Diagnosis of borderline personality disorder in adolescence: When, why, and how to integrate into treatment

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ROGERS Behavioral Health

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Disclosures

Lauren Ehret, PhD, LP, and Peggy Scallon, MD, DFAPA, DFAACAP, have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Summarize the facts to dispel at least three common myths about borderline personality disorder and its trajectory using data presented from well-designed studies
2. Identify two or more strategies that can be used to effectively deliver a BPD diagnosis to help clients and families

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What we'll cover in this webinar

Overview of borderline personality disorder

- Myths vs. facts of BPD
- Diagnosis, assessment, and longitudinal course of BPD
- Differential diagnosis of BPD vs. other psychopathology in adolescence
- Impact of stigma on diagnosis of BPD

Delivery of a BPD diagnosis to teens and families and treatment implications

- Myths vs. facts about giving adolescents a BPD diagnosis
- Deleterious effects of not providing a BPD diagnosis or misdiagnosis
- How to effectively deliver a BPD diagnosis to clients and families
- Psychoeducation and resources to provide clients and families about adolescent BPD

Case example illustrating BPD diagnosis and education process with clients and families

Moderated Q&A

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Overview of borderline personality disorder

Q&A Please use the Q&A feature to send your questions to the moderator.

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DSM-5 criteria

"A pervasive [**1+ year for adolescents]** pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present ***in a variety of contexts***, as indicated by **5 (or more) of the following**:"

1. Frantic efforts to avoid abandonment (real or perceived)
2. Unstable interpersonal relationships
3. Identity Disturbance: *markedly* and *persistently* unstable self-image
4. Impulsivity in 2+ areas that are potentially-self damaging (not including SH or suicide)
5. Suicidal and self-mutilating behaviors
6. Affective instability due to a marked *reactivity* of mood
7. Chronic feelings of emptiness
8. Inappropriate intense anger or difficulty controlling anger
9. Transient, stress-related paranoid ideation or dissociative symptoms

American Psychiatric Association, 2013

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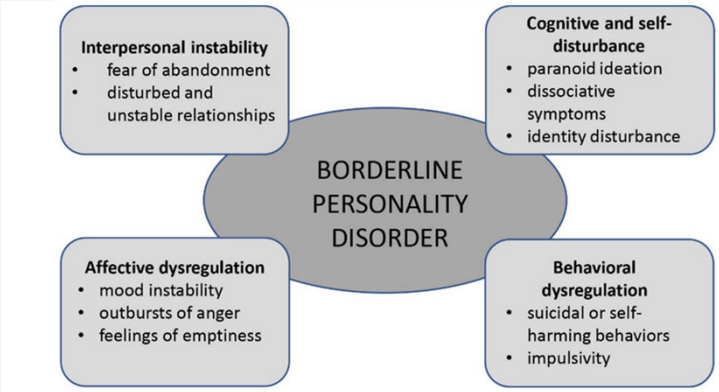

Adapted from Boztello et al., 2021

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Typical vs. atypical adolescent behavior

Typical:

- Increased moodiness
- Increased self-consciousness; feeling "on stage"; increased focus on body image
- Increased parent/adolescent conflict
- Experimentation with alcohol or drugs

Not typical *(Cause for concern)*:

- Intense, painful, long-lasting moods; risky mood-dependent behavior; SI/SH
- School refusal; perfectionism and unrealistic standards; bingeing, purging, or restrictive eating
- Verbal or physical aggression; running away; threatening to kill or harm self if parents do not give in
- Substance abuse; selling drugs; substance-using peer group

Adapted from Rathus & Miller, 2015

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Typical vs. atypical adolescent behavior

Typical:

- Increased sense of invulnerability (may lead to risk taking)
- Increased sexual maturation; sexual interest or experimentation.
- Increased interest in technology or social media

Not typical *(Cause for concern)*:

- Multiple accidents; getting arrested; excessive risk taking (i.e., drinking or texting while driving, shoplifting)
- Sexual promiscuity; unsafe sexual practices; casually meeting partners online; "sexting"; inter-partner violence; teen pregnancy.
- Spending many hours/day on the computer/phone on high-risk or triggering websites (i.e., pro-ana, looking up ways to SH or suicide, adult dating websites)

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Myths and stereotypes about BPD

1. You cannot diagnose someone with BPD until they turn 18.
2. All teens are moody, interpersonally sensitive, and impulsive. Criteria for BPD are not valid in adolescents – this is normative adolescent behavior.
3. Because teens are still developing, symptoms of BPD cannot be stable, enduring patterns of behavior as seen in adults with BPD.
4. BPD is a chronic and intractable illness – much more so than other mental health diagnoses. People with BPD do not get better.
5. BPD is caused by exclusively by environmental factors rather than biology or genetics.

