Borderline Personality Disorder in Adolescence: The Case for Medium Stay Inpatient Treatment

LAUREL WILLIAMS, DO
CARLA SHARP, PhD

Background. **The diagnosis of personality disorders in adolescents has been a topic of debate in recent years.** ***Method.*** **This manuscript reviews the case of an adolescent girl admitted for a medium length combined inpatient and partial hospitalization program. This probram has developed protocols to assess for Axis I and II pathology as well as various psychological processes. Comprehensive outcome measures were administered to the patient at discharge and follow-up.** ***Results/Conclusions.*** **Diagnosis of a personality disorder in adolescence appears to be associated with psychological processes usually identified in adults. Against the background of an emerging debate about the need to reform a culture of ultrashort inpatient care, this case study provides some support for more thorough assessment, diagnosis, and treatment of adolescents who appear to have comorbid Axis I and II disorders.** (*Journal of Psychiatric Practice* **2013;19:xx–xx**)

KEY WORDS: inpatient care, adolescence, personality disorder, depression, research

THEORETICAL AND RESEARCH BACKGROUND

The relevance of inpatient psychiatric care for children and adolescents has become a topic of debate in recent years. The Substance Abuse and Mental Health Administration's National Survey on Drug Use and Health, which is based on data from a 2007 survey of 22,433 persons 12–17 years of age, estimated that one in eight (12.5%) adolescents (i.e., youths 12–17 years of age) received treatment or counseling in a specialty mental health setting for problems with behavior or emotions.[1] **[AU: Just to confirm that this survey was conducted in 2007 even though the title lists 2008]** Of these, 2% of adolescents received services in an overnight or longer stay hospital, 0.8% were treated in an overnight or longer stay residential treatment center, and 0.4% received care in an overnight or longer stay therapeutic foster care home. Over the last few decades, inpatient adolescent settings have experienced a significant decline in service use. What is unclear is whether this change in delivery of psychiatric services for adolescents has been beneficial to the psychological and physical health of the adolescents or has reduced health care costs when assessed through a multidimensional lens (i.e., emergency center costs, costs of psychotherapies, costs of medication and medical management, lost productivity in the adolescents, their families, and society at large).

Against this background, the Adolescent Treatment Program (ATP) of the Menninger Clinic reorganized the unit in May 2008. This reorganization had four major goals:

1. To shift from a long-term inpatient program (8–16 weeks) to a 3–4 week program focusing on assessment and stabilization
2. To develop a partial hospital program for those who needed continued treatment within a structured setting but did not require an inpatient level of care
3. To provide evidence-based practice
4. To develop a research protocol to assess outcomes and quality assurance to promote the delivery of evidence-based care

Assessment and treatment in the ATP take place within the general framework of a mentalization-based approach.[2–6]

Rather than focusing on the mentalization-based treatment approach used in the ATP, in this article we discuss the diagnosis of borderline personality disorder in a 14-year-old patient on the unit. We have taken this approach for several reasons. First, the diagnosis of personality disorders in young adoles-

WILLIAMS: Menninger Clinic and Baylor College of Medicine, Houston; SHARP: University of Houston.

Please send correspondence to: Laurel L. Williams, DO, One Baylor Plaza MC 350, Houston, Texas 77030. laurelw@bcm.edu

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cents (12–17 years of age) remains controversial,[7–9] and some clinicians appear reluctant to consider the diagnosis.[10] The perceived instability of personality in adolescence[11] as well as the stigma associated with a diagnosis of personality disorder are both reasons for this reluctance,[12] in addition to the suggestion that symptoms of borderline personality disorder (BPD) are **[may be?]** better explained by Axis I symptoms.[13] By demonstrating a symptom profile in a 14-year-old patient that is indistinguishable from what, at age 18 years onwards, would be diagnosed as BPD, we hope to add to the accumulating evidence that supports the construct of BPD in youth. In addition, diagnosis and treatment of BPD in adults has proven reliable and effective (clinically and cost-wise).[14] If clinicians had more reliable methods for diagnosing BPD in persons younger than 18 years of age, research could assess the effectiveness of BPD treatment in younger patients, with the goal of promoting more effective treatment that would benefit individual patients and society as a whole.

