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Bridging the gap: the assessment and treatment of adolescent personality disorder in routine clinical care

Carla Sharp[1,2]

[1]Department of Psychology, University of Houston, Houston, Texas, USA
[2]Centre for Development Support, University of the Free State, South Africa

Correspondence to
Dr Carla Sharp, Department of Psychology, University of Houston, 126 Heyne Building, Houston, TX 77204, USA; csharp2@uh.edu

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ABSTRACT

Despite a marked increase in research supporting the assessment, diagnosis and treatment of personality disorder (PD) in adolescence, clinicians continue to be reluctant to apply treatment guidelines and psychiatric nomenclature in routine clinical care. This gap arises from several beliefs: (1) psychiatric nomenclature does not allow the diagnosis of PD in adolescence; (2) certain features of PD are normative and not particularly symptomatic of personality disturbance; (3) the symptoms of PD are better explained by other psychiatric syndromes; (4) adolescents' personalities are still developing and therefore too unstable to warrant a PD diagnosis; and (5) because PD is long-lasting, treatment-resistant and unpopular to treat, it would be stigmatising to label an adolescent with borderline personality disorder (BPD). In this paper, the empirical evidence challenging each of these beliefs is evaluated in the hope of providing a balanced review of the validity of adolescent PD with a specific focus on BPD. The paper concludes with recommendations on how routine clinical care can integrate a PD focus.

INTRODUCTION

Personality disorders (PDs) refer to a class of disorders characterised by long-standing patterns of maladaptive and inflexible affective, cognitive, interpersonal and impulse-control difficulties that produce significant impairment and distress. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is the standard classification of mental disorders used by mental health professionals in the USA. The most recent edition (DSM-5[1]) contains two parallel classification systems for PD: section II (Diagnostic criteria and codes) and section III (Emerging measures and models). The reason for two distinct classification sections is the significant controversy about how to best conceptualise PD. Therefore, the more traditional (categorical) approach to diagnosing PD was retained in section II, while section III proposes an alternative (dimensionally informed) approach to identifying PD. Specifically, section II of the DSM-5 contains 10 discrete categorically defined PD diagnoses: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent and obsessive-compulsive PDs, in addition to personality change due to another medical condition and other specified PD and/or unspecified PD. In contrast, section III of the DSM-5 departs radically from the categorical model in that it views PDs as different from normal-range personality functioning in degree and not type—therefore, quantitatively, rather than qualitatively. In section III, only 6 of the original 10 PDs were retained: schizotypal, antisocial, borderline, narcissistic, avoidant and obsessive-compulsive PD. This decision was motivated by the limited empirical research on schizoid, paranoid, histrionic and dependent PD. Clinicians are allowed to use either or both classification approaches.

The societal impact of PD is significant as reflected in emotional suffering, disability and economic burden. For instance, the suicide rate for borderline PD (BPD) is 8–10%.[2] The presence of a PD also interferes with response to treatment of co-occurring physical health conditions and psychiatric disorders, including migraine headache, HIV, anxiety disorders and substance use disorders.[3] PD is furthermore associated with high rates of unemployment, absences from work, and inefficiency at work, with only 25% of patients with BPD working full time and 40% receiving disability payments.[4] Associated with these high rates of impairment are increased inpatient and outpatient mental health service use compared with other psychiatric disorders.[5]

