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Personality pathology as a driver of positive psychotic symptoms beyond diagnostic borders

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Psychotic experiences such as hallucinations or delusions have their prevalence peak in childhood and become less prevalent into adolescence, adulthood, and old age. Peters and colleagues¹ in this issue investigated changes in borderline personality disorder (BPD) features across the life-span as a potential mechanism underlying the inverse relationship between positive psychotic symptoms and age. Using the data of a large population sample of 19,980 individuals aged between 16 and 95 years they found that BPD features explained 100% of the reduced prevalence of hallucinations and 61% of the reduced prevalence of delusions that occurred with increasing age. General psychopathology explained the inverse relationship between positive psychotic symptoms and age considerably less, suggesting specificity for BPD features in this regard. Remarkably, the mediating effect of BPD features was found in the general population *and* in a subgroup of participants with a probable psychotic disorder. This suggests that the decline in positive psychotic symptoms with age is indeed explained by changes in BPD features and not (only) by a decrease in the prevalence of psychotic disorders. Even though the study appears to be methodologically sound, future research is required to replicate the findings in a longitudinal study using established measures (preferably clinical interviews instead of screening questionnaires) to assess psychotic symptoms and personality pathology more rigorously. In this paper, we will discuss the results of Peters and colleagues' study¹ from a developmental and transdiagnostic perspective, postulating a) that positive psychotic symptoms are driven by stressful experiences in individuals with insufficient or maladaptive self-regulation and interpersonal skills, particularly during periods of life that put high demands on the individual (i.e., adolescence), and b) that positive psychotic symptoms as such can be interpreted as a transdiagnostic, dynamic marker of severity of psychopathology and, in particular, impairment in personality functioning.

Applying a dimensional perspective, BPD can be understood as an extreme expression of what lies at the core of personality pathology². According to the Alternative Model of Personality Disorder (AMPD) in DSM-5, the core of personality disorders – that is conceptually independent from specific personality disorder types or traits - is defined by marked impairments in self and interpersonal

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functioning captured by Criterion A³. Precursors of BPD may already be evident in childhood. However, (borderline) personality pathology typically first manifests itself in adolescence and can be reliably distinguished from normative adolescent development⁴. The developmental tasks that go along with the transition from childhood to adulthood require competences that come together in Criterion A of the AMPD; i.e., identity, self-direction, empathy, and intimacy. Thus, the emerge of personality pathology denotes an adaptive failure to develop competences needed to fulfil adult life tasks⁵. Symptoms of BPD peak in early to late adolescence, and then largely decline over the adult years, with periods of remission and relapse⁶. It is mainly the “acute symptoms” such as affective dysregulation, impulsivity, and self-harming behaviour that decrease with age. In contrast, the more “chronic symptoms” such as feelings of emptiness and maladaptive interpersonal functioning often persist over years and characterize BPD in adulthood⁷. Stressful life events and daily hassels may account for the waxing and waning course of BPD symptoms as they exacerbate negative affectivity in the presence of emotion dysregulation⁹. On the other hand, BPD symptoms themselves can be the generator of stressful experiences that individuals with BPD face such as separation, breakup, and serious problems with close other¹⁰.

Positive psychotic symptoms occur in the general population as well as in clinical samples. Even though they are most prevalent in childhood (with decreasing prevalence rates over the rest of the lifespan), they become more clinically significant with the transition into adolescence and early adulthood¹¹. This means that positive psychotic symptoms in adolescents and young adults are predictive for a wide range of negative outcomes, including the development of psychotic and non-psychotic mental disorders, multimorbidity, functional impairments, and suicidal behavior¹². Thus, they are no longer seen as pathognomic for psychotic disorders such as schizophrenia, but may be understood as a transdiagnostic risk maker for severe psychopathology and impairment. In addition, there is increasing evidence suggesting that affective instability and emotional reactivity to stress are related to psychotic experiences along the continuum^{13,14}. The affective responses to stressful experiences may contribute to the fluctuation of positive psychotic symptoms.

Bringing the two research fields together, Peters and colleagues’ study¹ adds to the evidence that psychotic symptoms occur extra- and transdiagnostically and that the prevalence rates decrease with age. In addition, the finding that BPD features explained the inverse relationship between age and psychotic symptoms is consistent with the literature on stress sensitivity and emotional reactivity of psychotic experiences. It can be interpreted as further evidence that psychotic experiences are triggered or exaggerated by stress in the context of insufficient emotion regulation skills. As adolescence puts high demands on the individual to take over an adult role and find their place in the society, it represents a particularly stressful period of life. At the same time, emotion regulation capacities are still under development, depending on brain maturation¹⁵. It is not surprising, thus, that (borderline) personality pathology peaks in adolescence, indicating a struggle or failure to develop the necessary self- and interpersonal skills to meet the challenges of this period of life. With the transition to early and then middle adulthood, the life circumstances become more sorted out alongside with matured self-

