Emerging Personality Disorder in Adolescence

Professor Sue Bailey
Consultant Child & Adolescent Forensic Psychiatrist
President, Royal College of Psychiatrists
Australia, November 2011

“I am – yet what I am, none knows or cares”
(John Clare, Asylum Northampton, 1844)
Reactive vs. proactive aggression

- Reactive aggression represents angry or hostile responses to perceived threats or provocations.

- Proactive aggression refers to deliberate behaviours that are aimed to obtain desired goals, and are motivated by the anticipation of rewards (Dodge, 1991; Dodge, Bales et al., 1996; Dodge, Lochman et al., 1997).
Psychopathic Personality Traits

- Interpersonal characteristics – manipulativeness, superficial charm
- Deviant behaviour – irresponsibility, impulsivity
- Affect – shallow emotions, lack of empathy
- Constellation explains some of the heterogeneity of child problem behavior
Psychopathic adults and adolescents

- Exhibit low physiological arousal in aversive situations (deficit in avoidance learning)

- Psychopathic individuals are less sensitive to punishment cues – to threat and distress cues

- Show deficits in moral reasoning and empathy
Anti-social behaviour, if with ‘psychopathic traits’, tends to be more

- Severe
- Chronic

These differences have stimulated the need to better understand the etiology, development, and manifestation of psychopathy, and accordingly research on juvenile psychopathy has gained momentum in recent years.
What do we know about children with psychopathic traits

Are callous unemotional traits – stable across different developmental periods?

What is the genetic and neurobiological framework

Affective processing
- Lack of empathy
- Lack of guilt
- Insincere charm

Neural basis
Genetic basis
Are all traits malleable and responsive to treatment?
What treatment strategies might be adopted?
What challenges need to be addressed?

Labelling and Ethical concerns?

Term ‘psychopathy’ – highly stigmatising developmentally inappropriate

Vs. – obligation to identify early need, for those at risk of life long harm, to self and others.
Treatment Efficacy

Adult psychopathy seen as hard to treat (Salekin, 2002; Duggan, 2011: In press).

- Need evidence base which evaluates current treatment in relation to children with high-CU Traits (Viding, 2007; Yeh & Chen, 2011).

- Neuro affective profile – suggests need modification of current treatment approaches.

- Avoid ineffective treatments

- Avoid punishment approach either boost weak affective response system (Hawes and Dadd, 2007) identify treatment strategies congruent with presenting strengths and weaknesses.

- Response to reward appears intact address features associated with malleability in relation to parenting style e.g. IQ, gender and timing and nature of interventions.
Measurement

- Age-appropriate measures to assess interpersonal affective features at early stages of development.

- Measures amenable and useful for application in clinical and research settings.

- Longitudinal research:
  - Establish temporal stability
  - Variations in behavioural manifestations
  - Distinguish which features associated with antisocial behaviour in general and persistent/violent offending/psychopathy in particular establish relation of all traits, along with other factors, to adult psychopathy
How troubled and troublesome children think

**Information Processing**

- Children who perceive or attend to hostile cues in others are more likely to become angry in social situations with a lowered threshold to anger (strong affective response)
Imbalance of Behavioural Activations Systems

- Failure of anxiety to modify disruptive or aggressive behaviours.

- At least synergistic effects of heightened sensitivity to threat, therefore use of avoidance strategies and anxiety.
Use of Evidence Based Treatment
Interventions utilised across the Youth Justice System primarily based on cognitive behavioural interventions

- Combined with Key ingredients of a therapeutic milieu, care and education.

- Working in parallel through verbal and non-verbal psychotherapies.
Psychotherapy Capacity to form emotional attachments with others allowing establishment of working relationships with the clinician

The ability for self examination and insight challenging where frequent and severe aggression, low intelligence and poor capacity for insight
Parenting
(Yeh, Chen et al., 2011)

- Reactive and proactive aggression are related to different antecedents.
  
- e.g. harsh parenting is more predictive of reactive aggression;

- Whereas indulgent parenting is more strongly associated with proactive aggression.
Research on psychopathic traits suggests that reactive aggression is more strongly linked to negative emotionality, whereas proactive aggression is more closely linked to decreased emotional reactivity, and an increased tendency to exhibit a calloused and unemotional response to threat or provocations.