While PDs are routinely diagnosed in adults with psychiatric problems, it was reported in 2003 that clinicians would assign a PD diagnosis to only 28% of adolescents even though 76% of adolescents actually met criteria for a PD using more objective diagnostic assessment tools.[6] In the 13 years since that publication, there has been a marked increase in empirical studies in support of the PD diagnosis in adolescence, especially BPD, which has been associated with a fivefold increase in published research.[7] These advances have been reflected in the legitimisation of adolescent PD diagnosis in psychiatric nomenclature (DSM-5 and the 11th edition of *International classification of diseases*) as well as national treatment guidelines in the UK[8] and Australia.[9] However, recent data regarding the acceptability of a PD diagnosis in adolescents would suggest that scientific evidence and national practice guidelines are yet to penetrate routine clinical care. For instance, in a survey of British psychiatrists conducted in 2009, the majority (63%) considered the diagnosis of adolescent PD invalid.[10] Furthermore, while 57.8% of psychologists in a study by Laurenssen *et al*[11] in the Netherlands and Belgium in 2013 agreed that PDs can be diagnosed in adolescents, only 8.7% of them reported that they diagnosed PDs in adolescents and only 6.5% offered specialty treatment.

The continued reluctance to diagnose PDs in adolescence is motivated by five beliefs about

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diagnosing PDs in adolescents: (1) psychiatric nomenclature does not allow the diagnosis of PD in adolescence; (2) certain features of PD are normative and not particularly symptomatic of personality disturbance; (3) the symptoms of PD are better explained by other psychiatric syndromes; (4) adolescents' personalities are still developing and therefore too unstable to warrant a PD diagnosis; and (5) because PD is long-lasting, treatment-resistant and unpopular to treat, it would be stigmatising to label an adolescent with BPD. Narrative reviews provide a broad overview of a specific topic for rapidly obtaining current information on a given topic and/or to build evidence in support of a particular argument.[12] The current review considers literature published over the last 10 years on adolescent BPD, with the exclusion of other PDs, simply because BPD has the largest empirical basis in adolescents compared with other PDs. While a relatively large literature base also exists for schizotypal PD[13] and antisocial PD/psychopathy[14] in adolescents, a thorough discussion of this literature would render a review of BPD superficial. Moreover, BPD is also the PD that is most often diagnosed in adolescents, and the burden of disease of adolescent BPD appears to mirror that of adult BPD. For instance, as in adults, children and adolescents diagnosed with the disorder have increased rates of hospitalisation due to suicidal ideation or attempts,[15] more severe comorbid pathology,[16] and poorer clinical and psychosocial functioning compared with other PDs.[17 18]

DOES PSYCHIATRIC NOMENCLATURE ALLOW THE DIAGNOSIS OF BPD IN ADOLESCENCE?

A quarter of clinicians in the Laurenssen *et al*[11] study believed that PD diagnosis in adolescents is not legitimised in standard psychiatric nomenclature or national treatment guidelines. Contrary to popular belief, the DSM system has allowed the diagnosis of BPD since the third edition.[19] All PD criteria (including the BPD criteria which are listed in box 1) are the same for adults and individuals <18 years with the exception that the symptoms must be present for 1 year instead of 2 years as in adults. A caution is included in the diagnostic criteria in that clinicians are urged to be careful about diagnosing PD in children and adolescents except 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.'[1] (p647)

For the assessment of DSM-5 section II BPD, several validated measures exist, including the Child Interview for DSM-IV Borderline Personality Disorder (CI-BPD),[20] the Shedler–Westen Assessment Procedure for Adolescents, Version II (SWAP-II-A),[21] the Personality Assessment Inventory Borderline subscale (PAI-BOR),[22] the Borderline Personality Disorder Features Scale for Children (BPFSC),[23] an 11-item version of the BPFSC for resource-constrained settings (BPFSC-11),[24] the McLean Screening Instrument for BPD (MSI-BPD),[25] the Borderline Personality Questionnaire (BPQ),[26] the Minnesota Multiphasic Personality Inventory—Adolescent version (MMPI-A),[27] and the Dimensional Personality Symptom Item Pool (DIPSI).[28]