Second, against the background of diminishing inpatient psychiatric hospital stays for adolescents in crisis, we wish to demonstrate that there is value in such intensive coordinated care, especially in the case of personality disorders in adolescence. We hope to demonstrate that this value lies in the capacity of the treatment team to collaborate successfully with the research assessment team, thereby providing not only valuable clinical information, but also data for clinical outcomes research. In demonstrating the value of medium stay intensive treatment, we by no means suggest that integrated multi-disciplinary care on an outpatient basis cannot achieve similar gains. Our goal is merely to provide data in support of an alternative model for future consideration.

CASE PRESENTATION

The patient is a 14-year-old Asian female with a 2-year history of depression and mood instability. She currently lives with her father; however, she resided for the majority of her life with her mother, until her mother's sudden death 3 years earlier. She had not seen her father regularly from the time she was 4 years old until her mother's death. The patient had recently expressed a desire to drink cleaning fluid **[AU: In the next paragraph you say liquid bleach. Probably best to be consistent]** in order to die. Her father felt overwhelmed and incapable of managing her chronic suicidality and extreme emotional lability.

Presenting Complaints

During the intake interviews, the patient complained of regular and intense suicidal thoughts. She had made plans to consume liquid bleach as a suicide method and written letters explaining her reasons for ending her life. She felt irritable and depressed most days, with lack of interest, lack of focus, and lack of sleep. She reported disliking herself and feeling guilty and physically flawed. She described episodes of rage in response to her father or others failing her in some fashion, even though she frequently would not reveal to them the precipitating issue. These episodes of rage were corroborated by her father. She had been verbally aggressive and had, at times, struck her father in anger. The patient would vacillate between feeling that her father was weak and incompetent or that she was weak or flawed, and therefore deserved to die. She frequently expressed a sense of hopelessness and emptiness in her life. This led her to Internet sites where she would misrepresent her age in order to find someone to "love her."

The patient was admitted to the hospital to address her imminent suicidal intentions with the goal of increasing her understanding of her depression, precipitous mood swings, aggression, and declining academic performance.

History

The patient and her father described the family relationships as "completely messed up." Her father indicated that his relationship with his ex-wife, while she was alive, was emotionally and physically abusive. Although it was reported that the patient's mother had acted aggressively and erratically, she was never treated for a specific mental health disorder. According to the patient's father, after the divorce, his ex-wife relocated several states away and would not allow visitation. The patient reported that her mother frequently struck her as a child. Child protective services were involved in her life from an early age. In addition, her mother regularly told the patient that her father was weak and incompetent and that he did not love her. The patient's father

spent many years within the court system working to regain his custodial rights. The patient believed that she had always been depressed but that her aggression toward others did not start until she returned to live with her father at age 11. She reported a history of finding it difficult to trust people and of feeling let down by family and friends. She expected people to treat her poorly. She had also begun to develop inappropriate relationships with older males in an attempt to feel better about herself and be loved. The treatment team was unable to fully assess her early development since her father had not been involved in her care as a young child. However, from the history that the patient and her father were able to provide, it appeared that the patient had lived in a chaotic and unpredictable world.

Prior to her admission, the patient had been prescribed several different psychotropic medications singly and in combination (antidepressants, atypical antipsychotics, and mood stabilizers) in addition to weekly individual supportive therapy. These interventions had reportedly been largely ineffective, with the exception of the recent medication combination **[AU: You discuss this in more detail later but it would be helpful to readers to briefly mention the meds she was on when admitted and what response she had had to them here]**.

Clinical Assessment

The patient and her father underwent several clinical and research assessments (described below) in order to clarify the patient's diagnoses, develop an appropriate treatment plan, and consider more immediate and long-term treatment issues and goals. The patient underwent a comprehensive psychiatric assessment, a substance and self-injury assessment, and projective and educational psychological testing that included the Rorschach test, the Wechsler Intelligence Scale for Children (WISC), and Woodcock Johnson **[AU: Was this the Woodcock–Johnson Tests of Cognitive Abilities?]**.

The clinical assessment started with individual meetings with specific team members (psychiatrist(s) **[AU: Was one or more than one psychiatrist involved?]**, psychologist, social worker, chemical dependency counselor, rehabilitation specialist, and nurses) during the first 72 hours of the patient's admission. These individual meetings were continued over the course of her inpatient stabilization. More importantly, these individual meetings were held in the context of a team environment and daily integration of the clinical and research assessments.

