The HYPE Clinic: an early intervention service for borderline personality disorder.

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Borderline personality disorder (BPD) usually emerges during adolescence and young adulthood and has profound effects throughout this vulnerable developmental phase and beyond. Hitherto, clinical interventions for BPD have focused on individuals with established and/or chronic forms of the disorder. However, over the past 15 years, a body of evidence has developed supporting the reliability, validity, and clinical importance of the diagnosis of BPD in adolescence, underscoring the need for prevention and early intervention for BPD. This paper describes the work of the Helping Young People Early (HYPE) Clinic in Melbourne, Australia. HYPE is a novel indicated prevention and early intervention service for BPD in youth (15–25 years of age). It uses an integrated, team-based intervention model comprising time-limited cognitive analytic therapy as developed by Ryle, case management, and general psychiatric care. The HYPE intervention is supported by effectiveness data. (Journal of Psychiatric Practice 2009;15:163–172)

KEY WORDS: borderline personality disorder, prevention, early intervention, adolescence, youth, young people, psychotherapy, comorbidity

Borderline personality disorder (BPD) usually emerges during adolescence and is estimated to affect 0.9% to 3% of community-dwelling teenagers and up to 3.5% of young adults. Limited data suggest that the outpatient prevalence of BPD is 11% in adolescents and 22% in youth (15–25 years of age). In inpatients, this prevalence rises to 49% in adolescents and 42% in young adults. Similar to BPD in adulthood, BPD in adolescence is associated with marked psychopathology and functional impairment and is prospectively associated with diverse functional and psychopathological poor outcomes, including a future diagnosis of BPD, increased risk for Axis I disorders (especially substance use and mood disorders), interpersonal problems, distress, and reduced quality of life. Moreover, these functional impairments appear to persist for decades.

We have previously outlined the case for developing early intervention strategies for BPD and a strategy for identifying patients for such programs through screening. Current data support targeting groups with precursor signs and symptoms (indicated prevention), along with early intervention for first-presentation BPD. Given the absence of any significant discontinuity between adolescent and adult BPD, such services should cross the traditional age bound-
aries between adolescent and adult services. To our knowledge, no services explicitly targeting this early phase of BPD have been developed and evaluated.

This paper describes the Helping Young People Early (HYPE) clinic, a unique service developed to provide both indicated prevention\(^1\) and early intervention\(^1\) for BPD. The goal of this service is to offer optimal effective treatment as early as possible in the course of BPD and to ensure that this intervention is appropriate to the phase of the disorder and to the developmental phase of the individual and his or her family. This focus distinguishes the HYPE program from the small number of worthy adolescent BPD services internationally that usually offer interventions to individuals with a severe and already entrenched disorder. The data presented in this paper are based on an audit of 169 consecutive cases seen in the HYPE clinic between August, 2002, and November 2005.

**SERVICE CONTEXT**

Adolescents with BPD commonly seek clinical help,\(^9,13\) but opportunities for early intervention are frequently missed.\(^9\) Clinicians often consider it controversial to diagnose personality disorders (PDs) in adolescents.\(^14\) Such diagnoses are frequently either discouraged or made too late, when functional impairment and iatrogenic complications have become entrenched. While the diagnosis is arguably less controversial in young adults, our clinical experience suggests continued reluctance to diagnose PDs early in the course of the disorder.

The HYPE clinic is part of ORYGEN Youth Health,\(^15\) the government-funded youth mental health service in western and northwestern metropolitan Melbourne, Australia. ORYGEN provides services to a catchment population of approximately 150,000 individuals who are 15 to 25 years of age and offers comprehensive mental health care for both psychotic and nonpsychotic disorders. Founded in 1998, HYPE became fully operational in 2000 as a service for patients who were 15 to 18 years of age, which was later extended to include patients up to 25 years of age.

