Young People in Transition: Continuities and Discontinuities in Developmental Psychopathology from Childhood through Emerging Adulthood

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Declaration of interest: none
Majority of adult psychiatric morbidity first becomes evident before 25 years old

• Evolving from childhood emotional & behavioural disorders
• *de novo* after puberty

(Kessler et al., 2005; 2007)
Emphasis given to childhood effects upon adult psychopathology

Comparatively little attention to developmentally proximal influences
Developmentally proximal influences

- Developmental transitions can contribute to alterations in the course of mental health and psychopathology

- Influence of early experiences on later psychopathology and mental health are likely mediated and sometimes reversed by later experiences

(Schulenberg et al, 2004)
Continuity mostly prevails

- Functional trajectories established throughout childhood and adolescence likely carry into early adulthood
  - Work with/against accompanying changes in roles and settings
- Stressors associated with transition can contribute to the manifestation or consolidation of subthreshold psychopathology
Possible mediating mechanisms
(Rutter, 2006)

- Genetic mediation
- ‘Kindling’ effects
- Environmental influences
- Coping mechanisms
- Cognitive processing of experiences
Discontinuities provide a window into the mechanisms operating across this period

Clues for prevention and early intervention
Distal & proximal developmental influences are often intertwined

- **Distal might lead to proximal**
  - Parental substance abuse ➔ lack of support/monitoring

- **Proximal might mediate distal**
  - Adverse childhood experiences ➔ transitional difficulties into adulthood
But...

- Proximal & distal might operate independently
  - ➔ discontinuity
  - e.g. marriage mitigating earlier influences upon antisociality, psychopathology, and substance abuse
An exclusive focus upon distal factors is ‘non-developmental’

Assumes that the determinants of mental health are invariant across the lifespan
Social & clinical complexity

- Many risk factors for mental disorders are themselves complex social and clinical problems
  - Poverty
  - Child abuse
  - Antisociality
  - Substance use
- DSM-IV syndromes *per se* are unhelpful for guiding prevention and early intervention
What does this mean for youth mental health?

Youth mental health encompasses more than early intervention.
What does this mean for youth mental health?

- Evolving disorders
  - Developmental disorders
  - Emotional and behavioural disorders
  - ‘Developmental cascades’ (Masten & Cicchetti, 2010)

- Time limited disorders
  - +/- Downstream effects
  - Sequential comorbidity (Rutter, 2006)
    - Psychopathological
    - Functional

- Enduring disorders with onset in youth
oh darling... what a pity...
I think your interesting personality
has just been classified as
a personality disorder.
Normal or abnormal?

- Almost all psychopathology involves continuity with normality.
- Boundary between mental disorder & transient or normative developmental changes believed to be difficult to distinguish.
  
  ...but is it?

- Distress, dysfunction & need for assistance less problematic.
  - Often precedes diagnosis or 'caseness'.
Personality problems usually become apparent in adolescence or emerging adulthood

- Acknowledged in DSM since 3rd edition
- Demographically crowded period of life (Arnett, 2000)
- Potential for ensuing developmental disruption high, even if the clinical features subsequently attenuate (Skodol, Pagano, et al., 2005)
It’s not just about childhood adversity...
Distal risk factors for BPD

- childhood abuse or neglect
- problematic family environment
- low socio-economic status
  
  (Cohen, 2008; Carlson, 2009)

- Risk factors for most mental disorders (multifinality)
Genetics of BPD

- **Heritability 35-45%**
  - Torgersen, 2008; Distel, 2009; Distel, 2008; Kendler, 2008; Bornovalova, 2009; Distel, 2011

- **Gene-environment interaction & correlation** (Distel, 2011)

- **Genes that influence BPD features also increase the likelihood of being exposed to certain adverse life events**
Precursor signs & symptoms of BPD (Chanen, 2012)

- Temperamental characteristics & mental state abnormalities
  - angry tantrums & crying/demanding behaviours
  - ADHD, ODD, conduct disorder, substance use, depression, and DSH
    - ‘heterotypic continuity’
  - BPD features among the strongest long-term predictors of later BPD and poor outcomes
    - ‘homotypic continuity’

- Difficulties with emotion regulation and relationships precede problems with impulse control (Stepp, 2011)
BPD is a disorder of young people

- Normative increase in BPD traits after puberty
- Perhaps bringing the problems associated with BPD to clinical attention
- Wanes in early adulthood
  - partly due to maturational or socialization processes (Cohen, 2005 #2231)
  - reveals increasingly deviant group compared with peers (Crawford, 2005)
  - more like 'adult' BPD phenotype.
BPD is a disorder of young people