Section III includes no cautions about diagnosing PD in adolescents. Symptoms are not required to have lasted for 1 year, but should be 'relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood' (p761). DSM-5 section III requires clinicians to consider two sets of criteria (A and B) in the assessment of BPD. Criterion A requires judgement of the severity of problems in identity, self-direction, empathy and intimacy. To rate impairment on these dimensions, clinicians use the Levels of Personality Functioning Scale provided in DSM-5 section III (pp775–778) on a five-point scale ranging from little or no impairment (0) to extreme impairment (4). Criterion B requires the presence of four or more of the following seven pathological personality traits—emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk taking and hostility—of which at least one must be impulsivity, risk taking or hostility. According to section III, these traits can be assessed with the Personality Inventory for DSM-5 (PID-5).[29] An adolescent version of the PID-5[29] has recently been validated for use in adolescents.[30]

Summary

Clearly, the DSM system allows the diagnosis of PD from both a categorical (section II) and alternative (section III) perspective, thereby challenging the belief that psychiatric nomenclature does not allow the diagnosis of PD in adolescence. It should be noted, however, that, currently, almost all empirical support for adolescent PD has been found for section II conceptualisations of PD, given the relative recentness of section III. For instance, thus far, only one study has been conducted on the validity of the PID-5 in adolescents,[30] and no study has evaluated the Levels of Personality Functioning Scale in adolescents. Moreover, concerns have been expressed regarding the clinical utility of section III—that is, at which cut-off should a clinician decide whether treatment is indicated and at which dosage. Similarly, at which cut-off point is insurance coverage justified? These are questions for further research which is currently underway.

Box 1 DSM-5 diagnostic criteria for borderline personality disorder

A pervasive 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 five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation 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 (eg, spending, sex, substance use, reckless driving, binge eating).
5. Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (eg, 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 (eg, frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

DSM, *diagnostic and statistical manual of mental disorders*

ARE CERTAIN FEATURES OF BPD SYMPTOMATIC OF PERSONALITY DISTURBANCE OR TYPICAL OF ADOLESCENCE?

In the Laurenssen *et al* study,[11] nearly half (41.2%) of clinicians believed that adolescence is a stormy developmental period and that BPD in adolescents is transient. It is certainly true that many BPD features show high prevalence in typical adolescence. For instance, research shows that between 20% and 30% of teens engage in at least one impulsive behaviour at any point in time. These behaviours include drinking or binge drinking, driving with someone under the influence of alcohol, binge eating, and physical fights in the past year. Approximately 15.2% of teens report having shoplifted.[31 32] All these behaviours fall under the impulsivity criterion of BPD. In addition, 17–22% of teens engage in non-suicidal self-injury, 16% consider suicide, 13% have created a plan, and 8% report trying to take their own life in the past year.[33] Most researchers of adolescence would also agree that affective instability is a hallmark feature of adolescence.[34] However, 70–80% of teens do not engage in these kinds of behaviour on a regular basis, and the basic idea of an adolescent 'storm-and-stress' period has been largely debunked by research showing that most adolescents navigate the developmental demands of this period without evidence of extremes in maladaptation. For instance, while it is certainly true that parent–child conflict increases in adolescence, conflict with parents does not indicate a serious or enduring rupture in parent–adolescent relationships.[35] Furthermore, while disruptions in mood and risk-taking do increase with adolescence, there is significant individual variation in these behaviours, which normalise again in early adulthood. In other words, there is a subgroup of adolescents for whom features characteristic of BPD may persist into adulthood who must be identified and treated before maladaptive variation in personality pathology becomes entrenched.

