorbidity'. A dimensional view of BPD combines sub-syndromal (indicated prevention) and syndromal (early intervention) BPD. This also avoids unnecessary disputes about whether someone is eligible for the programme because of arbitrary diagnostic thresholds when there is a clear need for care. Nonetheless, operational criteria for personality pathology should be rigorously applied, often supported by semi-structured interview. This is especially so because DSH is relatively common among adolescents and young adults (Nock, 2010) and although it is commonly associated with BPD, it is also associated with a range of

other clinical syndromes, which often present clinically as 'blends' of psychopathology, rather than prototypical 'adult' syndromes.

Fitting the Treatment to the Patient (Not the Patient to the Treatment)

The very nature of BPD makes it unrealistic to expect that young people with BPD will organise themselves to attend regularly in the early phase of treatment. Rather, increased capacity for self-care and self-management is a goal of treatment. Expectations about and tolerance of disruptive behaviour needs to match the phase of intervention, while always being mindful of the safety of patients, carers and clinicians.

Youth with BPD often have difficulty fitting in with (adult) clinicians' expectations to attend appointments regularly and on time. HYPE adopts a flexible (time and location of appointments) and transparent (processes and policies) approach to engagement. When clinicians' needs (e.g. duty of care) might be experienced as being at odds with the patient's expressed needs, this is acknowledged. The CAT model facilitates this discussion through the early establishment of common ground. Our approach to challenges to engaging and treating young people and strategies for managing these difficulties are described elsewhere (Chanen & McCutcheon, 2008a; McCutcheon, Chanen, Fraser, Drew, & Brewer, 2007).

Responsibility for attendance is progressively handed over to the patient. Early in treatment, young people are actively followed up (e.g. telephone calls, letters and home visits) with a focus upon barriers to attendance. The early, joint development of a shared understanding of the patient's difficulties is used to promote this discussion and allows the therapist to be aware of collusion with the patient's dysfunctional relationship patterns. Early in therapy, therapist collusion might be deliberate and strategic (e.g. home visits to a passive, angry and controlling patient) to facilitate a dialogue promoting change.

Easy Accessibility

Early intervention programmes need to be offered to everyone presenting for care, rather than 'cherry picking' participants based upon non-evidence-based assumptions or judgemental attitudes about 'suitability' for therapy. Access to and use of high quality care does not require a commitment to regular psychotherapy.

Not everyone who is offered intervention will accept it and 'easy access' needs to be complemented by a mechanism for 'easy exit' after a defined period (usually 6 weeks) of vigorous attempts at engagement. Exit should also be accompanied by an invitation to return when needed.

Because co-occurring psychopathology is the norm in BPD, programmes need to have limited exclusions for co-occurring psychopathology, especially substance use disorders. Also, as described above, some of this psychopathology represents precursor signs and symptoms for BPD. Co-occurring psychopathology should be addressed within the overall BPD treatment plan, rather than provide a reason to fragment the patient and their care. This is particularly important in BPD, as every increase in the number of agencies involved also increases the potential for miscommunication. Multi-agency involvement is typical for this patient group. HYPE case manager/therapists adopt the same active, open, transparent and collaborative attitude with all concerned. The jointly constructed reformulation is used (with the patient's consent) within the CAT approach to promote a shared, plain-language understanding of the patient's difficulties that ensures all are 'singing from the same song sheet' and minimises professional disputes or 'splits' (Kerr, 1999). This model also facilitates advocacy on behalf of the young person.

Time-Limited and Intermittent Intervention

Time-limited intervention is a means of providing the young person with an opportunity to practice what they have learned in treatment and sets the expectation at this early stage of illness of living a fulfilling and functional life. Given the young age of this patient group, it is also a means of avoiding prolonged and/or collusive relationships from developing. Pragmatically, it also increases the capacity of the

programme to see a sufficient number of individuals to achieve its prevention aims.

Limiting Iatrogenic Harm

The time limit also serves to limit the potential for iatrogenic harm, which is unusually high in BPD (Mulder & Chanen, 2013) and a particular risk associated with early diagnosis and intervention.

Service Context

The HYPE programme (Chanen, McCutcheon, et al., 2009) is part of Orygen Youth Health (McGorry, Parker, & Purcell, 2007), the government-funded youth mental health service in western and north-western metropolitan Melbourne, Australia. Orygen services a catchment population of approximately 160,000 15–25-year-olds and offers a comprehensive mental health service for severe mental disorders.