regulation and interpersonal skills, contributing to the decline of the “acute” BPD symptoms such as affective instability, impulsivity, and self-harming behavior. Thus, more sorted life circumstances alongside with the cessation of BPD symptoms as stressors on their own may contribute to the mediation effect that the BPD features had on the relationship between age and positive psychotic symptoms in Peters and colleagues’ study¹. Finally, the finding that general psychopathology was not as good a mediator between age and positive psychotic symptoms as BPD features may suggest that impairments in self and interpersonal functioning – the core of personality pathology according to the AMPD that is independent of internalizing and externalizing pathology – explain a significant and incremental part of the severity continuum of psychopathology at which extreme end positive psychotic symptoms lie⁵. Clinically, this means that we should assess and treat personality pathology (i.e., deficits in self and interpersonal functioning) and features of or full-threshold acute mental disorders at the same time because their interplay represents a potent driver of the development of severe psychopathology and impairments in the long-term.

References

1. Peters EM, Yates K, DeVlyder J, Lodhi RJ, Kelleher I. Understanding the inverse relationship between age and psychotic symptoms: The role of borderline personality traits. *Acta Psychiatr Scand*. Published online July 12, 2022. doi:10.1111/acps.13475
2. Sharp C, Wright AGC, Fowler JC, et al. The structure of personality pathology: Both general ('g') and specific ('s') factors? *Journal of Abnormal Psychology*. 2015;124(2):387-398. doi:10.1037/abn0000033
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th Ed. American Psychiatric Publishing; 2013.
4. Fonagy P, Speranza M, Luyten P, Kaess M, Hessels C, Bohus M. ESCAP Expert Article: Borderline personality disorder in adolescence: An expert research review with implications for clinical practice. *Eur Child Adolesc Psychiatry*. 2015;24(11):1307-1320. doi:10.1007/s00787-015-0751-z
5. Sharp C, Wall K. Personality pathology grows up: adolescence as a sensitive period. *Current Opinion in Psychology*. 2018;21:111-116. doi:10.1016/j.copsyc.2017.11.010
6. Winsper C. Borderline personality disorder: course and outcomes across the lifespan. *Curr Opin Psychol*. 2021;37:94-97. doi:10.1016/j.copsyc.2020.09.010
7. Videler AC, Hutsebaut J, Schulkens JEM, Sobczak S, van Alphen SPJ. A Life Span Perspective on Borderline Personality Disorder. *Curr Psychiatry Rep*. 2019;21(7):51. doi:10.1007/s11920-019-1040-1
8. Videler AC, Hutsebaut J, Schulkens JEM, Sobczak S, van Alphen SPJ. A Life Span Perspective on Borderline Personality Disorder. *Curr Psychiatry Rep*. 2019;21(7):51. doi:10.1007/s11920-019-1040-1
9. Miskewicz K, Fleeson W, Arnold EM, Law MK, Mneimne M, Furr RM. A Contingency-Oriented Approach to Understanding Borderline Personality Disorder: Situational Triggers and Symptoms. *Journal of Personality Disorders*. 2015;29(4):486-502. doi:10.1521/pedi.2015.29.4.486
10. Allen TA, Dombrovski AY, Soloff PH, Hallquist MN. Borderline personality disorder: stress reactivity or stress generation? A prospective dimensional study. *Psychol Med*. 2022;52(6):1014-1021. doi:10.1017/S003329172000255X
11. Schimmelmann BG, Michel C, Martz-Irmgartinger A, Linder C, Schultze-Lutter F. Age matters in the prevalence and clinical significance of ultra-high-risk for psychosis symptoms and criteria in the general population: Findings from the BEAR and BEARS-kid studies. *World Psychiatry*. 2015;14(2):189-197. doi:10.1002/wps.20216
12. Staines L, Healy C, Coughlan H, et al. Psychotic experiences in the general population, a review; definition, risk factors, outcomes and interventions. *Psychol Med*. Published online August 25, 2022:1-12. doi:10.1017/S0033291722002550
13. Marwaha S, Broome MR, Bebbington PE, Kuipers E, Freeman D. Mood Instability and Psychosis: Analyses of British National Survey Data. *Schizophrenia Bulletin*. 2014;40(2):269-277. doi:10.1093/schbul/sbt149
14. Muddle S, Jones B, Taylor G, Jacobsen P. A systematic review and meta-analysis of the association between emotional stress reactivity and psychosis. *Early Intervention Psych*. 2022;16(9):958-978. doi:10.1111/eip.13247

15. Silvers JA. Adolescence as a pivotal period for emotion regulation development. *Curr Opin Psychol.* 2022;44:258-263. doi:10.1016/j.copsyc.2021.09.023

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