In support of this recommendation, prevalence rates of BPD in adolescents have been shown to be around 3% in the UK,[36] 1% in the USA[37 38] and 2% in China,[39] with a cumulative prevalence of 3%,[38] mirroring adult prevalence rates. Rates in clinical samples are much higher, suggesting 11% in outpatients[40] and 33%[16] and 43–49% in inpatients.[41] Longitudinal research has shown that, while BPD symptoms generally decline from mid-adolescence to adulthood, one-fifth of teens show an increase in PD symptoms over the decade from mid-adolescence to early adulthood.[42] Longitudinal studies have also shown that functional impairments (social and academic/occupational) persist from adolescence through to adulthood despite instability of symptoms.[43] Poor functional outcomes persist for years in individuals who showed borderline features in adolescence, including increased risk of substance use and mood disorders, interpersonal problems, poorer quality of life, higher levels of general distress[43 44] and service utilisation,[45] and increased rates of pain, physical illness and mortality over time.[46]

Recent Item Response Theory analyses of the borderline criteria have also suggested that, when clinicians diagnose BPD in adolescence, they must carefully consider the self–other relatedness criteria of BPD (abandonment fears, identity disturbance, unstable relationships and emptiness) given that these criteria, as opposed to the behavioural criteria (impulsivity, affective instability, anger, self-harm), appear to have lower thresholds and are better discriminators of BPD across the latent trait of BPD in adolescents compared with adults (Sharp C, Steinberg L, Michonski J, Kalpakci A, Fowler C, Frueh C. DSM borderline criteria function across age groups: a mixed-method study. Under review; Online).

Summary

Accumulating evidence suggests that, for a subgroup of children, BPD symptoms persist and, if left untreated, may lead to inadequate dosage or inappropriate treatment approaches (eg, social skills training for the interpersonal problems of BPD).[11] Careful assessment of borderline symptoms using a variety of validated measures will aid clinicians in identifying whether more thorough clinical assessment is warranted. Sharp and Fonagy[47] have provided details of all screening, self-report and interview-based measures in this regard, including psychometric properties of each. A limitation in this regard is, however, that the field lacks an evidence-based approach to deciding what assessment to use in what setting and the sequence of assessments needed for optimal precision in the diagnostic process. In the meantime, practitioners will first and foremost rely on competent clinical evaluation utilising standard psychiatric nomenclature (ie, DSM-5 section II) and may complement clinical assessment with screening measures. In addition, Chanen *et al*[48] propose three borderline criteria as justification for inclusion in indicated preventive programmes.

ARE SYMPTOMS OF BPD BETTER EXPLAINED BY OTHER PSYCHIATRIC SYNDROMES?

As with adult BPD, adolescent BPD is highly comorbid with depression, anxiety and externalising disorders.[16] While empirical data are scarce in adolescents, data in adults indicate that BPD may be most often misdiagnosed as bipolar disorder.[49] In a study from 2010, 51% of bipolar patients had five or more traits that were deemed to be more typical of BPD,[50] suggesting a risk of misdiagnosis of half the patients presenting with bipolar disorder. Similar to assuming borderline symptoms to be a transient adolescent phenomenon, the assumption that another disorder better accounts for the symptoms of BPD may lead to non-response to treatment. Thus, the comorbidity of BPD with other disorders should not be seen as indicative of overlap; in fact, recent latent trait studies factor-analysed BPD alongside internalising and externalising disorders and showed that BPD criteria were not fully accounted for by internalising and externalising pathology in adults[51] and adolescents (Sharp C, Elhai JD, Kalpakci A, Michonski J, Pavlidis I, Fonagy P. Criterion validity of borderline personality disorder within the internalizing-externalizing spectrum in adolescents. Under review; Online). Rather, the shared variance with other disorders potentially indicates that personality pathology increases the risk of other clinical syndromes, pointing to a liability model of comorbidity.

Other data that support the idea of BPD as a discrete disorder come from factor-analytical studies reviewed elsewhere,[52] demonstrating a unidimensional factor structure for BPD in adolescence, meaning that the criteria and symptoms of BPD hang together as a coherent syndrome. A word of caution is warranted here though. Factor-analytical studies of adult BPD alongside other PDs do not support the notion of a discrete BPD syndrome, but rather suggest a latent structure of personality pathology in which BPD criteria represent some of the shared variance among all personality pathology.[53] This research does not negate the existence of BPD, but it suggests that BPD captures the fundamental characteristics of all severe personality pathology.