Clinically, the patient did not display any signs or symptoms suggestive of either bipolar or psychotic processes. She appeared significantly depressed, as evidenced by poor grooming, anhedonia, continued passive suicidal thoughts, and a dysphoric affect. She quickly became embroiled with interpersonal strife with two male peers and three female peers. Family sessions were generally explosive in the beginning, with the patient becoming emotionally dysregulated within the first 10–15 minutes—she often could not complete a full 50-minute session. In individual therapy, she was initially largely silent; however, in group therapy, she would quickly become argumentative with peers and staff. Staff were largely split in how much they "liked" the patient. The patient quickly determined which staff she **[felt she?]** could trust and were "on her side" versus those staff members who reportedly singled her out unfairly regarding complying with unit rules.

Research Assessment

Axis I. As part of the outcomes-based research protocol administered on the unit (see Sharp et al., 2009[15]), which incorporates both a categorical and dimensional perspective, the patient was administered the clinician-assisted version of the Diagnostic Interview Schedule for Children (DISC-IV)[16] and the Youth Self-Report (YSR).[17] Given that parents and youth each contribute a unique perspective regarding the youth's problems,[18] a parent-report DISC and a Child Behavior Checklist (CBCL)[17] were also included.

The parent-reported DISC suggested a diagnosis of dysthymia, with sub-threshold symptoms of separation anxiety disorder and oppositional defiant disorder. The self-reported DISC suggested a diagnosis of a major depressive episode and conduct disorder. Both the patient and her father reported suicidal ideation and behaviors, which were confirmed by high endorsement on the deliberate self-harm questionnaire (DSHI).[19] The YSR and CBCL showed the same mixed pattern of externalizing and internalizing problems as the DISC, which is typical of BPD **[AU: If a ref is needed here, please provide it**

and I can renumber the subsequent citations if needed. Of course, it would be ideal if you could cite a reference on BPD that has already been used earlier in the paper](ref needed).

Axis II. To assess personality pathology in general, the Personality Assessment Inventory–Adolescent (PAI-A)[20] **[AU: Please provide citation]** was used. The patient's PAI-A clinical profile was marked by a significant elevation on the borderline (BOR) scale, indicating problematic personality traits of a severity uncommon even in clinical samples, including anger outbursts, emotional lability, intense and volatile relationships, abandonment fears, impulsivity (including drug use), self-harm, and suicidal behaviors.

The Childhood Interview for DSM-IV Borderline Personality Disorder (CI-BPD)[21] and the Borderline Personality Disorder Feature Scale for Children (BPFS)[22] were administered to more specifically assess emerging **[AU: Should we delete "emerging" here as you did elsewhere?]** BPD. On the CI-BPD, the patient endorsed all nine BPD symptoms except for identity disturbance, which was subthreshold, and chronic feelings of emptiness, which she did not endorse at all. Both self-report and parent-reported BPFS scores were two standard deviations above published means for community samples using this measure[22] and were above the clinical cutoff as determined in a clinical setting.[23]

Emotion regulation and executive functioning. The Cognitive and Emotion Regulation Questionnaire[24] showed that the patient had widespread emotion regulation difficulties, including problems with self-blame, acceptance, rumination, positive refocusing, positive reappraisal, catastrophizing, and other-blame. This pattern of emotion regulation difficulties was confirmed by the administration of the Behavior Rating Inventory of Executive Function (BRIEF).[25] The patient's Global Executive Composite was significantly elevated compared with the scores of her peers, suggesting significant difficulty in one of more areas of executive functioning. More fine-grained analyses revealed elevations in both the Behavioral Regulation Index (which captures the ability to shift cognitive set and modulate emotions and behavior via appropriate inhibitory control) and the Metacognition Index (which reflects the ability to initiate, plan, organize, self-monitor, and sustain working memory).

Child attachment. In the mentalization-based framework, the assessment of attachment relations is central to developing a conceptualization of the adolescent's problems. To this end, the Child Attachment Interview (CAI),[26] the Security Scale (SS),[27] and the Parental Bonding Inventory (PBI)[28] were administered. Together, these measures suggested that the patient has an insecure attachment style, especially with regard to representations of her mother. More specifically, she had low ratings of emotional openness, that is, instead of making reference to emotional states of self or others in her narratives, she relied on the behavioral or physical characteristics of self and others. The patient's narratives also displayed a lack of balance of positive and negative references to attachment figures, with her father being described in solely positive terms ("funny," "nice," and "friendly") and her mother solely in negative terms ("complicated," "stressful," "bad"). Insecure attachment to her mother was further indicated by limited use of detailed and relevant examples. The patient displayed high levels of preoccupied and unresolved anger toward her mother as well as high levels of dismissal and derogation of the maternal attachment figure. The resolution of conflicts did not seem to occur in attachment relationships and minor violations of coherence in the recounting of narratives occurred. Taken together, the patient's ratings on the CAI suggested a main classification of Insecure, Dismissing to her mother, but Secure to her father.