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Biology of BPD vs. other psychopathology

Heritability:

- The heritability estimate for BPD from large, population-based twin studies is **46%**
  - In other words – 46% of the variability in dimensional BPD traits is due to genetic factors
  - In contrast, heritability estimates for MDD is 31% – yet clients often report believing their depression is caused by a "chemical imbalance"

In fact, BPD is caused by a *combination of genetic and environmental factors* (**biosocial model**) and is not necessarily "less genetic" than many other traits regarded as "biological" in origin

Skoglund et al., 2021; Petterson et al., 2019

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Myths about diagnosing BPD in adolescents

- It will do more harm than good because of how stigmatized it is
- Most adolescents and their parents react negatively to receiving this diagnosis
- It will ruin my rapport with the adolescent and/or their parent(s) and negatively impact their treatment
- Borderline PD diagnosis should not be given until age 18. It is not valid in adolescence
- The BPD diagnosis takes away hope
- There is nothing that can be done
- These are normal adolescent behaviors
- Avoiding the BPD diagnosis protects patient from stigma

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Facts

- There is robust literature to support making the diagnosis of BPD in adolescents as young as 11 years-old
- The diagnosis offers clarity, strategies, hope, and community
- The prognosis is good
- DBT is an effective treatment for adolescents
- Data suggest considerable malleability of BPD traits in youth, making this a key developmental period during which to intervene

Chanen et al., 2017; Guile et al., 2021; Lenzenzweger & Castro, 2005

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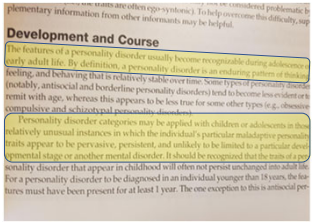
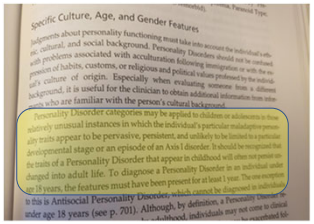
#1 Myth:
You cannot diagnose someone with BPD until they turn 18

Fact: DSM-5, DSM-IV-TR and ICD-11 explicitly allow BPD to be diagnosed in youth < 18 years-old





American Psychiatric Association 2000; 2013 ; WHO, 2019

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Diagnostic criteria

Both DSM-IV-TR and DSM-5 state:

- **"The features of personality disorder usually become recognizable during adolescence or early adult life."** (APA, 2013)
- **"…By definition, a personality disorder requires an onset *no later than* early adulthood."**
- DSM-5 criteria for diagnosing personality disorders in people < 18 years-old:
  - "The features must have been present for **at least 1-year**" (2 yrs for adults)
  - "Personality disorder categories may be applied with children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be ***pervasive***, ***persistent***, and ***unlikely to be limited to a particular developmental stage*** or ***another mental disorder***."
  - Disturbances in **at least 5** of the 9 BPD symptom domains (for BPD specifically)

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Differential diagnosis of BPD in adolescents: Nonsuicidal self-Injury (NSSI)

NSSI ≠ BPD!