Referral and Initial Assessment

Youth with BPD commonly seek clinical help but opportunities for early intervention are frequently missed (Chanen et al., 2007). Referrals are made to Orygen's single point of entry and are usually precipitated by symptoms of another disorder (e.g. major depression), not BPD *per se*. First episode psychosis patients are always allocated to Orygen's Early Psychosis Prevention and Intervention Service, regardless of comorbidity.

Selection of Patients

The primary inclusion criterion for HYPE is having three or more DSM-IV BPD criteria. Previously published data (Chanen, Jovev, Djaja, et al., 2008) indicate that 39 % of non-psychotic patients assessed at Orygen meet this threshold. This threshold reflects HYPE's mixed indicated prevention and early intervention mission (Chanen, Jovev, McCutcheon, et al., 2008), recognises the dimensional nature of BPD (Zimmerman, Chelminski, Young, Dalrymple, & Martinez, 2012), and reduces practical disputes about 'eligibility' when there is a clear clinical need for intervention, such as when there is prominent parasuicidal behaviour, impulsivity and affective instability, without meeting the threshold for a categorical diagnosis of BPD.

HYPE has no specific exclusion criteria for other forms of psychopathology in recognition of the heterogeneity of BPD, where comorbidity is the norm at any age (Chanen et al., 2007). Low IQ is not a contraindication to treatment in HYPE, provided the individual has sufficient verbal skills to participate in the programme.

Patients are not compelled to attend HYPE. Those with substance use problems or a history of overt aggression are asked not to attend appointments while intoxicated and to respect the safety of themselves and others while at Orygen. However, there is no 'behavioural contract' with new patients, as this is often experienced as both provocative and an invitation to a battle for control. Rather, these issues are addressed if and when they arise during referral, assessment or treatment, using the CAT model.

Screening and Assessment of BPD in Young People

Despite its high prevalence in clinical services, many clinicians lack the skills or confidence to assess BPD in young people. BPD often complicates assessment, frequently causing patients to feel intruded upon or overwhelmed. Operationally, a BPD criterion is defined as 'present' if it is displayed outside any period(s) of other major mental disorder(s), such as major depression, and there has been a recurrent pattern for 2 or more years (1 year longer than required for adolescents in the DSM-IV). Clearly, many PD features are exacerbated by other periodic mental disorders but they must be present, at least to some degree, outside of these periods.

Sometimes, distinguishing mental state from trait-based problems can be difficult but our overall experience is that the process (described elsewhere, Chanen, McCutcheon, et al., 2009) is usually uncomplicated. Assessment can be

facilitated by using a screening instrument, such as the 15 BPD items from the Structured Clinical Interview for DSM-IV Axis II disorders (SCID-II) Personality Questionnaire and its operating characteristics in outpatient youth have been described elsewhere (Chanen, Jovev, Djaja, et al., 2008). A score of 13–15 (out of 15) indicates a possible BPD diagnosis and 9–12 a possible sub-syndromal BPD diagnosis. Detailed clinical assessment for BPD is then conducted, supplemented by a semi-structured BPD interview (e.g. SCID-II BPD module).

Treatment Model

The elements of HYPE's integrated, team-based treatment model are described above (Principles of Early Intervention). A single practitioner (called a case manager) provides both psychotherapy and case management and all patients are jointly managed with a psychiatrist (or senior psychiatric trainee) and reviewed weekly by the entire treating team. The reasoning behind this model is both pragmatic and theoretical. First, integrating therapy, case management and psychiatric care minimises the number of clinicians involved, reducing opportunities for disputes or 'splits' among professionals. Second, combining therapy with case management provides opportunities to generalise progress in therapy to other problems and situations. Third, the costs involved in having two clinicians (therapist and case manager) per patient are relatively higher, as the work is never divided *pro rata*. Finally (and in our view most importantly), a team-based approach, provides a supportive environment for clinicians and facilitates the development of a 'common language' through a shared model of BPD and appropriate interventions for the disorder.