Summary

BPD is not better explained by the presence of an internalising or externalising disorder. Given that findings for adolescent BPD by-and-large mirror those for adult BPD (as reviewed in this paper), it is expected that adolescent BPD will also emerge as representative of adolescent personality pathology in general, further justifying clinical attention.

ARE ADOLESCENTS' PERSONALITIES TOO UNSTABLE TO WARRANT A PD DIAGNOSIS?

Two myths have led to the propagation of the belief that adolescents' personalities are still developing and therefore too unstable to warrant a PD diagnosis. The first is the myth that children do not have personalities and therefore cannot have PD. And the second is that PD is stable in adults; therefore, if stability cannot be demonstrated in adolescents, the disorder cannot be valid in adolescents. Both myths have been debunked by empirical research. A large body of empirical research now strongly links personality traits to early-emerging temperament traits. Specifically, children manifest individual differences in their experiences and expression of negative and positive emotions as well as self- and behaviour-regulation which are remarkably stable over time.[54] With regard to maladaptive personality traits, research also demonstrates moderate to strong levels of rank-order stability for PD symptoms in the range 0.40–0.65,[55] which is similar to the rank-order stability of adult PD. Even in children, the rank-order stability of PD symptoms seems to mirror that of adult and adolescent PD.[56] This means that an individual's ranking among other individuals in terms of PD pathology remains relatively stable over time. PD symptoms do show mean-level change over time, but with symptoms having their onset and peak in adolescents and thereafter declining through young adulthood and adulthood. Less stable in both adolescents and adults is PD diagnosis.[54] Thus, contrary to the traditional view of PD as persistent and always detectable, even in adults high rates of remission and change have been reported for a categorical PD diagnosis. However, it is important to remember in this context that, while BPD may remit, studies generally converge to suggest continued impaired functioning in social and occupational domains.[47]

Summary

The development of personality in general, and PD specifically, is much more stable in adolescents than previously thought, and much less stable in adults than previously thought, converging to challenge the notion that PD cannot be diagnosed in adolescents because it is still under construction.

IS IT STIGMATISING TO LABEL AN ADOLESCENT WITH BPD?

The stigma of BPD is thought to result from the belief that PDs in general are severe, persistent and treatment-resistant compared with other psychiatric syndromes.[57] Therefore, labelling an adolescent (or adult for that matter) with BPD is seen as stigmatising. As reviewed in the previous section, a PD diagnosis is not as stable as previously thought. Importantly, BPD is not treatment resistant, and remission has been demonstrated in one of the longest follow-up studies of adult BPD.[58] Evidence-based treatment has been developed with support from randomised controlled trials in adolescents for cognitive analytic therapy (CAT),[59] mentalisation-based treatment (MBT)[60] and dialectical behaviour therapy (DBT).[61] Details of each approach and data on the results of the randomised control trials can be found in Sharp and Fonagy.[47] In short, although replication of these studies is necessary, they have shown a reduction in not only critical BPD symptoms such as self-harm and suicidality, but also associated clinical features such as drinking and number of hospitalisations. Common to all these therapeutic approaches is a set of basic features,[31] which are reiterated here: (a) extensive effort to maintain engagement in treatment (validation in conjunction with emphasis on the need to address behaviours that interfere with therapy); (b) a valid (evidence-based) model of pathology that is explained and feels relevant to the patient; (c) an active therapist stance—that is, an explicit intent to validate and demonstrate empathy and generate a strong attachment relationship; (d) reinforcement of epistemic trust[62]—that is, facilitating a belief in the possibility that something can be learned in therapy; (e) focus on emotion processing and the connection between action and feeling (eg, suicidal ideation is associated with abandonment feelings); (f) inquiry into patients' mental states (behavioural analysis, clarification, confrontation); (g) a structure that provides increased activity, proactivity and self-agency (ie, the therapist avoids the expert stance and rather 'sits side by side' with the adolescent in a partnership); (h) the structure is manualised and adherence to the manual is monitored; (i) both therapist and client must feel a commitment to the approach; and (j) supervision is essential to identify deviation from the manualised structure and provide support for adherence. Given the notion of BPD as representative of severe personality psychopathology as discussed above, it is reasonable to argue that evidence-based treatments of BPD would work equally well in addressing the problems of other adolescent PDs, although research on other PDs is lacking.

