



EDITORIAL

Diagnosing BPD in Adolescents: More good than harm

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I have recently given presentations about borderline personality disorder (BPD) and conduct disorder. These talks were given to clinicians working with young people who would have lots of experience treating these disorders given how prevalent they are (20-40% in clinical settings) (Chanen, & McCutcheon, 2013; Nock, Kazdin, Hiripi, & Kessler, 2006). After the talks, there were many remarks from the audience about the harm of making these diagnoses in young people and clinicians said they would still not make these diagnoses.

At times like these, I am initially irritated and wonder why I bother. Then I remember that it has taken me over a decade of working almost solely with mood-disordered adolescents to become skilled at differential diagnosis and identifying the benefit of evidence based treatment for BPD and conduct disorders. I thought I would share my top three evidence-informed reasons for why it is important to diagnose BPD in adolescents when diagnostic criteria are met.

Reason 1: BPD in adolescents is very similar to BPD in adults. The symptoms are the same, except the criterion of self harm is more frequently met in adolescents (this is also true at the population level). A large Canadian study found that over 70% of youth who meet criteria for BPD will also meet criteria four years later in acute care settings (Greenfield et al., 2015). Outpatient stability appears less but is substantial (Strandholm et al., 2017). Is the disorder still present in adulthood? Studies of adults with BPD consistently identify a higher rate of adolescent onset of the disorder compared to other disorders (Crawford et al, 2008; Links, Steiner, Offord, & Eppel, 1988). Finally, BPD in adolescents is as stable over time as BPD in adults, and properly treated, has a better prognosis compared to depression and bipolar disorder (Zanarini et al., 2011).

Reason 2: Treating other disorders first may help reduce BPD symptoms. The under-appreciated problem in our field is that BPD is associated with the largest amount of comorbidity of arguably any other single axis 1 or axis 2 disorder and this may be a consequence of the emotional

dysregulation that is the core feature of BPD (Kaess et al., 2013). My experience is that focus on any specific psychiatric disorder other than BPD when a youth has BPD comorbidity leads to a worsening of other symptoms, and possibly an increase in acute mental health visits. It is therefore critical to identify BPD comorbidity early in the clinical formulation process.

Reason 3: Evidence based treatments for BPD may be more effective than treatments for major depression. The most common comorbidity of BPD is a depressive episode; about 65% of youth and adults with BPD have MDD in their lifetime (Boylan, Dyce, & Semovski, 2017). Many adolescent clinicians are reluctant to make a diagnosis of BPD when there is a known severe comorbid condition, and indeed, this is supported by the DSM. However, the comorbidity is also stable, suggesting that youth with BPD can also have depression. I would argue that the failure to make the diagnosis of BPD in adolescents is one of primary reasons for treatment refractory mood disorder. In adolescence the risks associated with hospitalization, entrenched mental health identities, and family disruption is high – particularly in adolescents who meet criteria for BPD. The result of knowing a BPD diagnosis can help providers diligently apply outpatient treatment with family education in a way that mobilizes active (as opposed to passive) participation in treatments.

Most of what I have written is in support of making a BPD diagnosis when criteria are met. Is there a harm in making a diagnosis without treatment? Probably. However, the good news is that specialized treatment (DBT, MBT) is effective for BPD but is not the holy grail. Good Psychiatric Management is an approach for clinicians/physicians which focusses on conveying a clear diagnosis of BPD to patients with intensive psychoeducation (Gunderson, Masland, & Choi-Kain, 2018). In the absence of a working model, there are wonderful online and print resources that we can simply provide to youth and families as they are so therapeutic and accessible. www.borderlinepersonalitydisorder.com

com provides video modules for continuing education for physicians and clinicians as well as access to materials and measurement tools for clinicians.

I hope that this brief commentary may encourage a handful of colleagues to learn more or to practice screening or making the diagnosis using a tool, such as the McLean Screening Instrument or the Child Interview for BPD. Doing so will very likely be one of the most strategic suicide and self injury prevention or treatment strategies you will ever employ, and your adolescent patients will be more likely to move out of their homes and get jobs.

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References

- Boylan, K., Dyce, L., & Semovski, V. (2017). Borderline personality disorder in children and adolescents: Discriminant validity in relation to major depressive disorder. *Journal of Psychology and Psychiatry*. Online only resource.
- Chanen, A. M., & McCutcheon, L. K. (2013). *British Journal of Psychiatry*, 202, 24-29.
- Crawford, T. N., Cohen, P., First, M. B., Skodol, A. E., Johnson, J. G., & Kasen, S. (2008). Comorbid axis I and axis II disorders in early adolescence: Outcomes 20 years later. *Archives of General Psychiatry*, 65, 641-648.
- Greenfield, B., Henry, M., Lis, E., Slatkoff, J., Guilé, J.-M., Dougherty, ... de Castro, F. (2015). Correlates, stability and predictors of borderline personality disorder among previously suicidal youth. *European Child and Adolescent Psychiatry*, 24, 397-404.
- Gunderson, J., Masland, S., & Choi-Kain, L. (2018). Good psychiatric management: A review. *Current Opinions in Psychology*, 21, 127-131.
- Kaess, M., von Ceumern-Lindenstjerna, I.-A., Parzer, P., Chanen, A., Mundt, C., Resch, F. & Brunner, R. (2013). Axis I and II comorbidity and psychosocial functioning in female adolescents with borderline personality disorder. *Psychopathology*, 46, 55-62.
- Kennard, B., Silva, S., Vitiello, B., Curry, J., Kratochvil, C., Simons, A., ... March, J. (2006). Remission and residual symptoms after short-term treatment in the Treatment of Adolescents with Depression Study (TADS). *Journal of the American Academy of Child and Adolescent Psychiatry*, 45, 1404-1411.
- Links, P. S., Steiner, M., Offord, D. R., & Eppel, A. (1988). Characteristics of Borderline Personality Disorder: A Canadian Study. *Canadian Journal of Psychiatry*, 33, 336-338.
- Mehlum, L., Tørmoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Laberg, S., ... Grøholt, B. (2014). Dialectical Behavioural therapy for adolescents with repeated suicidal and self-harming behavior: A randomized trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 53, 1082-1091.
- Nock, M. K., Kazdin, A. E., Hiripi, E., & Kessler, R. C. (2006). Prevalence, subtypes and correlates of DSM-IV conduct disorder in the national comorbidity survey replication. *Psychological Medicine*, 36, 699-710.
- Strandholm, T., Kiviuusu, O., Karlsson, L., Pankakoski, M., Pelkonen, M., & Marttunen, M. (2017). Stability and Change in Personality Disorder Symptoms in 1-Year Follow-up of Depressed Adolescent Outpatients. *Journal of Nervous Mental Disorders*, 205, 15-22.
- Zanarini, M. C., Horwood, J., Wolke, D., Waylen, A., Fitzmaurice, G. & Grant, B. F. (2011). Prevalence of DSM-IV borderline personality disorder in two community samples: 6,330 English 11 year olds and 34,654 American adults. *Journal of Personality Disorders*, 23, 607-619.