BPD In Adolescence: Early Detection and Intervention

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Quick Points

• The idea that we have to wait until 18 to diagnose a personality disorder makes little clinical sense and flies in the face of current evidence.

• In our clinical experience most adult patients with BPD recognize that their symptoms started in adolescence.

• Personality evolves in children. Parents often recognize that their children can have very different personalities from each other.

• Psychiatry has been comfortable diagnosing most other DSM conditions in younger people.
Adolescent BPD Case

- “Maria” is a 17 yo junior in HS. SWF who lives at home with parents.
- Multiple (at least 12) previous psychiatric hospitalizations for depression, suicidal ideation and self-injury.
- Despite high IQ, has had poor grades since middle school.
- She feels that others do not and cannot possibly like her. Has few friends.
- Has traded sex for drugs and alcohol on multiple occasions.
- Also feels that sex with boys “is the only way” to get them to like her.
- Many of the brief sexual relationships have been abusive.
Case - continued

- Feels she “deserves” abusive relationships.
- Acknowledges that drug, alcohol, sex and self-injury frequently are used to regulate how she feels in the moment.
- Most intolerable is her sense of self-loathing. She cannot stand herself and “feels like crawling out of my skin” when not high.
- Feels intense shame and guilt about what she does and some relief from the intensity of doing what she “knows best”.
- She is remarkably attuned to non-verbal communication especially with female peers. Says she “knows” that someone doesn’t like simply by the way the other looks at her.
Historically

- Historically clinicians saw BPD symptoms in adolescence as either an extreme variant of normal functioning, or solely as a reflection of poor parenting. “Blame condition.”

- Adolescents with BPD behaviors were seen as “promiscuous” and “manipulative”.

- BPD was a condition that clinicians refused to treat. Even today there is a prejudice against treating BPD.
• BPD usually emerges during adolescence and is estimated to affect 0.9% to 3% of community-dwelling teenagers and up to 3.5% of young adults.

• In inpatients, this prevalence rises to 49% in adolescents and 42% in young adults.

• Today we can apply DSM-IV BPD Criteria to Adolescents:

Efforts to Avoid Abandonment

- Hospitalized for a suicide attempt after a break-up with a romantic partner, or rejection by a close friend or peer group.

- A profound sense that someone essential to their well-being will never come back.

- Suicidal and other maladaptive behaviors are sometimes reinforced by loved ones and caregivers.
Unstable Relationships

- Parents and friends alternate between being best parent/friend in the world and then vilified.
- A reflection of all-or-nothing or black-and-white thinking.
- On hospital units, divide staff into good and bad.
- Good/Bad designations can easily change!
- These designations are often mood dependent.
Unstable Sense of Self

- This criterion is harder to define in adolescents with BPD.
- Adolescence a time of defining identity.
- We see profound and enduring self-loathing as a core self-construct in many of the kids we work with.
- Some are chameleon-like (porous) -- adapt readily to whatever group of friends or trend or emotion or even psychiatric symptom is current.
- Recognize that others have a better sense of who they are than they do.
Dangerous Impulsivity

• In younger adolescents with less access to cars and money, reckless driving and spending are unusual.

• Indiscriminate sex (vs. “promiscuity”), drug abuse, eating problems, and running away from home are more common—often used to regulate emotions.

• Older adolescents take risks with driving and spending, similar to adults.

• Some adolescents “hook up” with much older adolescents/adults.
Recurrent Suicidal Behavior

- Self-injury in the form of cutting is the most common presenting symptom.
- Other behaviors include burning, head banging, punching walls, attempts to break bones and “insertions”.
- Suicide attempts include drug ODs, guns, hanging, jumping, car (crashes, carbon monoxide).
- Behaviors can be reinforced by the well-intentioned attention of caregivers.
Affective Instability/Extreme Mood Reactivity

- Feel things “quicker” and with less apparent provocation than others.
- Feel things more intensely than others.
- Slower return to baseline than others.
- Behavior is often mood dependent.
Chronic Feelings of Emptiness

- In adolescents this is often expressed as boredom.

- Temporarily relieved by risky or “intense behaviors” (intense relationships, sex, drugs).

- Sometimes expressed as feeling “lonely” or alone.
Anger Regulation Problems

- Fights occur most with those closest to the BPD adolescent.
- “Fights” can take the form of destruction of property, bodily violence, or hurtful verbal attacks.
- The DSM specifies anger but it is not only anger but other intense emotional states that are difficult to regulate.
- Using anger only as a criterion can lead to not having enough criteria!
Paranoia and Dissociation

- Some BPD adolescents have been abused.
- Some suffer co-occurring PTSD.
- Dissociation, depersonalization and derealization are common in the group with trauma.
- Paranoia can manifest as the assumption of evil or bad intention by another.
Non-DSM Criteria in BPD Adolescents

