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# Borderline Personality Disorder in Adolescence

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### Costs and Consequences of BPD

Borderline personality disorder (BPD) is characterized by high personal distress, poor physical health, and functional disability. Those with the disorder are likely to experience impairment in school and work, as well as in relationships with romantic partners, family members, and friends.<sup>1</sup> For example, when good psychosocial functioning was defined by at least one emotionally sustaining relationship and a successful work or school record, only 25% of patients with BPD met this threshold, as compared to almost 60% of patients with another personality disorder.<sup>1</sup> Societal costs are also high, which is primarily due to high rates of unemployment<sup>2</sup> and treatment utilization.<sup>3</sup> Despite high rates of health services use among those with BPD, the suicide rate is high: approximately 8% of individuals die by suicide.<sup>4,5</sup>

Importantly, this impairment is not limited to those with a diagnosis of BPD but extends to individuals presenting with sub-threshold levels of symptoms. For example, elevated features of BPD in young adults are associated with poor 2-year academic performance and interpersonal problems.<sup>6</sup> Even those meeting a single criteria for BPD show elevated rates of Axis I disorders, suicidal thoughts and behaviors, psychiatric hospitalizations, missed work due to psychiatric illness, and impaired global functioning.<sup>7</sup> Thus, BPD and even symptoms of the disorder are to be taken seriously, and efforts at early intervention and prevention are imperative to reduce the personal, interpersonal, and societal costs of the disorder.

### Epidemiology and Developmental Course of BPD

BPD affects 1% to 3% of the general adolescent and adult populations,<sup>8-10</sup> yet is highly prevalent in psychiatric treatment settings. Among adolescent and adult

psychiatric patients, the prevalence of BPD ranges from 10% to 22% in outpatient clinics<sup>9-12</sup> and 40% to 50% in inpatient settings.<sup>13,14</sup> While girls and women are more frequently diagnosed with BPD in treatment settings compared to boys and men, community-based studies generally do not support differential rates of diagnosis by gender.<sup>15-17</sup>

The development of personality disorder symptoms spans the entire life course. In fact, the onset of BPD typically occurs during adolescence and symptoms can be readily detected by early adolescence, if not earlier in childhood.<sup>18-21</sup> In addition, substantial temporal stability has been demonstrated among children and adolescents for dimensional measures of BPD features or underlying traits.<sup>18,22-26</sup> Among youth in a community sample, Bornovalova and colleagues (2011) reported moderate rank-order stability in BPD from ages 14 to 24, suggesting that youth that are high at 14 relative to their peers were also likely to remain high at age 24 relative to their peers, and conversely, those low at 14 were also likely to remain low at 24. However, BPD symptoms were most elevated and stable from ages 14 to 17, and the overall mean of symptoms declined significantly from ages 17 to 24. Overall, these findings underscore the stability of BPD and point to adolescence as a particularly high-risk period.

Within 6 years of first presentation or index admission, approximately 70% of patients with BPD will attain symptomatic remission.<sup>27</sup> Unfortunately, functional impairment and disability often linger even after patients have attained remission status.<sup>28,29</sup> For example, over 10-year follow-up, those with BPD were less likely than patients with other personality disorders to achieve good psychosocial functioning, and they attained it more slowly. This failure to achieve good psychosocial functioning over the follow-up was largely due to high rates of occupational impairment.<sup>1</sup> In another study of the course of interpersonal symptoms, those with negative affect when alone and fear of abandonment were the slowest to remit, with 15% to 25% of those exhibiting these symptoms at baseline continuing to show them at 10-year follow-up.<sup>1,30</sup> Thus, engaging in meaningful work appears to be important for recovery from BPD.

Consistent with this, treatment models from various traditions have stressed the need for social integration amongst individuals with BPD. For example, Linehan (1993)<sup>31</sup> emphasizes building a life worth living as the crux of Dialectical Behavior Therapy.