**Referral and Initial Assessment**

Referrals are made to ORYGEN’s single point of entry and are usually precipitated by a mental state disorder (e.g., major depression), not BPD traits. The range of Axis I comorbidity is detailed in Table 1. Patients with a first episode of psychosis are always allocated to ORYGEN’s Early Psychosis Prevention and Intervention Service,\(^16\) regardless of comorbidity.

**Entry and Exclusion Criteria: Characterizing the Target Group**

HYPE referrals must meet the general ORYGEN entry criteria. The most frequent referral sources for HYPE are hospital emergency departments or crisis services (25%), self-referral (24%), other healthcare agencies (18%), family or friends (17%), and educational services (5%). According to the BPD criteria in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR),\(^1\) an individual must meet five or more diagnostic criteria in order for a diagnosis of BPD to be made. The primary inclusion criterion for HYPE is meeting three or more DSM-IV-TR BPD criteria. This lower threshold reflects HYPE’s mixed indicated prevention and early

### Table 1. Sample characteristics and diagnostic data for 169 consecutive referrals to HYPE

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (standard deviation)</td>
<td>19.0 (2.7)</td>
</tr>
<tr>
<td>Female sex, n (%)</td>
<td>137 (81%)</td>
</tr>
<tr>
<td>Australian born, n(%)</td>
<td>138 (82%)</td>
</tr>
<tr>
<td>Never married, n (%)</td>
<td>153 (91%)</td>
</tr>
<tr>
<td>Occupation, n (%)</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>73 (43%)</td>
</tr>
<tr>
<td>Student</td>
<td>55 (33%)</td>
</tr>
<tr>
<td>Part-time or full-time employment</td>
<td>32 (19%)</td>
</tr>
<tr>
<td>Home duties</td>
<td>7 (4%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Living with at least one parent, n (%)</td>
<td>80 (47%)</td>
</tr>
<tr>
<td>Number of DSM-IV-TR BPD criteria, mean (standard deviation)</td>
<td>4.5 (1.3)</td>
</tr>
<tr>
<td>Current full syndrome BPD diagnosis, n (%)</td>
<td>72 (43%)</td>
</tr>
<tr>
<td>Current Axis I diagnoses, n (%)</td>
<td></td>
</tr>
<tr>
<td>Any mood disorder</td>
<td>115 (68%)</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>25 (15%)</td>
</tr>
<tr>
<td>Any substance use disorder (excluding nicotine)</td>
<td>28 (17%)</td>
</tr>
<tr>
<td>Any disruptive behavior disorder</td>
<td>11 (7%)</td>
</tr>
<tr>
<td>Any eating disorder</td>
<td>14 (8%)</td>
</tr>
</tbody>
</table>
intervention mission\textsuperscript{10} and recognizes the dimension-
al nature of BPD. Setting a lower threshold also reduces practical disputes about “eligibility” when there is clear clinical need for intervention (e.g., prominent parasuicidal behavior, impulsivity, and affective instability), even though the individual does not meet the DSM-IV-TR threshold for a categorical diagnosis of BPD. Previously published data\textsuperscript{6} indicate that 40\% of nonpsychotic patients assessed at ORYG-
EN (approximately 200 patients/annum) meet the threshold of at least 3 BPD criteria.

HYPE has no specific exclusion criteria for other forms of psychopathology, because psychiatric comor-
bidity is the norm in BPD in youth and adulthood.\textsuperscript{9,18} In fact, childhood or adolescent disruptive behavior disorders, depressive symptoms,\textsuperscript{2,19} and substance use disorders (particularly alcohol use disorders) are important precursor signs and symptoms\textsuperscript{20} for BPD (signs and symptoms predictive of later BPD symp-
tomatology) and are reviewed in detail elsewhere.\textsuperscript{10} Intellectual disability is also not an absolute con-
traindication to treatment in HYPE, provided the individual has sufficient verbal skills to participate in the program. Patients who do not wish to attend HYPE are not compelled to do so (see discussions of “Consent and Confidentiality” and “Informed Refusal” below). Those with substance use problems are asked not to attend appointments while intoxicated. Patients are also asked to conduct themselves with respect for the safety of themselves and others while at ORYGEN. However, there is no explicit behavioral contract, because 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 within the overall treatment model (see below).