Beyond treatment for those already meeting criteria for PD, there is also now growing interest in early intervention for adolescent BPD, as promoted by Chanen and colleagues.[47] They have developed a programme in Australia called Helping Young People Early (HYPE) which is a comprehensive and integrated indicated prevention and early intervention programme for young people (15–25 years of age) which shows promising outcome data. Published outcome data for HYPE are relatively short term, and it remains unclear whether the early management of BPD in adolescence reduces the burden on psychiatric and correctional services later in life. Such long-term outcome data are key to further bolstering early intervention efforts for BPD and other PDs.

Summary

As evidence-based treatment is disseminated to clinicians and trainees, it is expected that the biases regarding the treatment of adolescent BPD will diminish and wane. However, the dissemination of knowledge of adolescent PD and associated treatment approaches remains a challenge. While hard data are lacking in this regard, anecdotal evidence suggests that training in the assessment, diagnosis and treatment of adolescent PD is not included in curricula in psychology, psychiatry, social work and other allied health professional training programmes. An important next step would be dissemination of the knowledge that has accumulated over the last 15 years and ensuring its uptake in training curricula.

INTEGRATING A PD FOCUS INTO ROUTINE CLINICAL CARE

In the preceding sections, the sources of reluctance to assess and treat PD in adolescence were evaluated and discussed. In the concluding section of the paper, a set of recommendations are provided to be considered by clinicians wishing to integrate a PD focus into routine clinical care. These recommendations are

not aimed at setting up specialised services for PD, but suggest first steps that may be taken to integrate a PD focus into routine clinical care. First, because many of the associated clinical features of BPD are probably not considered to be part of the BPD diagnosis, the disorder remains underdiagnosed in general paediatrics. For instance, the paediatrician is probably the first clinician to discover that an adolescent is engaging in self-harm, but will not consider BPD as an explanation for the problem without knowledge of the validity of BPD in adolescents. Moreover, the presence of a BPD has been shown to interfere with response to treatment of co-occurring physical health conditions often encountered in general paediatrics, such as migraine headaches, sexually transmitted diseases, depression, anxiety and substance use.[3] Therefore, management and clinical teams should be made aware of the literature on BPD in adolescents. In-service training may include lectures or seminars on BPD in adolescents and staff may be encouraged to attend specialised workshops and conferences on PD in adolescents. Second, it is highly recommended that the validated measures of adolescent BPD discussed here and elsewhere[47] are incorporated into standard assessment batteries not only to familiarise clinical staff with the symptoms of BPD but to facilitate assessment of BPD traits. Finally, specialised training in DBT, MBT and CAT will enable clinicians to effectively treat BPD symptoms in adolescents.

CONCLUSION

This paper evaluates and challenges some common beliefs about BPD in adolescence by showing that: (1) standard psychiatric nomenclature allows the diagnosis of BPD; (2) PD features are not typical of adolescence and, if left untreated, are associated with poor long-term outcomes; (3) symptoms of BPD are not better explained by typical adolescent development or other psychiatric syndromes; (4) PD symptoms are moderately stable through life; and (5) BPD in adolescents may be treated like any other psychiatric disorder, and neglecting to do so may perpetuate the stigma attached to the disorder. While more research is needed to further inform routine clinical care, the data that have accumulated over the last 15 years on adolescent BPD call for the integration of a PD focus into routine clinical care.

Competing interests None declared.

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Carla Sharp

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