Although they are combined, the model clearly distinguishes between therapy and case management in order to avoid therapy sessions being 'hijacked' by day-to-day crises. Case management is defined as work that focuses upon general psychiatric care, housing, educational or vocational issues, family matters, liaison with other services and agencies and the management of suicidal crises or deliberate self-injury. Therapy is defined as time spent using the therapeutic approach and specific tools of CAT (see below), reflecting upon how and why the presenting problems have emerged and recur and the development of more adaptive ways of coping in the context of a benign and supportive therapy relationship. Although sessions normally observe a 'fifty minute hour', shorter sessions are possible, depending upon the capacity of the individual to manage therapy. This allows therapists to address patients' often unpredictable needs by offering some case management in addition to therapy within a realistic time frame. If the minimum amount of therapy (usually 25 min) is not achieved, another therapy session is scheduled in its place, preferably in the same week. If therapy sessions are repeatedly disrupted, this becomes a focus for the therapy itself.

Consent, Confidentiality and 'Informed Refusal'

Verbal informed consent is routinely obtained from the young person, along with parental or guardian consent. The right to and limits of confidentiality are clearly outlined to all involved at the outset and a clear statement is always made that 'duty of care' will prevail and that the safety of the young person and others is paramount.

BPD directly and adversely affects young people's capacity to access and use treatment services. Failure to attend appointments and other forms of non-communicative behaviour are expected and are not immediately interpreted as refusal of treatment. HYPE emphasises engagement and outreach, initially to inform potential patients about the actual nature of the treatment programme (often dispelling unfounded fears) and the risks and benefits of participating or not. Following 6 weeks of vigorous efforts to engage the young person (at least weekly phone calls, letters and home visits, where appropriate), non-attendees are discharged with an invitation for re-referral. A clear message of refusal is always respected, unless duty of care considerations must prevail.

The Episode of Care

Our clinical experience is that most youth drop in and out of treatment and prefer time-limited therapy contracts. This notion of 'intermittent' therapy for personality disorders has received some support in the literature (Paris, 2007). The CAT time limit does not preclude future episodes of CAT, either completing the balance of the 16-session intervention or in the form of 'booster' sessions. The emphasis in CAT is upon having an agreed ending, which is usually achieved. For those patients who do have a planned ending (as opposed to dropping out), the usual practice is to discharge them after their first follow-up appointment.

Family Involvement

Family conflict is a prominent feature of adolescent PD and 37 % of HYPE patients are not living with any biological parent by mean age 16 years (Chanen et al., 2007), rising to 57 % by mean age 19 years (Chanen, McCutcheon, et al., 2009). Consistent with young people's preferences, the HYPE intervention is mostly individually based but the usual practice is to at least involve family members or carers in assessment, treatment planning and psychoeducation and to provide support within the limits of confidentiality and resources. The primary aim of this involvement is to facilitate engagement and change in the patient. Where indicated, HYPE offers more formal family intervention sessions, conducted by the primary therapist and another HYPE clinician, as appropriate, within the overall CAT model.

Psychoeducation, Stigma and Discrimination

The BPD diagnosis is communicated with cautious optimism, based upon the natural history of improvement in BPD traits (Chanen, Jovev, McCutcheon, et al., 2008), the evidence supporting the effectiveness of the HYPE intervention (Chanen, Jackson, et al., 2008, 2009), and the natural limitations of such interventions. Education and training for patients and professionals about the nature of BPD in young people emphasises that they have infrequently entered into the mutually hostile relationship with the health system that often characterises adult BPD. There is little need to 'undo' iatrogenic complications or adopt defensive or discriminatory institutional practices, such as prohibiting inpatient care.

Pharmacotherapy

There are no methodologically sound studies of pharmacotherapy for BPD in young people. Psychotherapy and case management are given primacy in the treatment model and pharmacotherapy is presented as an adjunctive collaborative endeavour for co-occurring mental state (Axis I) disorders, such as mood or anxiety disorders, within the CAT model. The potential for polypharmacy is monitored (and discouraged) through weekly clinical review meetings.

After Hours Response and Inpatient Care

Written management plans are developed for all patients and made available electronically to Orygen's 24-h crisis team. These outline the jointly developed formulation of the patient's difficulties, current management plan and specific recommendations for management during acute crises that are based upon the shared formulation and goals developed with the patient. HYPE's primary aim is to promote appropriate self-care and self-management skills for community living and to minimise the risk of iatrogenic harm. Inpatient care is usually only used when all options for community treatment have been exhausted. Admission is usually voluntary, infrequent, brief and has specific goals. HYPE case managers work with inpatient and crisis teams to facilitate a 'common language', to minimise collusion with patients' problems and to achieve the goals of admission.