Screening and Assessment of BPD in Young People: Distinguishing State from Trait

Despite the high prevalence of BPD in the clinical services, many clinicians lack the skills or confidence to assess adolescent BPD. Our experience is that diagnosing BPD in young people is feasible and usually uncomplicated. However, assessing whether problems are state- (Axis I) or trait- (Axis II) based can be problematic in youth, because the DSM-IV-TR lacks suitable, developmentally appropriate illustrations of PD criteria\textsuperscript{5} and also because comorbidity with Axis I disorders is common in adolescent BPD.\textsuperscript{9} In addition, BPD itself often complicates assessment, since it frequently causes patients to feel intruded upon or overwhelmed (see discussion of “Difficulty Engaging” below).

HYPE uses the 15 BPD items from the Structured Clinical Interview for DSM-IV Axis II disorders Personality Questionnaire (SCID-II-PQ\textsuperscript{21}) to screen all nonpsychotic ORYGEN patients.\textsuperscript{8} Individuals scoring 9 or greater (9–12 for subsyndromal BPD; 13–15 for full syndrome BPD) receive a detailed clinical PD assessment, which includes the SCID-II BPD interview module. Reliability of diagnoses is maintained through a consensus diagnosis process (with a senior HYPE clinician) for each DSM-IV-TR BPD criterion.

Detailed BPD assessment is usually assisted by a timeline, which is jointly constructed with the patient. Meaningful personal historical events (e.g., birthdays, holidays, losses) are marked along a line, charting the previous 24 months or more. The onset and offset of mental state disorders is highlighted, allowing specific enquiry about premorbid or inter-
morbid personality traits and the patient’s usual self. Mood variability can be charted by adding a ver-
tical (y) axis on the left hand side (scaled from +10 (euphoria) to zero (euthymia) to −10 points (severe depression). Periods of persistent low mood are then explored for associated major depressive symptoms and, if present, are marked as major depressive episodes. The same technique can be used with informants. Operationally, a BPD criterion is defined as present if it is displayed outside of any periods of diagnosable Axis I disorders and there has been a recurrent pattern for 2 or more years (1 year longer than required for adolescents in the DSM-IV-TR). Clearly, many PD traits are exacerbated by periodic Axis I disorders, but the traits must be present, at least to some degree, outside of these periods in order to diagnose a PD.

TREATMENT MODEL

The HYPE clinic employs an integrated, team-based treatment model with the following elements:

\begin{itemize}
  \item Rigorous diagnosis of BPD and other personality pathology
  \item Individual cognitive analytic therapy (CAT; see below)\textsuperscript{22,23}
  \item Assertive case management (referred to in the following discussion as case management) integrated with the delivery of psychotherapy
\end{itemize}
Active engagement of families or caregivers, with psychoeducation and up to four sessions of family intervention

General psychiatric care, with specific assessment and treatment of co-occurring psychiatric syndromes (comorbidity), including the use of pharmacotherapy when indicated

Crisis team and inpatient care, with a clear model of brief and goal-directed inpatient care

Access to an activity group program that is shared with other programs at ORYGEN Youth Health

Individual and group supervision of staff

A quality assurance program.

A single practitioner provides both psychotherapy and case management and all patients are jointly managed with a psychiatrist (or senior psychiatric trainee), and each case is reviewed weekly by the entire treatment team. The reasoning behind this model is both pragmatic and theoretical. First, integrating therapy, case management, and psychiatric care minimizes the number of clinicians involved, reducing opportunities for disputes or “splits” among professionals. Second, combining therapy with case management provides opportunities to generalize 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 our experience, services often do not make this distinction clear, resulting in therapy sessions being “hijacked” by day-to-day crises. Case management is defined as work that focuses on 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 specific tools of CAT (see below), reflecting on how and why the presenting problems have emerged and recur and development of more adaptive ways of coping. Although sessions normally observe a “50-minute hour,” shorter sessions are possible, depending on 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 20 minutes) 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.