≈ 3% community-dwelling teenagers and youth

(Bernstein et al. 1993; Moran et al. 2006)

Younger age associated with higher BPD score

(e.g. Ullrich & Coid, 2009)
BPD in youth associated with multiple psychosocial problems

- Axis I conditions (including substance use)
- Poorer psychosocial functioning
- More internalising and externalising problems
- Family breakdown
- Welfare dependency
- Involvement with justice child protection systems
- Health risk behaviours (sexual, substance use)

BPD prospectively associated with

- Future BPD diagnosis
- Increased risk for axis I disorders (especially substance use and mood disorders)
- Interpersonal problems
- Distress
- Reduced quality of life.
  
  (Cohen et al. 2005; Crawford et al. 2008; Winograd et al. 2008)

- Persist for decades (Winograd et al. 2008)
BPD & depression prevention

- Co-morbidity
  - Connections at the level of latent internalizing and externalizing dimensions (Eaton et al. 2011)
  - Possible gene-environment correlation
    - e.g., ADHD (Distel et al. 2011)

- Having either syndrome in childhood or adolescence predicts the onset of the other in later life (Cohen et al. 2008)
BPD & depression prevention

- BPD predicts
  - First incidence of mood, anxiety & substance use disorders (Grant et al. 2010)
  - Longer time to remission of MDE, shorter time to relapse, and worse outcome (Grilo et al. 2010; Skodol et al. 2011)
Clinical staging

- Personality pathology rarely confined to a single diagnostic entity (Clark, 2007)
  - Co-occurs within Axis II and across Axes I and II

- Tendency for mental disorders to co-occur might be a predictable consequence of the involvement of common liability factors for multiple disorders (Krueger & Markon, 2006)
  - e.g. genetic & environmental correlations between BPD traits and ADHD symptoms 0.72 and 0.51, (Distel, 2011).
Clinical staging

- Promote early intervention
- Make more sense of the confusing array of biological research findings in psychiatry
  - e.g., no evidence in young people with BPD of heightened sensitivity to emotional facial expressions
    - (Jovev, et al. 2011)
  - amygdala or hippocampal volume reduction
    - (Chanen et al. 2008; Brunner et al. 2010; Goodman et al. 2010)
Early, late, iatrogenic?

- Early clinical features
- Features of evolved and/or persistent disorder
- Iatrogenic features
Duration of illness factors

- Duration of BPD
- Treatment
  - e.g. Prolonged polypharmacy (Zanarini et al., 2004)
    - 40% ≥ 3 concurrent medications
    - 20% ≥ 4
    - 10% ≥ 5
- Recurrent or chronic common mental disorders (Zanarini et al., 2004)
  - Cumulative traumatic events (Zanarini et al., 2005)
- Associated lifestyle factors

Early intervention programs should prevent poor outcomes, not diagnostic categories.

Alter the life-course trajectory of personality pathology in young people.

Healthier adulthood should be the outcome of interest.
‘Best bet’ for immediate action is indicated prevention and early intervention

- Sub-syndromal or full-syndrome BPD at first presentation
- Target diverse poor outcomes, not just ‘late-stage’ DSM-IV syndrome (McGorry, 2007)
  - Progression to symptomatically chronic BPD uncommon (Shea et al., 2002; Zanarini, et al., 2006 & 2010)
  - 1° prevention of 2° disorder (Kessler et al. 1993)
    - e.g. BPD predicts incident substance use, mood and anxiety disorders (Grant et al., 2008)
Diagnosis should guide treatment choice...

...most treatments in psychiatry non-specific
Psychosocial treatments

- Less reliant on specific diagnoses
- Often ‘trans-diagnostic’
- Often target functional and interpersonal domains
- Require certain skills that might not be widespread in the mental health workforce
‘Complex’ interventions are likely to be needed for complex problems

How do we develop a workforce to deliver such interventions?

Youth mental health also involves the care of ‘late stage’ or ‘late presentation’ (i.e. complex) problems
Clinical complexity

- DSM-IV syndromes *per se* are unhelpful for guiding prevention and early intervention
- Many risk factors for mental disorders are themselves complex social and clinical problems
- ‘Complex’ interventions are likely to be needed for complex problems
- How do we develop a workforce to deliver such interventions?
- Youth mental health also involves the care of ‘late stage’ or ‘late presentation’ (i.e. complex) problems
Youth mental health is developmental by definition

Framed around continuities and discontinuities that are a specific feature of this period of life.