- The ***combination*** of self-injury behaviors (NSSI) + cognitive symptoms of BPD (notably persecution ideation in stressful situations) is suggestive of the presence of BPD
- In recent studies, 58% of suicidal BPD adolescents reported NSSI, whereas 51.7% of female adolescents engaging in NSSI met criteria for BPD
- Suicidal and NSSI behaviors should always prompt the clinician to screen for BPD. BPD might also manifest itself as repeated somatic problems or as poor adherence to the treatment of somatic complaint

Guile et al., 2018

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Differential diagnosis of BPD in adolescents: Bipolar disorder

- Bipolar disorder may also present with depressed mood and NSSI
- Look at patterns of mood switching with ***sustained*** periods of ***uncharacteristic*** elevated, expansive, or irritable mood AND ensure sufficient # and severity of DSM-5 criteria for mania are met ***simultaneously***.
- **Bipolar disorder = DISTINCT EPISODES, not CHRONIC**

Bipolar disorder

Borderline personality disorder

Guile et al., 2018

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Misdiagnosis of BPD is common in both adolescents and adults

- BPD was misdiagnosed ***68% of the time*** in a recent sample of 72 adult psychiatric inpatients admitted for suicide risk
- Compared to patients without BPD, those with BPD were:
  - Significantly younger
  - ***Prescribed more psychiatric medications***
  - More depressed
  - Had greater suicide ideation
  - Significantly more likely to be readmitted within 1, 3, and 6 months of discharge

Gregory et al., 2021

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Medication management

- A 2010 review by the Cochrane collaboration found that ***no medications*** **show promise for "the core BPD symptoms of chronic feelings of emptiness, identity disturbance, and abandonment"**. However, some medications may help comorbid conditions. (Stoffers et al., 2010)
- A 2017 review found that "evidence of effectiveness of medication for BPD remains very mixed". (Handcock-Johnson et al., 2017)
- A 2020 review found that research into pharmacological treatments for BPD had declined, and more results confirmed no benefits. Despite lack of evidence of benefit, quetiapine and SSRI antidepressants continue to be widely prescribed for BPD. (Stoffers-Winterling et al., 2020)

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Outcomes and cost of BPD

Suicide

- Paris et al.(2001) for instance, report a chance of 10.3 % over a 27-year follow-up.
- Percentage of BPD-patients that eventually dies by suicide is found to be between 2% and 17%, depending on the length of the follow-up.
  (Oldham, 2006; Pompili et al., 2005; Zanarini et al., 2006)

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Prevalence rates of BPD

Sample	Adolescents	Adults
Community-Based Samples (USA, Canada, UK, Hong Kong)	0.9%-3.6% (6.9% for BPD Traits)	0.7-5.9%
Suicidal individuals referred to Emergency Dep't	Up to 78%	43%
Outpatient Mental Health Settings	11%	10-12%
Inpatient Mental Health Settings	Up to 50%	20-22%

Guile et al., 2021; Bernstein et al., 1993; Ørts Clemmensen et al., 2013; Greenfield et al., 2008; Kaess et al., 2014; Johnson et al., 2008; Lewinsohn et al., 1997; Chanen et al., 2008; Grilo et al., 1996; Lenzenweger et al., 2007; Gregory et al., 2021; Ellison et al., 2018

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Diagnosis of BPD:
Impact of gender, culture, and sexual orientation

Population	Rates of BPD (Naturalistic Samples)	Experimental Research
Sexual Minorities	↑ **BPD in Non-Heterosexual Teens and Adults (all genders)** *Even when controlling for symptoms of depression and anxiety*	↑ **BPD in *men* *perceived* as sexual minority by therapist** *Not significant* in men perceived as heterosexual or women
Gender	↑ **BPD in Females,** though some evidence of bias **Gender Differences in Symptom Expression**: • Girls/Women – ↑ internalizing • Boys/Men - ↑ externalizing	↓ **Accuracy** in diagnosing BPD in **male**, but not female, clients. *Some evidence of bias against diagnosing BPD in men when it is present.*
Race/Ethnicity	**Mixed Results –** no strong association - No differences between groups in BPD features or diagnosis but ↑ **Identity Disturbance in** White and East Asian vs. Black participants - ↑ BPD features in Whites vs. other groups in some past studies	None found for BPD in British experimental study

Bozzatello et al., 2018; Chang, Sharp, & Ha, 2011; Johnson et al, 2003; Reuter et al., 2016; Eubanks-Carter & Goldfried, 2006; Johnson et al., 2003; Liebman & Burnette, 2013; Mikton et al., 2007