Parenting style and stress. The patient completed the Alabama Parenting Questionnaire (APQ),[29,30] which was used to assess parenting style. The Stress Index for Parents with Adolescents (SIPA)[31] was administered to the patient's father to assess the stress associated with raising his daughter. The SIPA showed that the patient's father felt particularly overwhelmed by his daughter's antisocial and aggressive behavior as well as the life restrictions involved in the responsibilities of parenting. The patient's father reported feeling incompetent to cope with his daughter as well as the lack of a close, mutually supportive relationship with her.

Case Conceptualization

A key feature in the organization of the unit is that each team member's input is considered carefully when a patient's diagnosis and treatment recommendations are discussed. The patient's team met after all the different assessments had been completed, including the important behavioral observations provided to her inpatient team on **[during?]** the third week of stabilization and assessment. Clinical, research, and observational data from nurses, teachers, and other peers were incorporated in order to accurately evaluate the patient's Axis I and II diagnoses. Clinically, the patient did not display signs or symptoms that were consistent with a psychotic or manic/hypomanic diathesis. The team discussed the differences between the research findings, the patient's clinical interviews, and the staff's observational data, especially as they related to her reported antisocial and aggressive behaviors. The formulation the team agreed on was that the patient's antisocial and aggressive acts (physicality with her father, drug use, breaking of rules) were more accurately described in the context of BPD and did not warrant an additional conduct disorder diagnosis. The final diagnostic formulation for the patient involved diagnoses of major depressive disorder, severe, recurrent without psychotic features, cannabis abuse, and BPD.

Of special additional importance was the fact that the patient's suicide index remained high. The risk of deterioration and attempted or completed suicide, combined with the patient's continued disorganized presentation, was the main reason for her extended inpatient hospitalization. The focus during the patient's inpatient stabilization was twofold: to create an improved relationship with her father and to assist her in developing improved coping strategies. These goals were targeted to address her hopelessness and sense of worthlessness within a secure environment where she could not access substances and had reduced means and opportunities for suicide.

Several predisposing factors for Axis I and II disorders were identified in the the patient's psychosocial development. First, both parents appeared to have a psychiatric history, given the father's recognition that he was anxiety prone and the high likelihood that the patient's mother had had an Axis I and/or II mental disorder as reported by both the patient and her father. The second major predisposing factor was the patient's insecure attachment to her mother. The patient's internal working model of her mother indicated that her mother did not offer a safe and consistent base from which the patient could operate as a growing child. Thus, she felt repeatedly let down and was angered by her mother's betrayal and abandonment.

The clinical formulation also identified a number of critical precipitants. These included the patient's chaotic and violent home environment, the recent death of her mother, and the subsequent upheaval that had resulted in her living with the father whom she barely knew beyond her mother's reportedly derogatory opinions. In addition, the patient had started to use substances (cannabis and alcohol) in an attempt to regulate her mood and fit in with the older peers and adults she met on-line

A critical factor in maintaining the patient's problems was her insecure and preoccupied attachment representation of her mother. The team felt that the patient would not be able to move on from the preoccupied anger evidenced in her antisocial, aggressive, and self-harming behaviors until she began explicitly addressing her anger.

These predisposing, precipitating, and maintaining factors, coupled with her father's emotional limitations and stated ineffective parental and coping skills, combined to create an intensely unstable family environment in which both the patient and her father felt disconnected and unable to meet their own and each other's needs in the face of the continual tension within their relationship. Prior to her admission, the patient, her father, and her treatment providers felt embroiled in crisis mode. Neither the patient nor her father felt they had access to a safe space in which to explore each person's contributions to their ongoing conflicts or possible positive solutions that could help avert conflicts. This impasse had resulted in everyone—the family and treatment providers—becoming paralyzed and being held captive by the patient's steadily worsening behaviors.