Cognitive analytic therapy. CAT is the core of the HYPE therapeutic model and the lingua franca of the team. CAT is a time-limited, integrative psychotherapy that has been developed in the United Kingdom over the past 25 years, first by Anthony Ryle and subsequently by others. 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. In CAT, the self is seen as being characterized by an internalized repertoire of relationship patterns, acquired throughout early and subsequent development. When development is suboptimal (as in the development of PDs), and early caregiving interactions are not adequately nurturing or even destructive, these relationship patterns will be internalized and used inappropriately and/or inflexibly.

CAT is practical and collaborative in style, with a particular focus on understanding the individual’s problematic relationship patterns and the thoughts, feelings, and behavioral 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 narrative and diagrammatic “reformulations” written in plain language. These written summaries form the basis for understanding relationship problems both outside and within therapy and assist the patient to recognize and revise his or her dysfunctional relationship patterns. Because of its strong relational focus, CAT has been increasingly used with more complex and relational types of disorders, especially BPD, for which it has a specific model and intervention.

CAT has particular advantages for early intervention in BPD. Its integrative approach encompasses co-occurring problems, such as other personality pathology and mental state disorders, within the overall treatment model. This is especially relevant to the needs of patients with BPD.
for addressing substance use disorders and avoids the patient having to seek separate interventions, which could open up the possibility of rejection from services or “splitting.” In addition, psychological mindedness is considered a goal of, rather than a prerequisite for, therapy in CAT. Youth, especially those with BPD, rarely present as “therapy ready” in any traditional sense, and they usually have had limited and/or adverse experiences with 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, those with learning difficulties, or even those with mild intellectual disability.

Routinely, 24 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 the maximum amount of treatment offered in any occasion of care. A lesser amount might be negotiated with the patient, especially if the patient is ambivalent about committing to treatment.

**Consent and confidentiality.** Verbal informed consent is always obtained from the young person. Given the high rate of family breakdown in adolescent BPD, parental or guardian consent is sought when appropriate and possible. Under Australian law, “mature minors” judged competent to give informed consent can give sole consent to treatment. Should this situation arise, family involvement will often become a focus of treatment.

The right to and limits of confidentiality are clearly outlined during the first interview. Parents or caregivers are always offered support while maintaining the young person’s confidentiality. A clear statement is always made that “duty of care” will prevail and that the safety of the young person and others is paramount.

**Informed refusal.** BPD directly and adversely affects young people’s capacity to access and use treatment services. Failure to attend appointments, and other forms of noncommunicative behavior, are expected and are not immediately interpreted as refusal of treatment. HYPER places a strong emphasis on engagement and outreach. One aim is to inform potential patients about the actual nature of the treatment program (often dispelling unfounded fears) and the risks and benefits of participating or not participating. Following 6 weeks of vigorous efforts to engage the young person (at least weekly phone calls, letters, and home visits when 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 PDs has received some support in the literature. The CAT time limit does not preclude future episodes of CAT, either to complete the balance of the 24-session intervention or in the form of booster sessions. The majority of patients terminate treatment prior to 24 sessions. The emphasis in CAT is on providing an agreed-on 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.

Audit data indicate that 95% of referrals receive some treatment in HYPER. The mean duration of an episode of care is 27 weeks (standard deviation [SD] 19 weeks). Eighty-two percent of patients commence CAT and attend a mean of 11 sessions (SD 7.6 sessions). Only 19% of patients are ever admitted to hospital, with a median of 1 admission (interquartile range 1–3 admissions) during their care. The median duration of admissions is 2.4 days (interquartile range 1–5 days).