Treatment Fidelity and Supervision

Treatment fidelity and completion of the tasks of an episode of care (e.g. assessment, management planning, attendance, engagement and risk management) are monitored weekly. In common with most BPD treatment models, supervision is an

integral part of HYPE. It aims to support clinicians, allow time for reflection and to ensure a high standard of care. CAT supervision occurs weekly in small groups (two or three participants) and there is a peer group case discussion every 2 weeks. Individual case management supervision occurs once every 2 weeks.

Discharge

An explicit aim of HYPE is to promote support networks independent of mental health services and to avert unhelpful involvement with the mental health system. However, this is at odds with BPD patients' high needs for treatment of recurrent mental state disorders (Chanen et al., 2007) and their intolerance of aloneness. Referrals are often made to external, non-mental health networks for post-discharge support. Patients are also encouraged to practice what they have learned in therapy and to delay seeking further psychotherapy until their 6-month follow-up review. This does not preclude further case management or treatment of mental state disorders, as necessary. However, this is infrequently required.

Case Example: Madison

Madison was a 17-year-old female student living with her parents on the outskirts of a large city. She was referred from an Emergency Department, following an overdose of an unspecified number of tablets (paracetamol/acetaminophen, ibuprofen and zopiclone), combined with alcohol. She reported that she wanted to kill herself because her boyfriend wanted to end their 3-year relationship.

Madison reported 1 year of increasingly severe and persistent major depressive symptoms, increasing suicidal ideation, at least one other suicide attempt and several incidents of superficial cutting of her arms and abdomen. Concurrently, she also reported periods of dietary restriction and binge eating, gaining 20 kg (44 lb). She denied any history of anxiety, manic or psychotic disorder and there was no history of childhood inattention or hyperactivity.

These symptoms occurred on a background of longstanding relationship instability, impulsive behaviour (spending, alcohol and marijuana use, binge-eating), affective instability, feelings of emptiness and recurrent episodes of derealisation that lasted several minutes to an hour. She also reported 3–4 years of fluctuating low-grade depression, lack of motivation, feelings of worthlessness and suicidal ideation.

Madison began smoking tobacco and marijuana, and binge drinking alcohol with friends up to three times per week between the ages of 12 and 15 years. More recently, she only engaged in impulsive substance use (approximately weekly) when she felt low or upset.

Madison was the eldest of three girls and lived in an intact family. She was a planned pregnancy. She was described as a relaxed baby and generally her early childhood was unremarkable.

Her father was in the armed forces and the family relocated frequently and they struggled financially. Madison's father was often away for many months and her mother took part-time jobs outside the home. Madison and her younger sister were often left in the care of military friends or neighbours. Sometimes they were left unsupervised.

Madison changed schools frequently and her reading difficulty was not picked up until grade 4. At age 11, she disclosed that a male babysitter had sexually abused her several years earlier and she received six sessions of psychiatric care.

The family settled in one place when Madison began secondary school and her third sister was born. Madison's difficulties became substantially worse and her parents responded with increasing control and restrictions. This was met with increasing rebellion, which in turn exacerbated her parents' anxiety and authoritarian responses. She started dating a 16-year-old male and at age 14, she dropped out of school. She ran away from home for several days, used drugs and was sexually assaulted. Eventually, she was placed in foster care for 6 months, which allowed her to re-engage with school and for the conflict to settle enough for her to return home.

