“Helping Your Adolescent with BPD”

Step 1: Psychoeducation

Blaise Aguirre, MD
Medical Director
3East Residential
www.3East.org
Assistant Professor of Psychiatry
Harvard Medical School
@blaisemd
Quick Points

- The idea that we have to wait until 18 to diagnose a personality disorder 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 (or earlier).
- 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.
“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 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 were seen as promiscuous and manipulative.

- BPD was a condition that clinicians refused to treat. Still today we get referrals from clinicians who “don’t treat suicide.”
• 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 (I don’t like the word “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 on our unit.
- We also see burning, head banging, punching walls, attempts to break bones and “insertions”.
- Most patients have made at least one suicide attempt (generally OD but include guns, hanging, jumping in front of automobiles).
- 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.
- Mood reactivity is on a continuum. How much does it affect the person’s life?
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

References:
“Helping Your Adolescent with BPD”

Step 2: A More Effective Way Forward
Objectives

- To define Dialectical Behavioral Therapy (DBT).
- To identify the core components of DBT treatment.
- To explain the skill set and its application as used in adolescent populations.
BPD adolescents can be “difficult” patients

- They threaten suicide as they leave your office.
- They self-injure, sometimes in front of us.
- Call after hours and leave messages saying “goodbye”.
- They miss appointments.
- They appear to get better and then fall apart.
- They are often non-compliant.
- They devalue our clinical skills.
- They make us feel as if we personally have failed.
If You Learn Nothing Else Today

- Validation
- Manipulation
A Word About: Validation

- **Validation**
  - Conveys legitimacy and acceptance of the other’s experience or behavior
  - Does not judge another’s experience

- **Invalidation**
  - Delegitimizes valid experiences or fails to acknowledge their existence and/or legitimacy
  - Makes problems appear easier to solve than they actually are (for that person)
Manipulative Behavior

- Intention
- Effect
- Reinforcement
- Extinction
- Best they can
- Bad “manipulators”
- Our role as parents
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, parents 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.
Commitment to DBT Treatment

- Commitment strategies are a cornerstone of DBT Treatment.
- These strategies arose from evidence suggesting that people were more likely to behave in a particular way if they agreed to do so beforehand.
- Adolescents are more likely to be “encouraged” to do therapy. Parents, teachers, therapists or friends “encourage” adolescents to seek treatment, although they themselves might not be initially “motivated” to attend therapy.
- Adolescents are not be accepted into DBT treatment if there is NO commitment to change.
- Examples: Foot in the Door, Pros and Cons, Freedom to chose in the absence of alternatives.
Five Functions of Comprehensive Parenting

- Enhancing your kid’s capabilities.
- Improving their motivation to change.
- Ensuring that new capabilities are generalized from home to the kid’s everyday life.
- Enhancing the parent’s capabilities and motivation to be more effective with their kid.
- Structuring the environment to support the family’s capabilities.
Parenting Hierarchy for BPD kids

1: Life endangering behaviors (suicidality, self-injury)-Have to help keep your kid safe
2: Treatment interfering behaviors (multiple hospitalizations, missed appointments)-Have to help get to and keep your kid in therapy!
3: Quality of life interfering behaviors (substance abuse, multiple sex-partners) – Parenting 101
4: Increasing BPD knowledge and increase your own ability to deal with stress
DBT Assumptions about Patients

- Patients are doing the best they can.
- Patients want to improve.
- Patients must learn new behaviors in relevant contexts.
- Patients may not have caused all of their problems, but they have to solve them anyway.
- The lives of suicidal patients and BPD are unbearable as they are currently being lived.
DBT Modes of Treatment

- Individual Psychotherapy
- Skills Training Groups
- Telephone/Skills Coaching
- Therapists’ Consultation Team
- Family Skills Training
- Other Treatments (psychopharmac etc.)
Skills Training

- Teaches the skills that adolescents need in order to move closer toward their life goals.

- Taught in a classroom type setting which approximates a school classroom.

- They are provided notebooks to take notes of the skills being taught. Homework is required.

- In out-patient settings generally 90 minutes once per week.

- Help adolescents cultivate an ability to work these skills into their daily lives.
Individual DBT Psychotherapy

- One to two times per week.

- Skills training puts skills “in” (teaching).