The patient's prognosis was considered guarded as a result of her current psychological assessment and clinical presentation. Due to her provocative behaviors, substance abuse, and continued mood and relationship instability she was at risk for being a victim of abuse or becoming involved with the criminal justice system. Of most concern was that she was con-

sidered to be at continued risk for future suicide attempts or a completed suicide.

COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

Treatment

The patient was initially admitted to the Menninger Clinic's inpatient adolescent program for 4 weeks and was then transitioned to the clinic's partial program for a total treatment course of 8.5 weeks. Her treatment team consisted of a full time psychiatrist, psychologist, social worker, rehabilitation specialist, and addiction counselor. Within the program, the patient met bi-weekly with her psychiatrist. She received bi-weekly individual and family therapy, in addition to participating in a variety of psychoeducational groups as well as addiction groups and individual addiction therapy. She also received twice weekly group psychotherapy and participated in a bi-weekly dialectical behavior therapy (DBT) skills group as well as a mentalizing psychoeducational group.

Given the severity of the patient's depressive symptoms, psychotropic medications were also used. The patient was already receiving a regimen of lamotrigine 100 mg twice daily, aripiprazole 5 mg/day, and desvenlafaxine 50 mg/day prior to her admission. The desvenlafaxine was increased to 100 mg after the first week to address her continued complaints of dysphoria and hopelessness as well as behavioral observations by the nurses which indicated that the patient was lacking in self-care, irritable with peers and staff, and psychomotor retarded. No other changes to her medication occurred during the admission.

The patient, her father, her psychiatric records, and consultation with her outpatient psychiatrist indicated that previous single trials of different antidepressants over the past 2 years had not been efficacious. **[AU: Please indicate when the patient started the desvenlafaxine--i.e., how long before the lamotrigine was added? How long had she been taking the three drugs before her admission?]** Within the previous year, the patient had been prescribed first lamotrigine and then aripiprazole **[AU: Do you mean "Within the previous year, first lamotrigine and then aripiprazole had been added to the desvenlafaxine"?]** for continued mood instability and aggression. The lamotrigine was titrated appropriately and the family and the patient's psychiatric records indicated modest improvement in mood instability. The aripiprazole was then added more recently for ongoing issues with physical aggression. Although not as well studied in an adolescent population, adult research literature supports the efficacy of these two medication classes for treatment-resistant depression and for treatment of specific behaviors in BPD.[32–35] The patient did not experience any metabolic or physical adverse effects with this medication regimen.

The issue of polypharmacy was discussed by the treatment team and her outpatient psychiatrist in collaboration with the patient and her father. The patient was opposed to reducing or discontinuing lamotrigine or aripiprazole, fearing a worsening of her moods if those medications were discontinued. Given her history, it was decided not to discontinue any of her medications during her inpatient stabilization and instead to focus on improving her personal understanding of her diagnoses, her coping strategies, and her relationship with her father.

The patient's motivation for treatment was directly related to her ability to manage difficult affects and interpersonal stressors. Consistent with a mentalization-based theory of BPD,[36,37] **[AU: Did you mean to cite Fonagy and Bateman 2006 here? I could not find a Bateman and Fonagy 2006 citation]** when her affect and interpersonal relationships were relatively stable she was able to engage in logical, well reasoned thinking and conversation. The stronger her emotions, however, the greater difficulty she had in making reasonable assumptions and developing rational decisions. This difficulty was most prominent in her relationship with her father, but it also quickly became obvious in relationships on the unit with nurses, teachers, and peers. As is typical for persons struggling with BPD, she often vacillated between extremely negative and positive feelings toward people, which she would, in turn, act on.

From the perspective of the clinical team, this **[AU: What does this refer to here? the patient's affective instability?]** was the primary reason that this patient, and other adolescents like her, need an intermediate length of stay in a secure environment and/or within an organized and coherent outpatient treatment team **[program?]**. This approach allowed the treatment team to focus directly on improving

the patient's abilities to cope more effectively with affective storms and her attachment relationships without having access to means of self-harm, substances, or suicidal behaviors. This is especially important from a clinical perspective because the risk for repeated suicide attempts and/or completion is known to be highest in the weeks following an inpatient stay.[38] However, it is important to note that inpatient intervention without the bi-weekly involvement of parents may be iatrogenic, since such complete removal from the environment creates an unrealistic and unsustainable context in which the true causal patterns underlying the development and maintenance of the psychological problems are easily avoided.

