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BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder in Adolescents

Issues in Diagnosis and Treatment

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Borderline personality disorder (BPD) is frequently encountered in a variety of clinical settings.[1] On inpatient units, it is estimated that 20% of patients have comorbidity with BPD. In outpatient clinics, 11% of patients meet diagnostic criteria for BPD. Despite these statistics, BPD has neither the same level of public awareness nor the same level of research funding that other major psychiatric diagnoses have.

The American psychoanalyst Adolph Stern was the first to use the term "borderline" in describing a group of patients who had both neurotic and psychotic features.[2] He considered these patients to be in the "border line group." It was not until 1949, however, that the term was applied to children. Margaret Mahler used the term "borderline" to describe a group of children who displayed "low frustration tolerance, poor emotional differentiation from their mothers, and [who were] beset by a series of neurotic-like defenses."

Since Stern, the amount of research on BPD in adults has grown exponentially. Research on BPD in children and adolescents has not kept pace despite increasingly strong evidence of developmental antecedents for the condition in adult BPD.

Although an extensive historical review of the diagnosis of BPD in children and adolescents would be interesting, it is beyond the scope of this article. However, it is increasingly clear that BPD progresses from a strict psychodynamically based construct to a neurodevelopmental disorder with roots in the genetics of the child, the child's temperament, and the environment. BPD is marked by skills deficits in broad areas of developmental ability, including deficits in emotion regulation, distress tolerance, and interpersonal functioning.

Waiting for therapy

Although symptoms typically begin in adolescence, there has been a strong reluctance in the psychiatric community to diagnose BPD in anyone younger than 18. Even in adults with BPD, it remains a highly stigmatized disorder among physicians and mental health professionals.[3] Although DSM clearly allows for the diagnosis to be made in patients who have had enduring symptoms for more than a year, clinicians tend to write "deferred" on Axis II, even when an adolescent meets sufficient diagnostic criteria. What this means is that in many adolescents, mood and other behavioral and psychiatric disorders are diagnosed, and often medication is prescribed for symptoms even when clinical criteria for disorders other than BPD are not met.

Because of the reluctance to make the diagnosis, BPD has been underrecognized and underdiagnosed in adolescents and, as a consequence, has not been adequately studied. As such, its nature and course in adolescent populations are not well understood. Equally troubling is that studies show that treatment typically begins in early adulthood.[4] It appears that from the onset of symptoms to the definitive diagnosis of BPD, treatment can lag for many years. The lack of early treatment can mean years of suffering and years of practicing maladaptive (although temporarily effective) and self-reinforcing behaviors (eg, self-injury for emotional regulation).

Evidence suggests that BPD can be reliably diagnosed in adolescents[5]; however, other studies show that the

diagnosis is not always stable over the course of development. For instance, a prospective study undertaken by Chanen and colleagues[6] found that only 40% of adolescents aged 15 to 18 with BPD met criteria for the disorder at 2-year follow-up.

A community study looked at self-reported symptoms at 2- to 3-year intervals starting in early adolescence (age 14) and ending in early adulthood (age 24) in adolescent twins with BPD. The results showed a decrease in rates of the diagnosis over the study period, with significant reductions in symptoms at each study interval during the 10-year follow-up.[7]

What is already known about borderline personality disorder (BPD) in children and adolescents?

- BPD in adolescents has been a controversial diagnosis. Research indicates that the presentation in adolescents is very similar to that in adults.

What new information does this article provide?

- DSM does not prohibit the diagnosis of BPD before age 18. The earlier the diagnosis, the earlier an empirically validated treatment can be applied. Furthermore, BPD may not be a lifelong condition.

What are the implications for psychiatric practice?

- Adolescents overwhelmingly find the diagnosis to be validating of their experience. An early diagnosis can mean an earlier targeted intervention that will help avoid multiple and unnecessary medication trials and adverse effects.

Another study looked at 407 adolescents with cluster B symptoms.[8] The findings show that BPD and other cluster B symptoms tended to persist even when formal diagnostic criteria for cluster B on Axis II were no longer met.

