Can we diagnose personality disorders in adolescence? Should we?

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Learning Objectives

- Discuss the pros and cons of diagnosing personality disorders in adolescence (risk-benefit analysis)
- Review the evidence regarding the validity and reliability of a BPD diagnosis in adolescents
- Discuss the importance of early intervention and appropriate treatment for BPD in adolescence

Disclosures

I have nothing to declare.

'This changed my practice'

What is ISSPD?

- International Society for the Study of Personality Disorders (ISSPD)
- "Its mission is to stimulate and support scholarship, clinical experience, international collaboration and communication of research on all aspects of personality disorders including diagnosis, course and treatment."
- isspd2015.org

What I learned during residency

- Supervisors were very reluctant to diagnose a young person with a personality disorder or even to comment on personality traits.
- Arguments against a formal diagnosis included
  - doubts about the validity/reliability of the diagnosis
  - belief that an active 'Axis I' pathology does not permit the diagnosis
  - conceptualizing it as a reaction to a stressful psychosocial situation (chronic adjustment disorder)
  - stigma among mental health professionals re: diagnosis

DSM-5 re: Adolescent PD

A Personality Disorder is …

- An **enduring** pattern of inner experience and behaviour that deviates markedly from the culture ("maladaptive").
- This pattern is **inflexible** and **pervasive** (across broad range of situations), **stable** and of **long duration.**
- It affects 2/4 of cognition, affectivity, impulse control and interpersonal functioning.
- It causes **significant distress or impairment in functioning**.
- Usually recognizable in adolescence, and must be **present for at least 1 year** ("persistent") for a diagnosis in adolescence.
- It is not limited to a developmental stage or another mental disorder, and not attributable to substance use or medical condition.
- ASPD is the only PD that may not be diagnosed under age 18.

Course of Adolescent PD

- There are strong links between personality traits and early temperament, based on large body of empirical research.
- PDs have their onset in adolescence, likely precipitated by the developmental challenges of adolescence.
- Strong rank-order stability of PD symptoms (0.40–0.65) has been shown in teens, similar to the rank-order stability of adult PD.

Are symptoms of BPD not part of normal adolescence?

- Some of the behavioural symptoms of BPD (impulsivity, risk-taking, NSSI), as well as SI and affective instability, are prevalent in adolescence. However, majority (70–80%) of teens do not show these behaviours on a regular basis. (i.e. frequency and severity suggest maladaptive personality traits)
- Symptoms such as inappropriate, intense anger, abandonment fears, identity disturbance, and feeling of emptiness are more characteristic of BPD in teens.

Can we diagnose BPD in adolescence?

- DSM-5, ICD-11 and national practice guidelines allow the diagnosis of BPD in adolescence.
- A lot of empirical data from the last 15 years support the validity of the diagnosis.
- Diagnosis can be made reliably with clinical interview, based on DSM-5 criteria (Section II and/or III).
- Several validated measures can be used to support the diagnosis.

Validity of BPD Diagnosis in Adolescence

- Factor-analytical studies re: BPD in teens showed that the criteria and symptoms of BPD 'hang together' as a coherent syndrome.
- The diagnosis of BPD has been found as valid and reliable as in adulthood.
- The course and outcome of adolescent BPD separates from other disorders and cannot be explained by comorbid conditions.
- The severity and persistence of the symptoms of BPD are not consistent with typical adolescence, nor with pure 'Axis I' disorders.

Validated Measures for Diagnosing BPD in Teens

- Child Interview for DSM-IV Borderline Personality Disorder (CI-BPD)
- Shedler-Westen Assessment Procedure for Adolescents, Version II (SWAP-II-A)
- Personality Assessment Inventory Borderline subscale (PAI-BOR)
- Borderline Personality Disorder Features Scale for Children (BPFSC)
- McLean Screening Instrument for BPD (MSI-BPD)
- Borderline Personality Questionnaire (BPQ)
- Minnesota Multiphasic Personality Inventory—Adolescent version (MMPI-A)

Prevalence of BPD in adolescence

- 1-5 % in community samples
- In clinical samples:
  - 11 % of outpatients
  - 33-49 % of inpatients (1:3 to 1:2!)

Course of Adolescent BPD

- BPD traits are usually present after puberty. Peak prevalence of BPD in early adulthood, then decline.
- Earlier onset is associated with greater severity and poorer lifetime course.
- High rates of remission have been reported for a categorical BPD diagnosis both in teens and adults, but impairment in social and occupational functioning persists through adulthood.

Why should we diagnose BPD in adolescence?