Family work primarily consisted of a focus on effective communication and assisting the patient and her father to develop new strategies for coping when her affective storms began. As both began to practice speaking more directly to one another, more accurate understanding increased while confusion and assumptions decreased. This process was limited by the patient's fear that she won't get what she feels she needs from her father, a feeling state that causes her intolerable distress. At home, this distress often led to impulsive actions on her part, eroding the trust within the relationship. An important component of a secure environment such as provided by the inpatient setting is that it can allow exploration of these issues and give both the patient and her father time to learn and utilize more effective coping strategies as well as improved communication without the fear of an action that could be life threatening. Within this structured program, the patient showed an increased ability to manage overwhelming emotions and managed to return to baseline more quickly when she did become overwhelmed. Her father showed an increased ability to engage with her more directly with clear expectations.

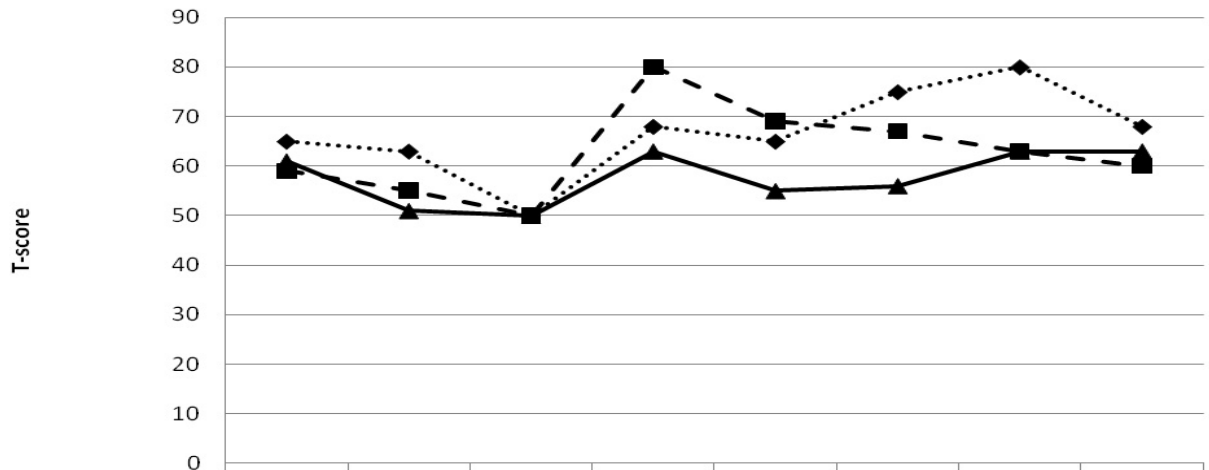
The patient learned how to set realistic and positive weekly goals for herself. The goal of much of the work she did in the program was to create a healthy structure for her life and her family. Prior to her admission, she was largely isolated from peers and school. She had sought solace in anonymous on-line chat rooms and indicated that she had no close friendships or activities/hobbies that she enjoyed. As a result, the patient often reported overwhelming feelings of loneliness that could lead to hopelessness and suicidal thoughts; these feelings were more likely to occur when she experienced a large amount of unstructured free time. She worked hard to identify leisure interests and the resources needed to participate in those interests. She reported that planning her time helped to manage overwhelming feelings in a more positive manner. She worked with her father to assist in planning for discharge by developing a wellness plan that included activities that were acceptable to both her and her father.

By the end of her treatment, the patient had made a decision to no longer use marijuana. She had completed a Substance Abuse Intervention Workbook and accepted responsibility for her prior use of the drug. She had also completed a substance abuse relapse prevention plan. This plan, which identified important triggers that had led Hannah to use marijuana in the past, was incorporated into her overall wellness plan.

Discharge and Follow-Up

Figure 1 summarizes changes in the patient's self-reported psychopathology from admission, to discharge to 6-month follow-up. T-scores of 65–70 on the DSM-oriented scales of the YSR are generally considered in the borderline clinical range, while scores above 70 are considered in the clinical range. Figure 1 shows that the patient's scores were in the borderline or clinical range for Affective problems, ADHD, ODD, CD, OCD, and PTSD at admission. At discharge, her scores dropped to below clinical range in each area except ADHD and ODD. At 6-month follow-up, all of the patient's scores had dropped below the clinical range. The patient's externalizing scores immediately post discharge, however, were elevated. The team hypothesized that, without the structure of the program, the patient initially returned to some of her more maladaptive strategies for managing interpersonal stresses. Although the team cannot be sure given their limited contact with the patient post-discharge (i.e., only through the research team), they also hypothesized that, as her outpatient treatment team was able to maintain a steady relationship with the patient and her father, she was able to more fully integrate newer adaptive strategies to cope with daily stressors.