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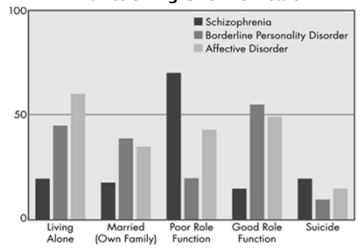
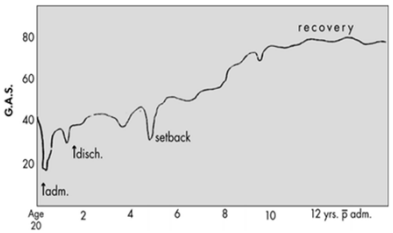
Early follow-back studies call into question gloomy outlook of BPD course illness

Diagnostic Comparison of Psychosocial Functioning Over 15 Years



McGlashan, 1986

Typical Course of Illness of BPD 20 years Post-Long-Term, Intensive Hospitalization



Stone, Stone, & Hurt, 1987

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Longitudinal course of BPD

The Collaborative Longitudinal Personality Disorders Study (CLPS)

Population: Treatment-seeking 18–45-year-old patients

- 175 with BPD
- 312 with Other Personality Disorders (Schizotypal, Avoidant, or OCPD)
- 95 with MDD but no personality disorder diagnosis
- 66% of initial patients completed the 10-year follow-up
- No group differences in completion rate

Design: 10-year prospective longitudinal study

Primary measures:

1. Diagnostic Interview for *DSM-IV* Personality Disorders
2. Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID-I)

Gunderson et al., 2011

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Longitudinal course of BPD

Results from the CLPS

After 10 years:

- **85% of patients with BPD *remitted*** (min.12 months duration)
- 12% of patients with BPD relapsed
  - Lower relapse rate and slower time to relapse than for patients with MDD or Other Personality Disorders
- Social functioning scores showed severe impairment with only modest (albeit statistically significant) improvement.
  - Patients with BPD remained significantly more dysfunctional across multiple areas of life functioning than individuals with MDD or Other Personality Disorders

Gunderson et al., 2011

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BPD symptom change over 10 years

- **All 9 DSM-IV BPD symptoms declined over time**.
- Rates of decline for each of the 9 criteria were similar
- Symptoms that were most prevalent at baseline remained most prevalent after 10 years.

Gunderson et al., 2011

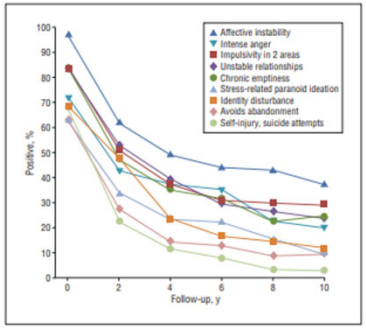

Figure 2. Prevalence of borderline personality disorder criteria. Positive indicates the cases with a score of 2 (definitely present and clinically significant) for each of the 9 borderline personality disorder criteria on the Diagnostic Interview for *DSM-IV* Personality Disorders, assessed for the 2 years prior to the follow-up point.

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Longitudinal course of BPD

Results from the McLean Study of Adult Development – a prospective longitudinal study (MSAD)

After 16 years:

- 60% of patients with BPD achieved 2+ years of recovery

After 24 years:

- Rate of death by suicide = 5.9% of BPD vs. 1.4% of comparison subjects
- Among Borderline patients, # prior hospitalizations significantly predicted death by suicide
- Most Borderline patients who died prematurely either by suicide (87.5%) or non-suicide-related causes (88%) were not recovered before death.
- Patients who did not achieve recovery were at disproportionately higher risk of early death than recovered patients.

Zanarini et al., 2014

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Predictors of treatment outcomes in adults with BPD (MSAD)

After 16 years:

- Earlier time to recovery is predicted by:
  - Less chronic or severe course of illness
    - No psychiatric hospitalizations prior to index hospitalization for study
    - Absence of a comorbid anxious cluster personality disorder
  - Adaptability/Competency
    - Higher IQ
    - Good full-time vocational record in 2 years prior to index admission
  - Temperament
    - High extraversion
    - High agreeableness

Zanarini et al., 2014

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Borderline symptoms at age 12 are predictive of poor outcomes during the transition to adulthood

N = 2232 British twins

- Increased borderline symptoms at age 12 predicted the following at age 18:
  - Increased likelihood of having "difficult personalities"
  - Struggle with poor mental health
  - Experience poor functional outcomes
  - **Become victims of violence**
- Borderline symptoms at 12 years old predicted poor outcomes *over and above* other behavioral and emotional problems during adolescence.
- Borderline symptoms in 12-year-olds were influenced by familial risk, particularly genetic risk, which accounted for associations with most poor outcomes at age 18.