The course of BPD may be complicated by complex patterns of co-occurring psychiatric disorders. For example, in a nationally representative survey of adults, among those with BPD, 84.5% also met criteria for another psychiatric disorder and met criteria, on average, for three diagnoses.<sup>15</sup> Specifically, the majority of those with BPD have a comorbid mood, anxiety, or substance use disorder.<sup>32</sup> For example, approximately 60% of individuals with BPD also met criteria for a lifetime substance abuse disorder.<sup>33</sup> This high rate of comorbidity is also true of adolescents. Those with BPD show elevated levels of both internalizing and externalizing disorders compared to adolescents with another psychiatric disorder.<sup>34</sup>

### Assessment and Diagnosis of BPD in Adolescents

Clinicians have historically been resistant to diagnosing BPD in adolescents due to one or more misconceptions about psychiatric nomenclature, normative personality development, and fears of stigmatizing youth.<sup>35</sup> Although diagnosis of the disorder prior to adulthood has been the subject of much debate,<sup>36</sup> the DSM-5<sup>37</sup> does allow the diagnosis of BPD in adolescents. There is now evidence that the diagnosis shows comparable validity and reliability in adolescence compared to adulthood,<sup>11,21,35</sup> and rank-order stability of BPD symptoms during this time is similar to that seen in adulthood.<sup>22</sup> Additionally, adolescents with BPD experience high rates of concurrent distress and dysfunction, and are likely to carry the diagnosis into adulthood.<sup>32,38-41</sup> Furthermore, a diagnosis of BPD in adolescence is associated with prognosis over and above other, more commonly diagnosed psychiatric disorders.<sup>34,42</sup> Thus, continuing the outdated practice of refusal to screen, assess, and diagnose adolescents with BPD fuels stigma about BPD among mental health professionals and prevents the adolescent from receiving appropriate treatment.

## Differential Diagnosis

Due to the complex clinical presentations of individuals with BPD, clinicians often struggle to diagnose the disorder when it is present, particularly without the aid of standardized interviews.<sup>43</sup> BPD is frequently confused for other disorders, especially bipolar disorder and major depressive disorder, which is likely attributable to overlapping diagnostic criteria.<sup>44,45</sup> Additionally, clinicians may hold the belief that certain features of BPD, such as impulsivity and stormy relationships, are simply normative for adolescence,<sup>46</sup> and they may also want to avoid diagnosing individuals due to the stigma attached to the disorder.<sup>47,48</sup> However, failure to detect and diagnosis BPD is clinically relevant; indeed, the presence of BPD adversely affects the course of substance use treatment,<sup>49</sup> and individuals with a personality disorder show poorer response to depression treatment.<sup>50,51</sup>

Major depressive disorder and bipolar disorder are common comorbidities of BPD, and the overlap among their diagnostic criteria can lead to confusion and difficulty with accurate diagnosis. However, attention to a number of features, particularly the quality and time course of symptoms, can help with diagnosis. In terms of quality of symptoms, greater fluctuations in anger and anxiety, and oscillations between anxiety and depression, appear to be unique to BPD.<sup>52</sup> The duration of mood states in BPD also tends to be short; specifically, affective instability refers to extreme mood fluctuations within a day.<sup>37</sup> In contrast to affective instability in BPD, hypomania is a marked departure from typical mood; the euphoria of mania is frequently grandiose and requires persistent increase in energy and productivity, allowing an individual to sleep significantly less than usual while still feeling rested. Furthermore, anhedonia and negative mood in depression are more stable compared to the affective instability and even the dysphoria seen in BPD, needing to persist at least two weeks to be considered depression. Careful consideration of the extensive comorbidity among these disorders, including the timing and quality of the symptoms, is required when patients may show signs of several disorders. Arriving at an accurate diagnosis, however, is essential for effective and ethical patient care.

Finally, childhood trauma is thought by some to be central to the development of BPD (e.g., Ball & Links, 2009).<sup>53</sup> While BPD is associated with childhood trauma and high rates of post-traumatic stress disorder (PTSD) (25%),<sup>54</sup> it is not the case that individuals diagnosed with the disorder have a history of abuse or trauma.<sup>55</sup> In other words, while a diagnosis of PTSD hinges on the occurrence of a traumatic event and sequela of exposure to the event, trauma exposure is not inherent in the definition of BPD. In fact, many individuals with BPD have not experienced childhood trauma in any form.<sup>54,56</sup> Ultimately, there is evidence that the two disorders are distinguishable, even in the case of complex PTSD.<sup>57,58</sup>