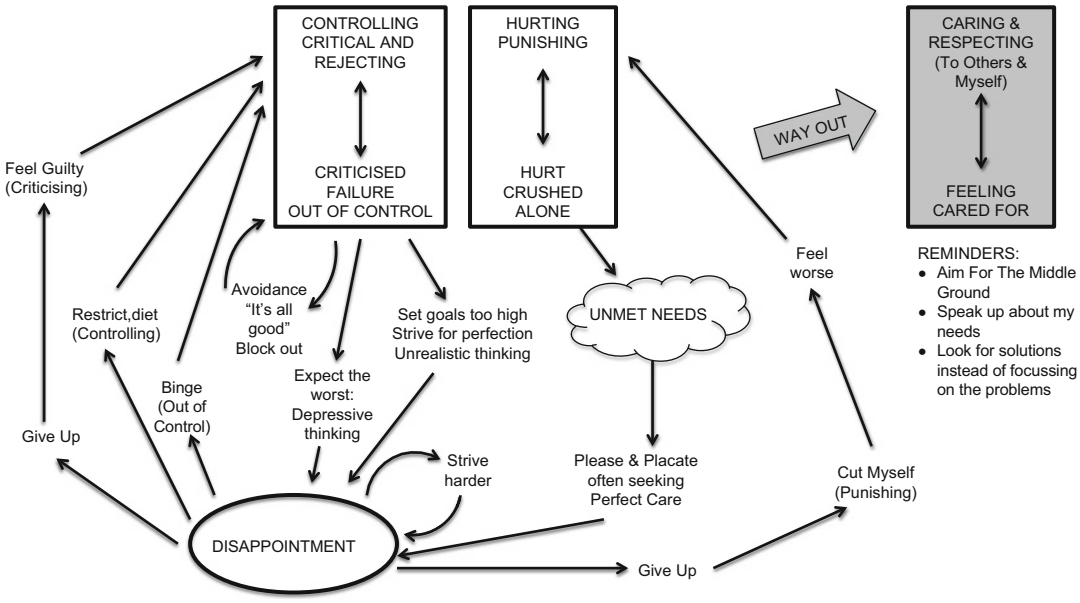

Fig. 23.4 Madison's sequential diagrammatic reformulation

Treatment

Madison was offered the standard HYPE programme, including 24 sessions of CAT, psychologically informed case management and general psychiatric treatment. Initial case management included two sessions with Madison alone, and one with her parents for an introduction to the service, assessment and psychoeducation. Around half way through the therapy, the therapist also visited her school to facilitate the transition into her final year of secondary school.

The shared goals for her treatment were to treat her major depression, reduce her risk-taking and to understand the relational patterns that drove her to feel bad about her ownself and to binge-eat.

Madison had regular psychiatric reviews during her 10-month episode of care as part of the team-based care. Antidepressant use was discussed early in her care but Madison declined. She did not receive any pharmacotherapy.

The first four sessions of CAT focused both upon her current difficulties and exploration of her developmental experiences. Madison felt cautious about discussing family relationships, resulting in a noticeable sense for the therapist to 'tread carefully'. She often answered the therapist's enquiries by saying that things were 'all good' and that she knew that her parents loved and cared for her. This was usually followed by bewildered silence, during which she sometimes stated that she couldn't understand why she felt so bad.

Madison's caution in talking about her early experiences was explored, especially the possibility that she might feel judged or criticised. Madison was able to identify that she had learned from her parents to set high goals, and to judge herself as a failure if she didn't manage to achieve these goals.

The first relationship pattern (Reciprocal Role) that was clearly identified was the one in which she felt others were *controlling*, *critical and rejecting* towards her (see Fig. 23.4). Initially, she could only state that in response to this, she felt overwhelmed, upset, angry and not good enough. Words that best described these feelings were added and changed over the next few sessions, in order to better capture the self-state and responses they elicited.

Madison was able to notice that she often expected others to be critical of her efforts, and this commonly led to her avoiding situations in

which she felt that she might be scrutinised. Discussion of her substance use revealed that this was a highly effective way of avoiding difficult emotional states. Over time, she was also able to acknowledge that this strategy was only effective in the short-term. She was surprised to consider that perhaps her 'risk-taking' and substance use looked 'out of control' to others, and therefore invited others to attempt to control her more. This exploration of the dyadic nature of the relationship pattern was a surprise and seemed to be engaging to her. The exploration of patterns during the early sessions was tentative and the therapist was able to sketch out some of these patterns to assist in keeping the sessions collaborative and open, and to demonstrate a sense of shared exploration of her experiences. This was a preliminary Sequential Diagrammatic Reformulation (which was developed into Fig. 23.4 over the course of therapy).

As well as making sense of the historical relational themes in her family, Madison was able to talk about her problems with her current boyfriend, which had precipitated the referral. Madison felt that their relationship had gone well for 2 years but, over the past 18 months, they had broken up and reconciled several times. She identified that she spent most of the time fearing he would leave, and therefore attempting to placate him, in the desperate hope that he would return her love and that she would feel 'perfectly' cared for.