- See themselves as loathsome, evil or contaminated and that they will end up contaminating others.
- Profound sense of hopelessness and self-hatred without other vegetative symptoms (not just depression).
- Marked lack of a sense of continuity of time.
- Great difficulty in consistently performing at school despite cognitive ability.
- In relationships there is a tendency to connect emotionally rather than physically or simply by gender.
- Complain that they are universally misunderstood or that they don’t feel they deserve to be understood.
- Remarkably attuned to non-verbal communication.
- Remarkably susceptible to others emotions.
Developmental Precursors to BPD

- Theory and cross-sectional data suggest several temperamental and environmental contributors to BPD
  - INTERNALIZING CONTRIBUTORS: propensity for negative affectivity further broken down into the factors of fear and distress
  - EXTERNALIZING CONTRIBUTORS: predisposition for high novelty seeking, impulsivity, and lack of constraint
  - Others (childhood trauma; low distress tolerance) thought to be major contributors as well

- Retrospective studies → adult BPD is associated with childhood EXT disorders (conduct disorder, oppositional defiant disorder, ADHD)
  - Retrospective reporting does not allow to determine the precise window of risk in childhood and adolescence
  - Nothing known about genetic and environmental overlap between EXT and INT with BPD (over time).
Early Childhood and Heritability

- Few studies testing heritability of BPD explicitly

- Heritability of temperamental vulnerabilities to BPD (affective dysregulation and behavioral undercontrol) is moderate (.40-.60)

- Inconsistent results in four cross-sectional studies explicitly testing heritability of BPD
  - Heritability ranges from zero to .76
  - All studies consistently show presence of additive genetic and non-shared environmental factors, but absence of shared environmental factors

- Many behavioral phenotypes increase in heritability over time (e.g., externalizing behavior, mood and anxiety disorder symptoms)

Longitudinal Research

- 2510 members of male and female monozygotic and dizygotic twin pairs from the Minnesota Twin and Family Study followed from age 11-24 (about 50% female)
  1. Assessment of BPD traits: Age 14, 17, 20, 24
  2. Internalizing and externalizing psychopathology measured at 11, 14, 17, 20, 24

• Bornovalova et al, 2010;
Findings

- BPD changes throughout adolescence and adulthood
  - Biggest drop from 17 to 24

- Internalizing and externalizing symptoms seem to serve as developmental contributors to adult BPD
  - Internalizing symptoms seem to have an especially strong effect on adult BPD when manifested at age 11 and 14
Impediments to Treatment

- Adolescents with BPD commonly seek clinical help but opportunities for early intervention are frequently missed.
- Clinicians often consider it controversial to diagnose personality disorders (PDs) in adolescents.
- Such diagnoses are frequently either discouraged or made too late, when functional impairment and iatrogenic complications have become entrenched.
- Treating adolescents with BPD can cause considerable stress and strong emotions in clinicians.
- Adolescents with BPD often struggle with interpersonal relationships – including with therapists – and may find it difficult to remain engaged in therapy.


Dedicated Treatments for BPD

- Dialectical Behavioral Therapy (DBT) also studied in adolescents

- Studied in adults:
  1. Schema-Based Therapy (SBT)
  2. Cognitive Behavior Therapy (CBT)
  3. Mentalisation Based Therapy (MBT)
  4. Transference Focused Therapy (TFT)
  5. Acceptance and Commitment Therapy (ACT)
  6. Interpersonal Group Therapy (IGP) and
  7. Systems Training for Emotional Predictability and Problem Solving (STEPPS)
  8. Manualized Cognitive Therapy

- Medication?
  - There is no compelling evidence for the use of medications to treat adolescent BPD. Medication should never be used as a primary treatment for adolescent (or adult) BPD

What is DBT?

- Developed by Marsha Linehan, Ph.D.
  - Attempted to treat suicidal patients with CBT which focuses on identifying and **CHANGING** the thoughts, behaviors and emotions that lead to suffering.
  - CBT had proven efficacious in the treatment of depression but made Borderline patients worse.
  - Found that standard “talk therapy” or dynamic therapies “felt good” to the patients as the felt **ACCEPTED** and understood.
  - Talk therapies helped some groups of patients but BPD patients continued to suffer.

- **DBT** balanced the **CHANGE** strategies of CBT with the **ACCEPTANCE** stance of dynamic therapies and Zen.
Why use DBT with Adolescents?

- It is easier to teach a “young dog” new tricks. Kids are used to learning. The DBT skills have practical application and are not abstract.
- When faced with a suicidal teenager, therapists often experience a sense of confusion and fear about how to begin treatment. DBT addresses this.
- DBT guides the focus to the appropriate area based on a treatment target hierarchy. It does not deal with the “why” until a person is safe.
- DBT targets symptoms such as impulsive aggression and self-injury.
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Final Thoughts

- Adolescent BPD looks a lot like adult BPD (particularly in women).
- Their symptoms tend to be based on skill deficits rather than intentional “acting out”.
- Rethink manipulation and promiscuity!!!!
- Early treatment includes habilitation vs. rehabilitation and psychoeducation.
- Dedicated treatments are emerging and increasingly empirically validated
- We must persist in ongoing efforts to increase public awareness of BPD.