As such, ‘child psychopathic’ traits may show different interactions with parenting, for reactive vs. proactive aggression.
Interventions for those with extant or emerging 'serious' Personality disorder.

Learning from work in adult field (Duggan, IONNA group and Bailey 2011)

- What do policy makers want to achieve? - Avoidance of bad publicity? - Or beyond
- What strategy do they need?
- What strategies do they already have that can be used to better effect?
How as clinicians and researchers do we support policy makers Key areas

- Improve psychological health
- Reduce young person's risk of serious harm to others
- Develop skills in the workforce to achieve both of these
Challenges for those working with adolescents and adults

- Identify those most at need of intervention at an early stage
- Pathway approach to initial screening
- If not been lost in transition and are identified
- Case formulation (CF) together with organisational intervention that will seek to enhance engagement with interventions
Delphi exercise

- Three domains required to be covered are:
  - Criminological
  - Mental health
  - Miscellaneous category that is not easily described
The domains were as follows:

- Recidivism: violent
- Suicide
- Substance abuse
- Recidivism: non-violent
- Mental states
- Engagement with treatment
- Relationships
- Aggression
- Cognitive-psychological function
- Death
- Self-harm
- Service outcomes
- Compliance
- Stages of change readiness
- Economic
- Social function
- Quality of life
- Self-esteem
- Employment-avocation
- Satisfaction with treatment
- Physical health
None can be ignored, because those that seem to be lower down the domains have an impact on the most undesired outcomes: death, self-harm, and serious harm to others.

Of relevance to young people in particular, is the readiness conditions required to engage in treatment.
PIPEs psychologically informed post treatment environments

(Initial findings including young adults hopeful)

- Key aspects to CF (Sim et al., 2005):
  - Integrative
  - Explanatory
  - Prescriptive
  - Predictive
  - Therapist
Key Functions

- To identify core problems of the individual
- To create hypotheses regarding antecedents
- Maintaining factors and consequences of problems identified
- To identify treatment needs
- To facilitate predictions regarding outcomes
- To increase empathy for young person
5'P's

- Problem
- Pre disposing factors
- Precipitating factors
- Perpetuating factors
- Protective factors
Forensic CF (Sturmy 2009) no guidelines on how to perform forensic CF's

But Tasks

- Develop a forensic CF framework
- Devising a checklist for quality assessment of forensic CF's
- Develop a training framework for forensic CF's
- Evaluating validity and reliability of forensic CF
- Evaluating the impact of CF on desired outcome such as personality function risk, offending and psychosocial functioning
Andrews and Bonta (2006) - general personality and cognitive social learning theory of offending

- Patients with PD are characterised by dysfunction in thinking, emotional regulation, and behaviour that arose in childhood and has been maintained into adulthood (Davidson 2008).

- Cognitive behavioural models most used.

- And most used to reduce reoffending in criminal justice systems (Mcguire 1995; NICE 2009).

- Risk, Needs, Responsivity principles (Bonta 2006).
Readiness conditions required
Improving engagement

**Internal**
- Cognitive
- Affective
- Volitional
- Behavioural
- Identity

**External**
- Circumstances
- Location
- Opportunity
- Resources
- Support
- Programme timing

(Sellen, 2009; McMurrann, 2009; Day, 2009; Howells, 2009)
# Review of outcome measures in forensic mental health

(Chambers, 2009; Fitzpatrick, 2010; Cohen & Eastman, 2000; Atkinson, 1992)