Discussion explored how the second Reciprocal Role pattern (Hurting and Punishing—Hurt, Crushed, Alone) had been internalised and was often enacted 'self-to-self' (when Madison was overcome by the distress of feeling like a failure) or enacted by others to her (in response to her impulsive risk-taking). Examples included when she verbally abused herself for becoming angry or for breaking her diet or when she became angry and punishing towards her sisters or her mother or boyfriend. Madison discovered that she spent a lot of time feeling depressed and guilty and thinking about punishing or killing herself.

Madison came to understand that these patterns developed because, as a young child, she had been very sensitive to her mother's isolation and worries. She learned to please her mother and to try to protect and look after her younger sister. The family moved around so often that Madison became good at making friends quickly. However, she also learned to not trust others fully, waiting for something to go wrong or for people to reject her or let her down.

Madison also identified that when she felt that she wasn't living up to others' or her own expectations (e.g. to do well at school), she felt guilty and turned to self-punishment. She also became increasingly disillusioned and rebellious. It was easier to excel at being bad than being good. She also learned that alcohol and drugs took away her feelings and concerns quickly and efficiently, even if only for a short time. She also discovered that her increasingly rebellious and dangerous behaviour had unanticipated consequences because it elicited either greater control and restrictions (e.g. from her father) or rejection from others (e.g. teachers and some peers). It also led to her disengagement with school and this invited self-criticism about her lack of purpose in life.

These discussions and discoveries were jointly summarised in her prose 'Reformulation Letter' (Fig. 23.5), which was read aloud at session 4.

Madison missed the subsequent two sessions after the letter was read out. She later said that she had obtained a job after school and in the excitement had not thought of calling to cancel. However, this allowed a conversation about possibly feeling criticised by the letter and also about her needs and those of her therapist. This led to an agreement to attempt to contact to reschedule in the future.

The middle phase of therapy was spent exploring and detailing the patterns initially outlined, and developing a clearer understanding of how these had emerged and how they were enacted between her and others as well as with herself.

Madison was very focused on issues in the present such as her relationship with her boyfriend, completing her secondary schooling and her weight. She was able to engage in the process of monitoring the identified patterns, and to work toward devising new strategies. She was able to

Fig. 23.5 Excerpts from Madison's reformulation letter

Dear Madison,

We have started trying to understand how your feelings of sadness, anger and depression started. When we first met these were so consuming, you felt you couldn't go on and had tried to take your own life.

You remember moving around a lot as a child, following your father who worked in the army. Your family often had to stick together and were cut off from friends and relatives who could support you and your parents. You feel protective of your Mum, and know that it was tough for her looking after you and your sisters on her own for long periods of time while Dad was away. You feel that she tried hard to give you attention and care, but also you can see that she relied on you a lot. On the one hand this might have felt special but on the other, it also led to you expecting more and more of yourself. You tried hard to please Mum, to do the right thing and to be the 'perfect child' you thought she wanted. I guess that the more she relied on you, the harder you probably tried to be the 'support' that she seemed to need? When you couldn't always keep this up, or know what she wanted, you started to feel guilty and angry with yourself. It seems that you developed high expectations of what you should be able to achieve. Whatever you did, it had to be perfect and when it wasn't, you would be upset and angry with yourself. Perhaps this was your way of trying to manage the unpredictable world that constant moving around created. It also led to a feeling of almost constant dissatisfaction and unhappiness, because things were never good enough and you often blamed yourself.

As you grew older, you took on more responsibility for helping your Mum, and felt more and more guilty about having any needs of your own at all. Even when other people had hurt you, you covered this up feeling ashamed, blaming yourself.

By high school, you were feeling so trapped and unhappy, and you were sick of trying to be the 'good girl'. You started staying out and smoking dope, trying to take away those sad feelings and to feel you were in charge of things yourself – even though this also meant that things got worse. You felt that your parents were always criticising, blaming, and making unreasonable demands of you. You felt angry and thought that you might as well go and do all those bad things they accused you of! When you were 14, things finally seemed to snap. After a fight at school, you ran away and slept wherever you could for a week, mostly smoking dope with your friends. Your parents tried to pull you back into line. There were lots of arguments and you felt you had to fight and resist them.

You went to live with Tina and her family for 6 months, and there you felt more understood. There were some attempts to get you all talking more, and your parents let you know they loved you and wanted you back. You realised that things were not working out very well, and you worked hard to try to settle down. In particular, you stopped smoking dope as much and you felt a bit less angry. Then things changed for you again when Tina moved away.