**Family involvement.** Family conflict is a prominent feature of adolescent PD, and 37% of HYPER patients are not living with any biological parent by a mean age of 16 years, which increases to 53% by a mean age of 19 years (Table 1). Consistent with young people’s preferences, the HYPER intervention is for the most part individually based. However, the usual practice is to at least involve family members or caregivers in assessment, treatment planning, and psychoeducation and to provide support within the limits of confidentiality and resources. The primary goal of this involvement is to facilitate engagement and change in the patient. When indicated, HYPER offers up to four formal family therapy sessions, conducted by the case manager or another HYPER clinician, as appropriate, within the overall CAT model.
Psychoeducation and stigma. The BPD diagnosis is justified in adolescents on clinical and scientific grounds. The BPD diagnosis is communicated to the patient with cautious optimism based on findings concerning the natural history of BPD traits that show a trend toward improvement and the evidence supporting the effectiveness of the HYPE intervention. Education and training for patients and professionals about the nature of adolescent BPD emphasize the differences between this group and adult patients with BPD. Young people with BPD have infrequently entered into the mutually hostile relationship with the health system that often characterizes adult BPD. There is little need to undo iatrogenic complications or adopt defensive institutional practices, such as prohibiting inpatient care.

Pharmacotherapy. There are few methodologically sound pharmacotherapeutic studies in BPD, and none of these studies has been conducted in young people. Psychotherapy and case management are given primacy within HYPE, while pharmacotherapy is presented as a second-line collaborative endeavor. The CAT model is used to formulate decision-making about medication. When there is supporting scientific evidence, comorbid mental state (Axis I) disorders, such as depression, should be vigorously treated. 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-hour crisis team. These outline the jointly developed formulation of the patient's difficulties, current management plan, and specific recommendations for management during acute crises. HYPE's primary aim is to promote appropriate self-care and self-management skills for community living and to minimize the risk of iatrogenic harm. Inpatient care is usually only used when all options for community treatment have been exhausted. However, indiscriminate refusal of admission is not warranted, unless a patient has a clear record of misuse of inpatient care and every effort has been made to manage this problem collaboratively.

Admission is usually voluntary, infrequent, brief (see Table 1) and has specific goals. HYPE offers inpatient staff training, and HYPE case managers work with inpatient and crisis teams to facilitate development of a “common language,” in order to minimize collusion with patients’ problems and to achieve the goals of admission.

Quality assurance. 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. Case managers also complete written clinical reviews and management plans, signed by the consultant psychiatrist, at baseline and every 3 months thereafter.

Supervision. In common with many BPD treatment models, supervision is an integral part of HYPE. The goal is to support clinicians, allow time for reflection, and ensure a high standard of care. Psychotherapy supervision occurs weekly in small groups (two or three participants), and there is a weekly peer group case discussion. Individual case management supervision occurs every 2 weeks.

CASE STUDY

Presentation

Ms. K was a 16-year-old female who presented with a 6-week history of major depression, with prominent suicidal ideation, accompanied by increasing anxiety symptoms, including panic attacks. She was failing her fourth year of high school because of truancy. She smoked cigarettes and marijuana daily, binge drank (> 120 g alcohol) at least weekly, and infrequently used oral amphetamines. Ms. K lied, shoplifted, and reported intermittently engaging in fights with peers at school. She also reported becoming depressed and suicidal when her family discovered her sexual relationship with her sister's boyfriend, which led to a violent family fight and Ms. K's ostracism among her siblings. Ms. K was the youngest of three siblings. Her sisters were 24 and 30 years of age. Ms. K's parents separated when she was 2 years old because of conflict and domestic violence. Ms. K's mother worked full-time to support her family, but they struggled financially. Both elder sisters moved in and out of their mother's home. They were often aggressive, had substance abuse problems, and had had multiple jobs and multiple relationships, resulting in several children from different fathers. Ms. K's early developmental history was unremarkable. She was a quiet child who admired her eldest sister, who had often acted as a
parental figure. After that sister left home when Ms. K was 12 years old, Ms. K began to smoke cigarettes and cannabis and became more aggressive and rebellious. Her relationships at home and at school quickly became conflictual.