## Assessment Tools

Diagnosis is confirmed by the presence of at least five of nine DSM-5 criteria (see Table 1 on Page 4).<sup>37</sup> These criteria are the same for adults and adolescents, however symptom duration is expected to be shorter prior to adulthood: symptoms must be present for one year in those < 18-years of age, and two years for adults. There are several measures that have been validated for the assessment of BPD in adolescents. These include semistructured interviews such as the Child Interview for Borderline Personality Disorder (CI-BPD);<sup>59</sup> Q-sort procedures such as the Shedler-Westen Assessment Procedure for Adolescents, Version II (SWAP-II-A);<sup>60</sup> and self-report measures such as the Personality Assessment Inventory Borderline subscale (PAI-BOR);<sup>61</sup> the Borderline Personality Features Scale for Children (BPFSC),<sup>23</sup> a shortened version of the BPFSC for resource-restricted settings (BPFSC-11);<sup>62</sup> the McLean Screening Instrument for BPD (MSI-BPD);<sup>63</sup> the Borderline Personality Questionnaire (BPQ);<sup>64</sup> the Minnesota Multiphasic Personality Inventory – Adolescent version (MMPI-A);<sup>65</sup> and the Dimensional Personality Symptom Item Pool (DIPSI).<sup>66</sup> The use of these assessment tools, especially those that have been designed to reduce patient burden, may be used in clinical practice to aid in detection, diagnosis, and initiation of treatment for BPD.

TABLE 1:

### DSM-5 Diagnostic Criteria for Borderline Personality Disorder

1. Frantic efforts to avoid real or imagined abandonment. *(Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)*
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). *(Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)*
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

### Treatment of BPD in Adolescents

Research suggests that BPD symptoms during adolescence demonstrate substantial malleability<sup>67</sup> and respond to intervention.<sup>36</sup> Thus, adolescence is a critical period for intervention. Several psychotherapy treatments have been specifically developed or adapted for adolescents with BPD, including Cognitive Analytic Therapy (CAT),<sup>68</sup> Emotion Regulation Training (ERT),<sup>69</sup> Mentalization-based Therapy (MBT),<sup>70</sup> and Dialectical Behavior Therapy for Adolescents (DBT-A).<sup>71</sup> While research on the effectiveness of these disorder-specific treatments is ongoing, initial results are promising, and it is likely that these structured interventions are superior to treatment as usual. According to a recent meta-analysis,<sup>72</sup> there was no existing evidence for any BPD-specific pharmacotherapy. Rather, “symptoms-focused” pharmacotherapy is sometimes practiced in adults, and given the lack of empirical support for this approach, should not be used to treat adolescent BPD.

### Stigma and Potential Effects

Individuals with BPD often have difficulties expressing anger and other intense emotions, struggle to self-soothe, and engage in suicidal and other dangerous behaviors. The very nature of these symptoms in combination with their volatility can be emotionally challenging for the clinician treating an individual with BPD. Thus, it comes as no surprise that mental health professionals often describe patients with BPD as “difficult,” indeed, at times the symptoms can challenge one’s professional identity and sense of competence. However, the use of pejorative and judgmental terms such as “difficult,” “demanding,” “manipulative,” “attention-seeking,” and “treatment resistant” to describe individuals with BPD and the symptoms of their illness has serious implications for the patient and the provider. These assumptions can be used to justify discriminatory practices, such as refusing to provide services and early termination from treatment.

BPD is one of the most stigmatized psychiatric disorders; indeed, Aviram and colleagues (2006)<sup>47</sup> found that mental health professionals tend to hold negative views of

individuals with BPD and are likely to distance themselves from these patients. Given the interpersonal hypersensitivity experienced by those with BPD, experiencing this stigma and distance can only exacerbate symptoms of the disorder. Individuals with BPD appear to hold extremely negative self-concepts and are high in self-stigma.<sup>73</sup>

Individuals with BPD often have a number of interpersonal difficulties that may be experienced as threatening or frustrating for others, which may be one factor in the stigma associated with the disorder. It is clear that with individuals with BPD, individuals cannot always rely on automatic interpersonal reactions and styles that may work with others. Rather, part of developing a truly therapeutic milieu requires mental health care workers treating individuals with BPD to receive ongoing support and supervision.<sup>31</sup> Treatments for BPD provide a number of recommendations for individuals treating BPD, including radical acceptance, person-centered approaches to interactions, and guidelines

for managing patient crises and threats to treatment. These skills are especially important in dealing with adolescents who may have BPD in order for treatments to have healing rather than iatrogenic effects.

## Conclusion

Individuals with BPD access treatment services at a high rate yet have poor outcomes. This paradox highlights our ineffective clinical management of this disorder. Although the onset of BPD typically occurs during adolescence, its diagnosis is often delayed for many years, and BPD-tailored interventions are only offered to those with the most severe forms of the disorder. Incorporating routine screening and assessment for BPD in psychiatric clinics serving adolescents is necessary to facilitate informed and evidence-based treatment decisions, as well as to ensure that health care policies and services adequately address the needs of those suffering from this illness.

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