You went home and tried to sort things out with your parents. You tried doing a course but then went back to school to do year 11. Most of this time, you felt down and that nothing could make you happy. You began bingeing when you felt upset. You would feel even more disappointed and guilty after these episodes. This made it harder to let people know you were upset and you got better and better at keeping it all locked inside. You also learned how to cut off from your feelings, to look from the outside like you were coping. You have become so good at this and others often don't really know how you feel. This keeps them out of your business, but it also means they can't support you either. By pushing others away, you stop them from being able to care and support you, even though this is actually often what you really want from them. It also means that you often go on feeling lonely.

It seems that all through the ups and downs of the last few years, your relationship with Will has been important. When you first started seeing him, he seemed so perfect. He was older and exciting and everything seemed so good. It felt like you were the centre of his world and this was just what you had been hoping for. After a few months, you began to feel that he wasn't always interested in you the way you wanted he to be. He wanted to spend more time with his friends than with you, and you felt overlooked and ignored. The more you asked of him, the more he pushed you away. So you tried bottling it up inside and not letting him know how you felt. This just led to more disappointment. When you broke up a year ago, you felt so devastated that you started to really punish yourself. As if this all meant that you were somehow a 'bad' person. Whether you do this by bingeing, harming yourself or bending over backwards to please others, none of these solutions lead to you feeling any better. Mostly they all lead to you feeling worse and more stuck.

Madison, it seems that while you did have some experiences of feeling cared for, by Mum and others, you have often found yourself feeling it is not enough, or hoping for 'more perfect' care from others. This frequently leads to feeling disappointed and let down when they cannot give you this. Similarly, your expectations of yourself are so high, that you are bound to feel 'let down' and disappointed with yourself. The solutions you tried were self-punishment and avoidance, but these make you feel depressed and haven't led you out of these vicious circles.

Regards,
(therapist)

Fig. 23.6 Excerpts from Madison's 'goodbye letter'

Dear Madison,

It seems to me that over the time that I have known you, you have been keen to sort things out better and to learn how to do this for yourself. I have seen you get better and better at letting people know what you think and what you need. You have been practicing how to be more assertive, and have been able to let me know when you were not sure where our sessions were headed, or when you thought we should talk more about a particular issue. You have also started to consider which friends treat you the way you want to be treated. These are very important skills that we all need to learn, and I feel confident that you can go on developing these skills into the future.

I said to you last week, that I feel this therapy is just the beginning. Not of a life of therapy, but a life of reflecting on what works for you and what doesn't. It is the beginning for you in lots of ways and this is bound to be both scary and exciting. I hope you can look back on this time as having been one in which you learned some skills that will help with this. There are still aspects of this work which may need more attention than others parts. For you, I wonder whether you still need to look out for your harsh Critical Voice, which tends to make little of your achievements and stops you enjoying the results of your hard effort? I hope that you can get better at turning this voice down so you can smell the roses a little more!

Madison, you have been very reliable, and thorough, and this tells me about how committed you are to sorting things through, even when this is tough. I know that you are a determined person, and that this will stand you in very good stead through the ups and downs ahead. I have also been very impressed by the strong caring side of you. You see injustice and things that are not right and want to do something about them. I think the world needs more people like you!

Last week we talked about the mixed feelings you have about finishing therapy. I too will miss our meetings and will look forward to the follow-up sessions to hear how things are going for you. I also know that it has been an achievement for you to complete this therapy, and I would like to congratulate you on doing well. I am sure that you will probably have other moments of doubt, sadness and even despair in the future. Nevertheless, I feel confident that you can overcome these.

I wish you all the best,
(therapist).

reflect and to consider what she wanted from the therapy relationship, and was able to accept being challenged by her therapist when she appeared to be avoiding a particular topic or issue.

As Madison gradually became more trusting, open and able to reflect upon the relationship patterns being enacted, her mood improved and her risk-taking decreased. She became more able to challenge her high expectations, especially about her school performance, and she became more open with what she wanted from others.

As she approached the final few sessions, she expressed some reticence about whether she would be able to manage after termination. However, she felt generally proud of her achievements thus far and reassured by her therapist's confidence that she could continue the work begun in therapy on her own.