Figure 1. Changes in the patient's self-reported psychopathology



	Affective	Anxiety	Somatic	ADHD	ODD	CD	OCD	PTSD
Admission	65	63	50	68	65	75	80	68
Discharge	59	55	50	80	69	67	63	60
12 months	61	51	50	63	55	56	63	63

TREATMENT IMPLICATIONS

Treatment was organized around the dual diagnosis of major depression in addition to a more chronic impairment in attachment that had led to signs and symptoms consistent with BPD. Our treatment team finds that discussing the concept and characteristics of BPD **[AU: Do you mean discussing these with the patient and family? or using them to approach the patient's care?]** allows for improved understanding and empathy, and a clearer direction for treatment, especially as there is growing evidence that personality disorders can be treated effectively resulting in an improved quality of life.[36] In our opinion, **[Our clinical experience suggests that?]** demystifying personality disorders and assisting patients and families to plan and prepare for recovery happens more readily when an organized and coherent treatment team approach is used over the course of several weeks compared with the 4–5 days that is typical of acute inpatient care.

This case also raises the issue of the appropriateness of polypharmacy. In this case, the patient's medications were not discontinued, because, based on a review of her medication history, the decisions leading to her medication regimen appeared to have been well thought out. She had had three adequate trials of single antidepressant medications without efficacy. Combining mood stabilizers and/or antipsychotics with antidepressants is considered an appropriate strategy for treatment-resistant depression[32,33] as well as for specific symptoms associated with BPD.[34] The recommendation to **[The treatment team recommended that?]** the outpatient psychiatrist who would be continuing her treatment maintain all medications for a period of several months and then, as clinically indicated, consider discontinuing first the aripiprazole and then lowering the dosage of the desvenlafaxine.

Two key concepts we want to emphasize are 1) the close coordination of the multi-disciplinary team that occurs within a structured treatment program, and 2) the value of information gained from an outcomes-based research protocol. An important point is that the research-based assessments that were conducted to track overall treatment outcome on the unit were also used to inform **[individual?]** clinical case formulations. As mentioned above, the research assessments are integrated **[reviewed?]** during the daily team meetings and integrated into the Diagnostic Case Conference during the third week of the admission. The clinicians can therefore use the information from the structured research assessments to complement their clinical assessments.

In addition to the seamless inclusion of research into practice offered by the inpatient environment,

the inpatient setting may also facilitate a safe holding environment. The patient's chronic suicidality, with her recent plan to ingest a lethal substance, use of substances to manage her moods, and limited psychosocial support system were the major factors that led to the recommendation for intermediate inpatient hospitalization. Treatment does not always need to occur in an inpatient program, if patients are carefully selected based on issues related to their social support system, active use of substances, and level of suicidal threat. Indeed our goal was to transition this patient to the next level of care when those three items had been safely managed. However, our goal here was to demonstrate quantitatively that medium stay inpatient treatment can have a positive effect—contrary to commonly held views that such treatment may be iatrogenic. We do not doubt that similar gains can be obtained in outpatient settings.

A key point is that adolescents similar to the patient described here present challenges to clinicians practicing alone. A psychiatrist who was primarily practicing as a psychopharmacologist might not have appreciated the way in which this patient's mood shifts were interpersonally driven and might have been tempted to increase, add, and change medications every few months as her symptoms appeared to wax and wane. An individual therapist would have had to manage the patient's cognitive distortions and suicidality in isolation, which could have led to the sensation of always operating in crisis mode and rarely having enough stability to work constructively on the core features of the patient's personality structure. Too often individuals such as our patient never receive family therapy. In those cases, family members feel increasingly frustrated, helpless, and hopeless to effectively intervene, which usually leads to increasing attempts to control the situation by more external and coercive means, which in turn lead to further erosion of family relationships. Finally, as peer relationships are especially important in adolescence, individuals without the ability to participate in group therapies may fall behind in developing effective peer relationships.