- Likely negative correlation between duration of illness and prognosis (via reinforcement and solidification of maladaptive patterns).
- BPD carries significant risks: self-harm, suicide, risky behaviours related to impulsivity, substance use, low academic attainment …
- BPD causes a lot of distress (to patients and families) and major functional impairment, which can be alleviated by appropriate treatment.
- Effective treatments exist.
- Harm related to misdiagnosis and ineffective treatments. (polypharmacy!)

Etiology of Adolescent BPD

- Moderate heritability - 40-60 % (twin studies).
- The short allele of serotonin transporter (5-HTTLPR) gene predisposes to BPD.
- Childhood adversity (low SES), neglect and/or maltreatment are important predisposing factors.
- Inconsistent findings on neuroimaging of teens with BPD, whereas clear structural changes in adults with BPD in brain areas (amygdala, hippocampus, OFC and ACC) that are key in emotion regulation and processing of social information. A window of opportunity to prevent permanent changes (by early intervention)?
- Similarly, inconsistent results re: HPA axis dysfunction (hyperresponsive to hyporesponsive/low cortisol response to stress).

Comorbidity

- High rates of comorbidity with both externalizing and internalizing disorders.
- "Complex comorbidity" (a mix of externalizing and internalizing disorders) - highly characteristic, and considered a warning sign for possible BPD, which is confirmed by longitudinal studies.
- Substance use disorders are extremely common as comorbidity, as a result of impulsivity and attempts at regulating intense emotions (due to poor ability to tolerate negative affective states).

BPD as developmental disorder

- BPD is now considered a developmental disorder by experts in the field.
- Its presentation evolves over time (heterotypic continuity).
- Early on externalizing behaviour is more prominent (with some internalizing features such as anxiety and/or depressive symptoms). Common comorbid diagnoses at this point include ADHD, ODD, and anxiety disorders.
- In late adolescence and adulthood, impulsivity and externalizing behaviour diminish, while association with internalizing disorders grows stronger (anxiety and mood disorders). Despite less prominent symptoms, there is continued distress and poor functioning.
- It is suggested that a dimensional diagnostic approach may be more appropriate and would allow more diagnostic stability over time.

Theories for development of BPD

Diathesis-Stress models of BPD	**Genetic factors ('Diathesis')**	**Environmental factors ('Stress')**
Crowell, Beauchemin and Linehan (2009)	Trait vulnerability (emotional sensitivity/reactivity, impulsivity)	Invalidating family environment
Fonagy and Luyten (2009)	Inherited mentalizing capacity Sensitive temperament	Disruption of early attachments Adverse childhood experiences
Gunderson and Lyons-Ruth (2008)	Hypersensitivity to interpersonal stressors	Problematic transactions with caregiver

The Dimensional Model of BPD (DSM-5)

A) Impairment in (2/4):
- 1. Identity (poorly developed or unstable self-image, chronic emptiness)
- 2. Self-direction (instability)
- 3. Empathy
- 4. Intimacy (too intense, mistrustful, needy, fears abandonment, idealizes/devalues)

B) Pathological Personality Traits (4/7):
- Negative Affectivity - emotional lability, anxiousness, separation insecurity, depressivity
- Disinhibition - impulsivity, risk-taking
- Antagonism - hostility (anger)

Treatment of Adolescent BPD

- Pharmacotherapy is advised against, unless it is indicated for comorbid disorders.
- 2 evidence-based programs for early intervention (4-6 months):
  - HYPE (Helping Young People Early) – comprehensive care based on CAT (cognitive analytic therapy) framework.
  - ERT (Emotion Regulation Training) – elements of STEPPS (Systems Training for Emotional Predictability and Problem Solving), DBT and CBT.
- Intensive treatment programs for adolescent BPD:
  - DBT
  - MBT

Shall we diagnose BPD in adolescence?

Misperceptions

- It may be a phase.
- They may grow out of it.
- Symptoms may be part of "normal" adolescence.
- It may be something else (an 'Axis I' disorder).
- STIGMA

Evidence

- The dx is reliable and valid.
- Effective treatments exist.
- Misdiagnosis leads to ineffective and possibly harmful treatments.
- BPD leads to longterm dysfunction and distress if untreated.

Summary

- We are able to reliably diagnose BPD in adolescents.
- The diagnosis of BPD is as valid in adolescents as in adults.
- We have effective treatment options that can change the prognosis and the longterm outcomes of BPD. Experts call for early intervention, for best outcomes.
- Comorbidity is the rule. The course and overall prognosis is determined by the personality disorder – it must be treated in order to achieve remission of the comorbid condition.

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