DSM and the adolescent clinical profile

DSM has 9 criteria for BPD and states that the diagnosis can be made in adolescents younger than 18 if the criteria have been present for more than a year. Integrating the clinical experience with DSM criteria yields the following profile: adolescents referred for treatment often report that symptoms started around puberty. BPD symptoms such as self-injury and impulsivity involving drugs, alcohol(Drug information on alcohol), and sex are far less common in younger children. The 9 DSM criteria are the following:

Efforts to avoid abandonment. The risk of suicide is increased in adolescents with BPD after a breakup with a romantic partner or problems with a roommate or friend. They experience a profound sense that someone essential to their well-being will never come back. The clinician must recognize that suicidal and other maladaptive behaviors are sometimes reinforced by loved ones and caregivers, in that the adolescent with BPD feels more cared for when in crisis and being attended to by compassionate caregivers.

Unstable relationships. Patients with BPD tend to have relationships that are either overidealized or devalued. Parents and friends can be categorized as being the best parent or friend in the world in one moment and then vilified in the next. This reflects all-or-nothing, or black-and-white, thinking, which is typical in adolescents with BPD. On hospital units, the adolescents can divide staff into good and bad staff—designations that can readily change. In an unprepared staff, this can lead to polarization and staff that either likes or dislikes the

adolescent.

Unstable sense of self. This criterion is harder to define in adolescents with BPD because adolescence is a time of defining identity. Clinically, we see enduring self-loathing as a core symptom. Others describe feeling "porous" to others' emotions.

Dangerous impulsivity. In younger adolescents with less access to cars and money, reckless driving and spending and are unusual. Indiscriminate and unprotected sex, drug abuse, eating problems, and running away from home are more common, and these behaviors are often used to regulate emotions. These mood regulation strategies are one of the key assessments that differentiate "typical" adolescent experimentation from the behavior of adolescents who have BPD.

Recurrent self-injury and suicidal behavior. Self-injury in the form of cutting is common; self-burning, head banging, punching walls, attempting to break bones, ingesting nonnutritive substances, and inserting foreign objects under the skin are other forms of self-injury. Although patients with BPD are at increased risk for completed suicide, cautious intervention is key because suicide attempts can be reinforced by the well-intentioned attention of caregivers.[9]

Affective instability/extreme mood reactivity. Adolescents with BPD recognize that they feel things "quicker" and with less apparent provocation than others, feel things more intensely than others, and are slower to return to their emotional baseline than others. Mood states tend to be in response to interpersonal and intrapersonal conflict and rarely last for more than a day, typically lasting only a few hours. This mood reactivity can be useful in differentiating BPD from Axis I mood disorders, in which mood states can last for many days or weeks.

Chronic feelings of emptiness. Adolescents with BPD tend to express that they are easily bored and do not like to sit quietly; the emptiness and boredom of being alone is intolerable. They find that the emptiness is temporarily relieved by risky or "intense" behaviors (intense relationships, sex, drugs).

Anger regulation problems. If there is physical aggression, it tends to occur most with those closest to the adolescent with BPD. The anger-fueled aggression can take the form of destruction of property, bodily violence, or hurtful verbal attacks.

Paranoia and dissociation. It appears that about 30% of hospital-based adolescent patients with BPD have experienced some form of abuse. Some present with co-occurring PTSD. In this subgroup, dissociation, depersonalization, and derealization are common.

The dialectical behavioral therapy profile

From a dialectical behavioral therapy perspective, the symptoms of BPD have been divided into 5 areas of dysregulation:

- Emotional dysregulation: adolescents with BPD are highly reactive and can experience episodic depression, anxiety, and irritability; they also have problems with anger and anger expression

- Interpersonal dysregulation: relationships are chaotic, intense, emotional, and hard to give up; the fears of abandonment can be pronounced

- Behavioral dysregulation: adolescents with BPD demonstrate dangerous, impulsive, and suicidal behaviors; self-injury, suicide attempts, dangerous drug use and unsafe sex are common behaviors

- Cognitive dysregulation: stressful situations and a history of trauma can lead to nonpsychotic loss of

reality testing and may include depersonalization, dissociation, and delusions

• Self-dysregulation: adolescents with BPD frequently have little sense of self; they feel empty and struggle mightily with a sense of purpose

The neuropsychological profile

Although the neuropsychological profile of BPD has not been described for adolescents, studies in adults have shown impairments in specific cognitive domains. One robust finding has been deficits in executive functioning, which suggests decreased frontal processing.[10-12] Such deficits would explain many of the behavioral findings in BPD, including a poorer capacity to plan, impulsivity, and increased difficulty in emotion regulation.

Given that adolescents have developmentally determined deficits in executive functioning, adolescents with BPD present with even more impulsive and less planned behavior than a typically developing adolescent. The deficits in executive functioning manifest as substance abuse, impulsive aggression, and maladaptive strategies to deal with intense emotions.