During the initial interview, Ms. K reported at least 4 years of recurrent patterns of unstable relationships (characterized by idealizing and devaluing others), deliberate head-banging and self-cutting, promiscuous and unsafe sexual behavior, inability to control her impulsive use of alcohol and marijuana, transient stress-related periods of “blanking out” for up to an hour, and periods of derealization. Although anger was prominent in her presentation, actual inappropriate angry outbursts were relatively recent in onset (during the previous 18 months) and infrequent (monthly).

Treatment in HYPE

Ms. K was clearly depressed and anxious at presentation. Her immediate treatment focused on management of suicidal ideation and anxiety symptoms. Treatment modalities included psychoeducation and anxiety management strategies (breathing and relaxation training). Ms. K was also started on fluoxetine 20 mg/day. In addition, Ms. K’s mother received psychoeducation, parenting sessions, and telephone support; she was later referred to a family support worker.

After three acute management sessions, CAT commenced in parallel with Ms. K’s general psychiatric care. This involved a narrative review of Ms. K’s life history, looking for repetitive relationship styles and patterns that were maintaining her difficulties. A jointly constructed “reformulation letter” was read with her at session five and a collaborative “diagrammatic reformulation” was subsequently developed. Therapy focused particularly on the passive ways in which Ms. K sought care from others, together with her unrealistic expectations about the kind of care that others might provide, which left her continually disappointed and asking for more. She learned that she often sought out relationships with others who repeated the abusing, controlling, and exploitative patterns that she had experienced since childhood. Ms. K was increasingly able to reflect upon what she wanted and valued in relationships and to consider how she might communicate these needs to others. She also began to trust that she could learn how to meet some of her needs herself, through the development of realistic expectations of herself and others. She began to actively consider her future, set manageable goals, and work toward achieving them. She agreed to a referral for vocational support toward the end of therapy. A more detailed discussion of Ms. K’s therapy is available elsewhere.

Ms. K’s depression resolved after 3 months of treatment but the violent altercations with her siblings continued. Two months later, she became acutely suicidal in the context of one such fight and both she and her mother feared they would be unable to keep her from harming herself. At a crisis appointment, Ms. K and her mother insisted upon inpatient admission. Rather than enter into a battle about this, Ms. K was offered a chance to visit the inpatient unit to assist in making a decision. Her involvement in the decision-making process allowed Ms. K to feel more in control and she was able to decide to return home that evening with crisis team support. She was seen by her therapist/case manager the next day and quickly began to settle.

In the middle of her therapy, Ms. K became homeless and went missing. Her case manager contacted her family by phone and mail at least weekly, but Ms. K could not be located for 1 month. When she was finally located, the patterns jointly identified in her therapy (responding to others being abusing and controlling by becoming angry and rebellious or anxious and avoidant of conflict) were used as a common language to understand her disappearance and to re-engage her.

Although initially very reluctant to work on drug and alcohol use, after 4 months of treatment, Ms. K’s alcohol use had declined substantially, she was no longer using amphetamines, and she was able to acknowledge the role of substance abuse in the patterns jointly identified in her therapy. She accepted a referral for further treatment from a youth drug and alcohol outreach service, which also served as a means of support upon discharge from the HYPE clinic.

Overall, Ms. K received 24 sessions of CAT and 20 other contacts, including case management, family sessions, and medical reviews.

CHALLENGES IN WORKING WITH YOUTH WITH BPD

Difficulty engaging. 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 in engaging and treating young people and our strategies for managing these difficulties are described elsewhere.33,34

Responsibility for attendance versus assertive outreach. The very nature of BPD makes it unrealistic to demand that young people with BPD organize themselves to attend regularly in the early phase of treatment. Rather, increased capacity for self-care and self-management is a goal of treatment, with responsibility for attendance 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 on 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.