The complex challenges involved in treating personality disorders can be better met by using structured and focused research assessments, which not only provide clinical information, but also helpful data on individual and group outcomes. Of course, not all coordinated treatment programs need to develop longitudinal outcome assessment protocols in order to diagnosis and treat adolescent personality disorders. Our research program was privately funded and was not included in the costs of admission for families. The research protocol had specific aims to further scientific understanding of adolescent psychiatric disorders and to track outcomes for our families over a period of 18 months. Our goal in this article was to demonstrate the value of integrating research into practice as a potential model for future reorganization of mental health services.

Psychiatric hospitalizations with rapid admission and discharge based on managed care acute criteria may have limited value in addressing the needs of adolescents with personality disorders and chronic suicidality. Research into lengths of stay has shown that, as stays have become shorter, increases in readmission specifically within the first 90 days have been observed.[38] Re-admission rates for individuals as a result of suicidal ideation/attempts are highest within the first 60 days after an acute hospital admission.[38] Even though the patient described here continued to exhibit difficulties after her discharge, as evidenced by her outcome data, she remained stable enough to continue treatment with an outpatient treatment team, which consisted of her referring psychiatrist and individual and family therapists. Therefore, we see the value of medium inpatient treatment as building the resilience needed for adolescents and their families to make better use of outpatient treatment that had fallen apart prior to admission.

Our approach to an intermediate length of stay is to move beyond the crisis period in order to assess and then assist the adolescent and family members to develop an effective therapeutic alliance, so that the individual and family can begin practicing new skills prior to returning to a higher stress environment.[39] In this patient's situation, unlike most current inpatient adolescent psychiatric stays, psychotropic medications were not the focus of the hospitalization, and the patient's medications remained largely unchanged, with a recommendation to her outpatient psychiatrist to maintain her medications unchanged for a period of several months. We believe that the patient's gains in treatment, as evidenced by the reduction in her scores on rating scales and her clinical assessments, were the result of the focus on relationship and skill building. This type of focus is difficult to maintain outside a

secure setting. If the patient had been discharged prematurely, it is our opinion that another crisis would have erupted within weeks of the initial hospitalization, necessitating another admission and raising the possibility of a successful suicide attempt.

RECOMMENDATIONS TO CLINICIANS AND STUDENTS

Many clinicians believe that the DSM-IV-TR does not allow for the diagnosis of personality disorders in adolescence. One reason for this belief may be the general lay concept that "personality" is not stable until adolescence is complete. However, the DSM-IV does in fact allow a diagnosis of a personality disorder to be made if criteria are met for at least a 1-year period (instead of a 2-year period). Moreover, there has been a steady increase in evidence supporting the diagnosis of juvenile BPD, as summarized in several recent review articles.[40,41] Such evidence includes support for the longitudinal continuity of the borderline construct from adolescence into adulthood,[42,43] findings concerning the genetic basis of BPD,[44–46] overlap in the latent variables underlying symptoms of adolescent and adult BPD,[47–49] similarity in the risk factors for adolescent BPD and the full-blown adult disorder,[50–52] and evidence for marked separation of course and outcome of adolescent BPD from other Axis I and II disorders.[22,42,53] Research examining the validity of diagnosing personality characteristics and the stability of personality in pre-adolescence and adolescence is a growing field.

In conclusion, our intermediate length of stay inpatient program coupled with a partial hospitalization program is designed to move treatment beyond the acute crisis of a short-term psychiatric hospitalization. In this sense, the case study described here and our model of care are similar to a model for 21st century reform of inpatient care recently published by Glick et al.[54] **[Was this the Glick et al. reference you wanted to cite here?]** Glick et al. summarized the goals that should be obtained during inpatient care, including withdrawal of ineffective or toxic medication over appropriate periods, treatment of comorbid conditions, addressing the intrapsychic life of the patient and family as well as social and environmental issues, adhering to recovery principles especially in terms of treatment planning, provision of psychoeducation, and establishing a therapeutic alliance. These goals cannot be obtained in 4–5 days, which is now the average length of stay in inpatient settings, but, in our opinion, they require an intermediate length of stay (3–6 weeks). Although this approach is not revolutionary,[55] **[Was this the Glick et al. reference you wanted to cite here?]** it requires health system reform, which in the case of emerging personality disorder may be worth the effort, given the costs this condition places on individuals and society alike.

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