The long-term outcome

Biskin and colleagues[13] recently published a study on current diagnoses and functional status of women who had received a diagnosis of BPD in adolescence. They also looked at factors that might be associated with long-term outcomes.

Girls with BPD that was diagnosed before age 18 (n = 31) were compared with those who had other psychiatric diagnoses but not BPD (n = 16). Each group was assessed over 10 years. Study findings indicate that 4.3 years after the initial diagnosis, only 11 of the patients with BPD still met criteria for the disorder; BPD did not develop in any of the patients who did not initially have BPD. Those who did not have symptom remission were significantly more likely to have a current episode of major depression, to have a lifetime substance use disorder, and to self-report childhood sexual abuse. The researchers concluded that their findings supported the validity of an adolescent BPD diagnosis and that prognostically, in nearly two-thirds of cases of adolescent-onset BPD, remission could be expected within 4 years.

These findings are consistent with a prospective follow-up that also found a 60% remission rate.[4] It is notable that the rate of recovery in adolescents parallels that seen over a similar period in adults with BPD.[13]

What we are seeing challenges one of the historically entrenched myths about borderline personality disorders. Research now shows that BPD is not a lifelong condition and that most patients, adolescents and adults, can expect to improve over time.[14]

Mary C. Zanarini, EdD, Professor of Psychology at Harvard Medical School, has been conducting an NIMH-funded study of the long-term course of BPD in adults for the past 19 years. In a personal communication, she reported that her findings show that patients with BPD have a substantially better prognosis than previously recognized; remissions are common and recurrences are relatively rare. She and Marianne Goodman, MD, of Mount Sinai School of Medicine, are conduct-ing a similar study among adolescents (aged 13 to 17) with BPD and a comparison group of emotionally healthy adolescents. Although the data are yet to be fully analyzed, their baseline data show strong similarities between adolescents and adults with BPD.

Not all good news

Prospective studies on the course of adult BPD show that the majority of patients have symptom remission, often within the first 4 years of follow-up.[15,16] However, even though over time most patients with BPD no

longer qualify for the diagnosis, follow-up studies in adults with BPD indicate that good psychosocial functioning is only attained in 60% of these patients. Vocational impairment is more frequently seen than social impairment.[17]

These findings highlight the need to direct patients with BPD to specialized treatments at an early age, when there is more potential to provide them with the skills that are necessary for improved long-term functioning, particularly in the educational and vocational domains. Furthermore, a number of factors, such as childhood sexual abuse and substance abuse, adversely affect outcome in adults with BPD.[18] Once again, lack of research means that much less is known about the factors that predict outcome in adolescents with BPD.

Targeted interventions

Several psychotherapies have been shown to lead to overall improvement in functioning in patients with BPD, although as with research in general, studies of psychotherapy in adolescents with BPD are few. Empirically validated therapies include dialectical behavioral therapy, mentalization-based treatment, schema-focused therapy, and transference-focused psychotherapy.[19-23] Most of these treatments have not been studied in adolescents.

Various treatment options are available for adolescents with BPD. These include standard cognitive-behavioral therapy, individual psychotherapy, and substance abuse treatment.[24] The best evidence-based treatment outcomes for adolescents with BPD come from dialectical behavioral therapy and cognitive analytic therapy.[25,26]

The bottom line

BPD appears to be a neurodevelopmental disorder, influenced by the person's genetics and brain development and shaped by early environment, including attachment and traumatic experiences. BPD also appears to remit in the majority of cases within 4 years of a formal diagnosis. Research and clinical experience underscore that a history of sexual abuse and alcohol and other substance use disorders is associated with failure to remit; affective lability is also associated with continuation of BPD.

Given that there is little reluctance on the part of psychiatrists to diagnose other psychiatric disorders, such as bipolar disorder, in children and adolescents and given that there appears to be a good prognosis for adolescents with BPD, clinicians should no longer be reluctant to diagnose BPD in those younger than 18. The DSM does not preclude it, the prognosis is not negative, and as with many disorders, early diagnosis can lead to timely and targeted treatment for this previously underserved and underrecognized population.

Finally, given the advent of new and validated therapies that target BPD, it is imperative that the diagnosis be made as early as possible so that targeted interventions can be applied. However, because BPD has numerous symptoms that over-lap with other disorders and because of the enduring nature of the symptoms of all borderline personality disorders, clinicians should understand that some features of BPD are likely to be chronic and, as such, be prepared for a long-term treatment relationship.[27]

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