<table>
<thead>
<tr>
<th>Temporal dimension</th>
<th>Input</th>
<th>Process</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure of care</td>
<td>Specific clinical interventions</td>
<td>Effectiveness and efficacy of care (what works for whom)</td>
<td></td>
</tr>
<tr>
<td>Provider systems</td>
<td>Somatic therapy</td>
<td>Seven principles (Atkinson et al., 1992)</td>
<td></td>
</tr>
<tr>
<td>Organisation of system</td>
<td>Psychological therapies/counselling</td>
<td>1. Outcome is multi-dimensional</td>
<td></td>
</tr>
<tr>
<td>Characteristics of facilities</td>
<td>Sociotherapy</td>
<td>Clinical (e.g. symptom reduction)</td>
<td></td>
</tr>
<tr>
<td>Number of facilities</td>
<td>Assessment</td>
<td>Rehabilitation (social and instrumental functioning)</td>
<td></td>
</tr>
<tr>
<td>Capacity of services</td>
<td>Rehabilitation (e.g. occupational therapy)</td>
<td>Humanitarian (quality of life, patient satisfaction)</td>
<td></td>
</tr>
<tr>
<td>Financial resources</td>
<td>Relationship between clinician and patient</td>
<td>Public safety (risk to self and others, recidivism, security risk assessment)</td>
<td></td>
</tr>
<tr>
<td>Human resources</td>
<td>Movement between tiers of services</td>
<td>2. Take account of multiple perspectives</td>
<td></td>
</tr>
<tr>
<td>Human resource development</td>
<td>Responsiveness and accessibility</td>
<td>3. Take account of individual utility differences</td>
<td></td>
</tr>
<tr>
<td>Service protocols</td>
<td>Waiting lists and bed-blocking</td>
<td>4. Strive for standardisation of measures and designs</td>
<td></td>
</tr>
<tr>
<td>Access criteria</td>
<td>Bed utilisation (inflow, length of treatment, outflow)</td>
<td>5. Use cross-sectional and longitudinal designs</td>
<td></td>
</tr>
<tr>
<td>Good practice guidelines</td>
<td>Pathways to and through care</td>
<td>6. Include measures of costs</td>
<td></td>
</tr>
<tr>
<td>Information systems</td>
<td>Frequency and duration of treatment</td>
<td>7. Consider relevance and impact</td>
<td></td>
</tr>
<tr>
<td>Government policy and legislation</td>
<td>Patterns of service use</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care Programme Approach monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continuity of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coercion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Execution of care (doing well what works)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Efficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriateness of care (using what works)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Adapted from Tansella & Thornicroft (1998). Different aspects of input, process and outcome can be measured at different geographical levels: patient level—local level—country regional level (i.e. micro→macro).
Measuring what matters

- **Process outcomes:**
  - Recognition
  - Case management
  - Pathway planning
  - Community partnerships

- **Pathway outcomes:**
  - Assessment and engagement
  - Mental health well being and pro social behaviours
  - 'Recovery ' and pro social behaviours
Systematic review of what works for interventions in children and adolescents with emerging antisocial personality disorder

Summary of recommendations:

- Early interventions
- Identify vulnerable parents including ante nataly
- Parents with other mental health problems
- Significant drug alcohol problems
- Mothers under 18, particularly with history of maltreatment in childhood
- Parents with significant previous or current contact with CJS
- Whilst avoiding increasing stigma associated with intervention / Labelling as anti social
Early interventions at risk children

- Non maternal care nursery pre 1 year olds
- Improve poor parenting
- Target multiple risk factors
- Interventions for children with conduct problems
- Functional family therapy versus
- Multi systemic therapy
Qualities of a good screening test
(Blazer & Hayes, 1998)

- Inexpensive
- Easy to administer
- Minimally uncomfortable to those in whom it is administered
- Detects a disorder earlier than would occur if a behavior (in this case, violent antisocial behavior) was severe enough to prompt an intervention
- Balances the ability to detect most cases of the disorder with the ability to rule out non-cases
- Not subject to variability across different testers or across time in the same tester
How research might evaluate the pathways of adults with established antisocial personality disorder or juveniles with emerging personality disorder

a) An initial screening process.

b) The provision of the case formulation, together with an organisational intervention that will seek to enhance engagement with interventions.

c) The development and evaluation of psychologically informed post-treatment environments (i.e. PIPES) designed to maintain treatment gains after transfer from specialised facilities/services.

d) Finally, each of these phases would need to have in-built economic and organisation evaluations, with tailored training packages to ensure their implementation.
Children with CU traits appear to be characterised by a particular neuro affective profile may reflect strong genetic vulnerability is it “chicken and egg” impact of maltreatment on developing brain.

Even if high heritability does not equate with immutability.

All subgroups however developed may respond best to modified treatment approaches matching / “personality type to treatment”.

Implications of ICD 11.