Wertz et al., 2020

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Delivery of a BPD diagnosis to teens and families and treatment implications

Please use the Q&A feature to send your questions to the moderator.

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Purpose of mental health diagnosis

- **Short-hand communication** between professionals about a client
- Convey something about the course and **prognosis** of what the individual is experiencing
- For making appropriate **treatment recommendations**:
- Ensuring the individual accesses interventions (therapy and medication) that are *evidence-based*
  - Treatments that we know, on average, are effective for reducing symptoms and improving functioning in people similar to the client at hand.
- Ensuring that clients are NOT given ineffective or excessive treatments, especially those that have the potential for harmful or unpleasant side effects or cost (money, time, etc.) when there is no expectation for benefit.

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Why WOULD I diagnose BPD in an adolescent patient?

BPD typically first manifests itself in adolescence – people don't wake up on their 18th birthday and suddenly manifest these symptoms

- 60% of people with BPD start self-harming by age 18
- 30% before age 13
- Early borderline pathology (before age 19 years) predict long-term deficits in functioning
- A higher percentage of these patients have BPD symptoms up to 20 years later

Early identification = Early Intervention = Fewer years of one's life living in misery

Chanen, 2015; Bozzatello, Bellino, Bosia, & Rocca, 2019

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Delayed BPD diagnosis or misdiagnosis

Deleterious effects…

- Avoidance of the BPD diagnosis leads to misdiagnosis…
- Misdiagnosis is bad and leads to…
  - Confusion
  - Erroneous treatment
  - "Splitting"
  - Delayed treatment
  - Polypharmacy
  - Perpetuation of stigma

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Diagnosis of BPD: Impact of stigma

- BPD is highly stigmatized among professionals, and it is also associated with 'self-stigma' among patients with BPD
- Stigma and inaccurate beliefs make clinicians are less likely to diagnose BPD when it is evident relative to other mental health diagnoses
- Some patients strongly identify with these alternative diagnoses leading to:
  - Less acceptance of BPD as a diagnosis
  - Less acceptance of evidence-based treatment for BPD as they don't want a treatment for a disorder, they don't believe they have or have negative beliefs about

Chanen & McCutcheon, 2013; Avarim, Brodsky, & Stanley, 2006; Rüsch et al., 2006

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Delivery of the diagnosis of BPD: Who, what, when and how to

- Complete a thorough clinical assessment including a review of alternative and co-existing diagnoses
- Observe youth and obtain collateral information
- Discuss first with parents-provide psychoeducation
- Then discuss with kids-provide psychoeducation
- Then discuss together

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Delivery of the diagnosis of BPD: Who, what, when and how to

- Describe observations and information gathered
- Review diagnostic criteria from DSM-5 – meet 5 of 9 criteria
- Discuss questions and concerns with parents and patients
- Provide psychoeducation and resources for parents and patient

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Assessment and diagnosis of adolescent BPD

Self-report screening tools:

1. Abbreviated Diagnostic Interview for Borderlines (Ab-DIB)
2. Borderline Personality Features Scale for Children (BPFSC-11)
   - Initially derived from the PAI used with adults
3. Dominic Interactive for Adolescents-Revised (DIA-R)
   - Interactive multimedia screening tool for multiple DSM-5 mental disorders and suicidality

Screening for BPD is feasible but not a replacement for clinical diagnosis.
(Chanen et al., 2008)

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Assessment and diagnosis of adolescent BPD

Semi-structured clinical interviews:

1. DIB-R
   - Used extensively in research on BPD in adolescents
2. Childhood Interview for *DSM-IV-TR* Borderline Personality Disorder (CI-BPD)
   - Designed specifically for BPD traits in children and adolescents