Liaison with other individuals and services. Multi-agency involvement is typical for this patient group. This includes primary health care, housing organizations, non-government welfare organizations, drug and alcohol services, child protection, social security, schools, and the justice system. HYPE case managers adopt the same active, open, transparent and collaborative stance with all concerned and usually coordinate communication. The CAT model is used (with the patient’s consent) to promote a shared, plain-language understanding of the patient’s difficulties that ensures the everyone is “singing from the same song sheet” and minimizes professional disputes or “splits.”35 This model also facilitates advocacy on behalf of the young person.

Discharge. An explicit aim of HYPE is to promote support networks independent of mental health services and to divert individuals from destructive involvement with the mental health system. However, this is at odds with BPD patients’ high need for treatment of recurrent mental state disorders.8 When required, care for these is usually sought outside the adult mental health system, from primary care physicians or psychiatrists or psychologists working in (government-subsidized) private practice. 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.

EVIDENCE SUPPORTING HYPE

To our knowledge, HYPE has conducted the only randomized controlled trial of early intervention (or any intervention) for adolescent BPD. The HYPE intervention is supported by a randomized controlled trial28 and by a quasi-experimental comparison with treatment as usual.29 The randomized controlled trial compared the effectiveness of adding two different forms of psychotherapy (CAT or Good Clinical Care [GCC]) to the comprehensive HYPE service model of care described above. Both were effective in reducing psychopathology and parasuicidal behavior and improving global functioning in teenagers with sub-syndromal or full syndrome BPD. There were no significant differences between the outcomes of the treatment groups at 24 months on the pre-chosen measures, but there was evidence that patients allocated to HYPE + CAT improved more rapidly. The magnitude of the change from baseline to 24 months was clinically substantial in both groups. On average, the number of behavioral problems and depressive and anxiety symptoms was reduced by half. There was also a marked reduction in parasuicidal behavior (non-suicidal self-injury and suicide attempts). Upon entry to the trial, 76% of the members of the CAT group and 68% of the members of the GCC group were engaging in parasuicidal behavior. At 24 months, this was reduced to 31% and 33%, respectively. On average, social and occupational functioning improved from “moderate” difficulties at baseline to “slight” difficulties at 24 months. Finally, BPD symptoms diminished by the
equivalent of dropping one DSM-IV criterion over 24 months.

The second study used the two groups described above to compare the effectiveness of the HYPE comprehensive service model of care incorporating either CAT or GCC with treatment as usual in the same service setting immediately prior to the implementation of HYPE. At 24-month follow-up, the patients in the HYPE + CAT group had lower levels of, and a significantly faster rate of improvement in, internalizing and externalizing psychopathology, compared with the group who received treatment as usual. Also, at 24 months, the patients in the HYPE + GCC group had lower levels of internalizing psychopathology and a faster rate of improvement in global functioning than the group who received treatment as usual. The HYPE + CAT group evidenced a median improvement in absolute terms over all continuous outcome measures of 1.07 SDs, followed by the HYPE + GCC group (0.84 SD) and the treatment as usual group (0.64 SD). Moreover, the two HYPE treatment groups showed a substantial reduction over time in the odds of a higher frequency of parasuicidal behavior incidents (odds ratio = 0.11 times for CAT, 0.09 times for GCC, and 0.23 times for treatment as usual).

Overall, these data support the view that specialized early intervention for BPD is more effective than treatment as usual. There are no data on the cost effectiveness of HYPE. However, implementing HYPE appears to be cost-neutral, compared to treatment as usual, when delivered by salaried (not fee-for-service) staff.29

CONCLUSION

It is time to accept that a diagnosis of BPD can be reliably and validly made when the disorder emerges during adolescence and young adulthood. BPD has profound effects throughout and beyond this vulnerable developmental phase, supporting the need for specific services that offer optimal effective treatment as early as possible in the course of the disorder. The HYPE model is an integrated, team-based early intervention that includes individual CAT integrated with assertive case management, active engagement of families or caregivers, general psychiatric care, and crisis care. The HYPE intervention is supported by effectiveness data and can be readily adapted to existing services in other locations and settings.

References