One of the main challenges that Madison faced at the end of therapy was her difficulty applying her newly developed strategies to her frequent binge eating. She attempted to focus upon healthy eating, rather than dieting, and to take a more 'non-judging' and 'accepting' position in relation to her disappointment about her weight and body. By the end of treatment, her binge eating had reduced but not completely resolved and Madison still felt disappointed.

In the final session, her therapist read her a *goodbye letter* (Fig. 23.6) that summarised her therapist's view of Madison's progress through therapy. Madison declined the invitation to write her own *goodbye letter*, opting for a verbal discussion of her experience of the therapy in the final session. Madison was offered four follow-up appointments but only felt the need to attend two of these, at 1 and 2 months after termination and chose not to make the final two follow-up appointments.

Remaining Barriers and Potential Risks for Prevention and Early Intervention

Despite evidence of sufficient reliability and validity for the BPD diagnosis in young people,

stigma is a key lingering barrier to the early diagnosis of BPD in day-to-day clinical practice. BPD is highly stigmatised among professionals (Aviram, Brodsky, & Stanley, 2006) and it is also associated with patient 'self-stigma' (Rusch et al., 2006). This fuels the perception that the diagnosis is 'controversial' (Chanen & McCutcheon, 2008b) and clinical experience suggests that many clinicians will deliberately avoid using the diagnosis in young people with the aim of 'protecting' individuals from harsh and/or discriminatory practices.

While concerns about stigma are genuine and the response is well intentioned, we believe that this practice runs the risk of perpetuating negative stereotypes, reducing the prospect of applying specific beneficial interventions for the problems associated with BPD, and increasing the likelihood of inappropriate diagnoses and interventions and iatrogenic harm (such as polypharmacy).

There is now robust support for the early diagnosis of BPD. The UK National Institute for Health and Clinical Excellence (NICE) (National Collaborating Centre for Mental Health, 2009) and the Australian National Health and Medical Research Council (National Health and Medical Research Council, 2012) guidelines for BPD support the diagnosis of BPD in adolescents and the forthcoming ICD-11 is proposing to remove age-related caveats on the diagnosis of PDs (Tyrer et al., 2011). Moreover, the ICD will include the identification of subthreshold personality pathology. These innovations foster not only the early diagnosis of BPD but also the identification of subthreshold BPD, supporting the aims of indicated prevention and early intervention. However, this will bring into the clinical realm, young people (and adults) who might once have been considered 'colourful' and potential benefits are accompanied by potential risks associated with 'medicalising' common problems; risks that are not confined to the field of BPD (Mulder, 2008).

Conclusion and Future Perspectives

BPD should now be seen as a lifespan developmental disorder with substantial ramifications across subsequent decades. Consequently, intervention at any stage should aim to alter the life-course trajectory of borderline personality pathology, not just its diagnostic features. At present, there is sufficient evidence to support diagnosing and treating the BPD syndrome when it first appears becoming part of routine clinical practice. This has never actually been precluded in the DSM-IV but has been explicitly adopted by the NICE and NHMRC guidelines for BPD (National Collaborating Centre for Mental Health, 2009; National Health and Medical Research Council, 2012) and it is likely to be supported by the ICD-11. There are also data showing that targeting subsyndromal borderline pathology through indicated prevention is a promising and clinically justified approach and that the benefits of intervention appear to outweigh the risks. However, this approach requires further development and evaluation over longer periods in order to ensure that there are no significant 'downstream' adverse effects.

Indicated prevention and early intervention also offer a unique platform for investigating BPD earlier in its developmental course, where duration of illness factors that complicate the psychopathology and neurobiology of BPD can be minimised. This might make more sense of the confusing array of biological and psychopathological research findings in BPD.

In the future, a more detailed understanding of individual and contextual risk factors, precursors, pathways and mechanisms for the development of BPD might enable the development of universal or selective preventive approaches, but these are likely to require the joint effort of research groups aiming to prevent the range of major mental disorders. 'Clinical staging' (McGorry, 2010) for BPD, which is analogous to disease staging in general medicine, offers a potential integrating framework for selecting appropriate interventions and predicting outcome. A key implication of such an approach is that treatment needs will differ by phase or stage of disorder, and by socio-

cultural context (Kirmayer, 2005; Paris & Lis, 2013) with the possibility that interventions might be more benign and/or effective in earlier phases of BPD.

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