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Case example

Q&A **Please use the Q&A feature to send your questions to the moderator.**

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Case example: Alex

- 14-year-old female to non-binary youth
- 2 past inpatient stays, 2 past PHP episodes
- Chronic SI: “What is the point?”, “I am a burden”
- Self-harm 1-2X weekly with blades, pen caps, paper clips
- Grades have dropped, Covid made things worse
- Conflict with parents; parents don’t agree
- Multiple medications; none have helped much, but atypical antipsychotic trials have resulted in weight gain
- Problematic and excessive social media use
- Lost contact with previous friendships; current friends are also suicidal, using substances
- Multiple diagnoses including bipolar disorder, psychosis, depression, ADHD, DID, OCD
- Dissociative phenomenon (voices, “alters”, tics) have resulted in diagnostic confusion
- Meets all diagnostic criteria for BPD
- Assessment scores indicate high depression, high SI, low activation, high social anxiety

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Case example: Alex

While in our residential program…

- Medications were tapered down to SSRI only; consideration of stimulant medication
- DBT and CBT skills-based interventions
- Behavioral Activation strategies on our unit
- Screen use re-set = restrict certain apps and set limits on time and place of use
- Discussed the harm of "splitting" with respect to behavioral management, diagnoses, treatment, medications and general expectations
- Taught parents DBT skills and provided psychoeducation
- Taught parents the importance of not accommodating
- Taught parents the importance of maintaining age-appropriate expectations
- Taught communication strategies to parents – emotion-coaching, and validation

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Case example: Alex

While in our residential program…

- Reviewed emotional identification and exposure-to-emotion strategies with patient
- Reviewed the concerns with polypharmacy-metabolic syndrome, weight gain, tardive dyskinesia and others
- Reviewed the concerns with repeated hospitalizations
- Reviewed prosocial supports and interests patient could pursue
- Re-framed the meaning of symptoms

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Key take-home messages: Diagnosis

- We should not hesitate to use the diagnosis of Borderline Personality Disorder in adolescents when it is accurate
- The medical literature suggests that early, accurate diagnosis supports the best outcomes
- There is a hopeful prognosis; patients and parents feel validated and more competent when we provide this framework.
- The outcome of avoiding the BPD diagnosis results in erroneous diagnoses, crystallized symptoms, iatrogenic harm including misguided treatment and polypharmacy
- Deliver the diagnosis with an openness, observation, sharing of information and psychoeducation and hopeful and useful strategies
- Early and accurate diagnosis is cost effective, ethical and combats stigma

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Key take-home messages: Treatment

- Team-based therapeutic approaches offer advantages
- Skills-based therapies are needed, particularly DBT-A
  - DBT treatment including individual, family, group therapies, and phone support is more effective than "treatment as usual"
  - Therapists should consider whether to keep the patient or refer out to a DBT center
  - If access to a DBT center does not exist, therapist should consider other options including referral to virtual PHP/IOP for DBT, or therapist could get additional training
- Communicate with all team members – therapist, school, pediatrician, psychiatrist, parents, extended family
- Hospitalization may be needed in times of safety risk, but can present concerns regarding "illness identity", disruption of school, splitting of team members and confusion regarding treatment approaches

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Key take-home messages: Treatment

Patient

- Maintain age-appropriate expectations such as school, driving, part-time job, hobbies
- Put limits and supervision in place for screen time

Family

- Parents may wish to get their own therapists and support
- Parents should convey hope and equanimity

Medication

- No medication treatment for BPD itself, but do treat co-morbidities
- Polypharmacy is not evidence-based and presents likely side effects

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Time for questions and answers…

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Resources for patient and family psychoeducation

National Education Alliance for Borderline Personality Disorder

borderlinepersonalitydisorder.org

American Academy of Child & Adolescent Psychiatry

AACAP.org

Borderline Personality Disorder in Young People

No. 127; Updated October 2019

Child Mind Institute

childmind.org

What Is Borderline Personality Disorder?

And why it's now being diagnosed and treated in teenagers

Behavioral Tech

A Linehan Institute Training Company

behavioraltech.org

Home › Resources › Resources for Clients & Families

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About the presenters….

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