- Individual therapy pulls skills “out” (application).

- Works in detailed chain-analysis of events.
DBT Group Therapy

- 5-8 patients per group.
- In outpatient settings once per week for 90 minutes.
- Groups are more experiential.
- Experience more social support.
- See how others integrate skills into their lives.
Skills Coaching

- Recognizes that problems most often occur out of the individual therapy session.
- Is used NOT as a therapy session, but as a way to provide coaching through a difficult moment.
- Skills coach can be but need not be the individual therapist.
- Skills are generalized to real life situations.
Consultation Team

- In order for therapy to work it is critical that the therapist be healthy and have enough support.
- Therapist Consultation is integral to a patient’s therapy.
- Therapists must be involved in a DBT consultation team.
- The goal of this is to keep the therapist on track with DBT and to prevent demoralization of the therapist.
- “Burn out” is primarily targeted.
- Therapists make commitments to each other similar to the commitments clients make in entering DBT.
- The DBT process is used with the therapists in the group.
- The same skills are encouraged, and reinforcements and punishments are used.
Parent’s Skill Training

- Parents are required to attend a multi-family parents’ group.
- They learn the same skill set as the adolescents learn.
- The group is also psychoeducational to teach parents about BPD and related disorders.
- Further, parents learn to understand and respond to specific adolescent behaviors, to encourage the use of skills at home, and to receive support from each other in a DBT framework.
DBT Skills Modules

- Mindfulness
- Interpersonal Effectiveness
- Distress Tolerance
- Emotion Regulation
- Middle Path
Three primary states of mind are presented: “reasonable mind,” “emotion mind,” and “wise mind.”

“Wise mind” is the integration of “emotion mind” and “reasonable mind.”

WHAT skills (What you do to get to wise mind: observe, describe and participate)

How skills (How you do this: Without judgment, focusing on one thing in the moment, and effectively)
Distress Tolerance

- 5 ways to solve a problem (accept, change relationship, stay miserable, solve, make worse)
- DBT emphasizes learning to bear pain skillfully.
- The ability to tolerate and accept distress is an essential mental health as pain and distress are a part of life. Further without the ability to tolerate distress impulsive actions will interfere with efforts to establish desired changes.
- Skills such as: Self-Soothing, Improving the Moment (prayer, distraction), Thinking of Pros and Cons
Emotion Regulation

- Emotions tend to be intense and labile (all emotions!!)
- Emotions just are (just like our senses—we teach patients not to judge them).
- The patient can control the behavior but not necessarily the primary emotion.
- Skills teach managing the duration and intensity of the emotion, recognizing the vulnerability factors to emotional states (sleep, drugs, illness) and learning to experience positive emotions.
- All emotions have action tendencies.
- A favorite skill for many is acting opposite to action tendency.
Interpersonal Effectiveness

- Skills help to take care of relationships (or repair a relationship).
- To balance priorities. To balance the person's needs with other's needs.
- To balance wants (things that a patient wants to do) with shoulds (things they ought to do).
- To build mastery and self respect.
- Teach about cognitive distortions that interfere with relationships (black and white, all-or-nothing thinking, assumptions become realities, disqualifying the positive, fortune telling, mind-reading, catastrophizing).
- Skills such as DEAR MAN, GIVE, FAST
Middle Path

- Focuses on teaching adolescents and their parents the concepts of dialectics, validation, and behavioral therapy.
- Specific emphasis on the relationship between parents and teens.
- Targets the power struggles of adolescent-parent life.
Humor & Irreverence Help

- Fed up with “treatment as usual”.
- Finding a new way to reach your kids.
- The power of the unexpected.
- Humor often connects with adolescents.
- EXCEPT WHEN YOU ARE EMBARRASING!
- Be prepared for it not to work.
Final Thoughts

- Parents have a central role in helping their kids.
- Many of their problems are skill deficits rather than intentional “acting out”. Rethink manipulation!!!!
- Early treatment includes habilitation vs. rehabilitation and psychoeducation.
- Dedicated treatments are emerging and increasingly empirically validated.
- DBT is a comprehensive, empirically validated. psychotherapy.
- Works well with adolescents.
- We must persist in ongoing efforts to increase public awareness of BPD and treatments like DBT.