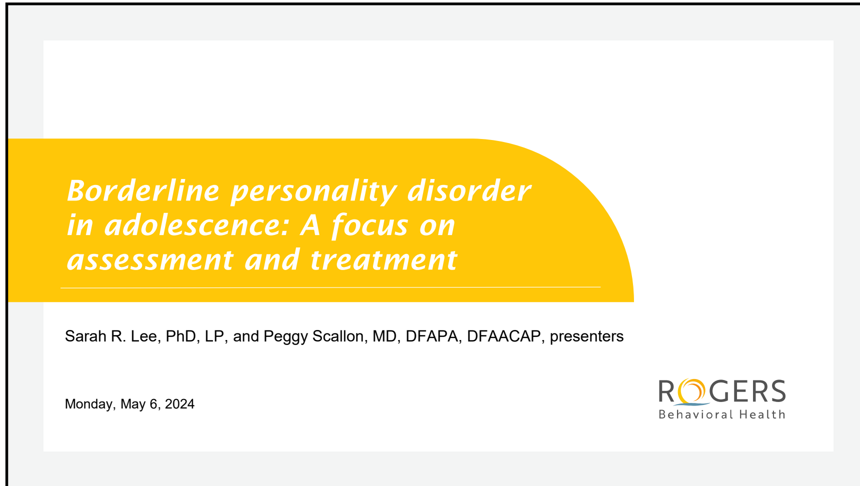

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Disclosures

Sarah Lee, PhD, and **Peggy Scallon, MD,** have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

The presenters have each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships. Further, Rogers Behavioral Health does not accept commercial support for its CE programs.

2

Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Name at least two assessments that can be used in the screening and diagnosis of (BPD) in adolescents.
2. Identify at least two possible treatment recommendations for adolescents with BPD.
3. Apply differential diagnosis and treatment approaches based on the case example presented.

3

What we'll cover in this webinar

- Assessment of borderline personality disorder in adolescence
- Delivery of diagnosis and treatment implications
- Case example illustrating diagnosis and education process

Our focus for the program is on the healthcare professional practicing in a clinical setting.

4

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Presenter subjectivities

Dr. Sarah Lee

Professional identities

- Clinical Supervisor
- Clinical psychologist
- Researcher, mentor

Personal identities

- She/her/hers
- White, cisgender, able-bodied, young adult woman

Dr. Peggy Scallon

Professional identities

- Senior Medical Director, Oconomowoc Campus
- Medical Director of Focus Depression Recovery Adolescent Residential Care
- Child and adolescent psychiatrist

Personal identities

- She/her/hers

We acknowledge that our experience, intersectionality, privilege – and lack thereof – inform what we each bring to our research, clinical practice, and teaching

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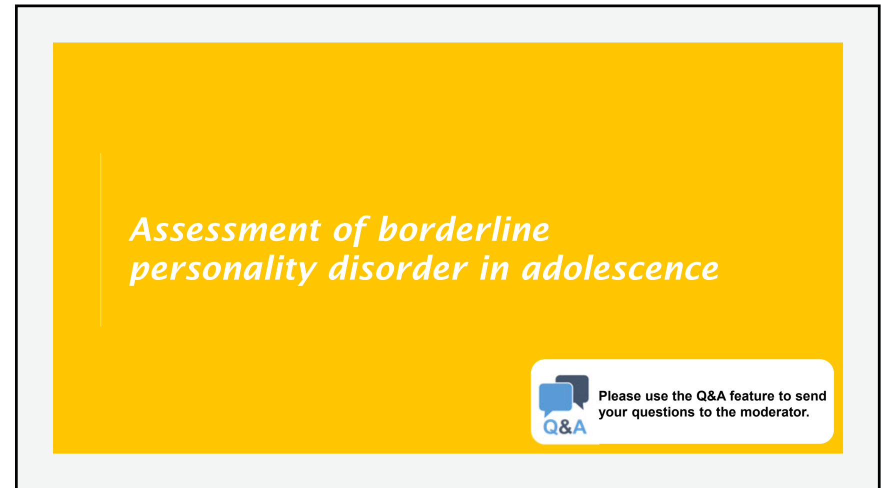

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Review: Myths about BPD in adolescence

1. You cannot diagnose someone with BPD before the age of 18
2. Borderline features are normative in adolescence
3. The symptoms can be better explained by another psychiatric diagnosis
4. Adolescent personalities are still developing, so personality disorder diagnoses would be inappropriate
5. BPD is long-lasting, treatment-resistant, and therefore too stigmatizing to diagnose

American Psychiatric Association, 2013; American Psychological Association, 2022; Bozzatello et al., 2021; Chanen, Sharp, Hoffman, & The Global Alliance for Prevention and Early Intervention for Borderline Personality Disorder, 2017 Greenfield et al., 2015; Guilé et al., 2018; Guilé et al., 2021; Swales, 2022

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Assessment of BPD in adolescents: Challenges

Assessment of personality is always challenging, because the pathology influences how the person responds

- Look for patterns related to descriptions of self, relationships, and functioning at school / work
- Pay attention to how the client interacts with you
- Get information from people close to the client (caregivers)
- Use of semi-structured or structured interviews, self-report questionnaires is recommended

Bozzatello et al., 2021

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Screening of BPD in adolescents

- Clinicians should screen for BPD, for adolescents who present with suicidal behavior or non-suicidal self injury; ***screening ≠ diagnosis***
- Abbreviated Diagnostic Interview for Borderlines (Ab-DIB)
  - A 26-item self report measure which takes 10 minutes to administer
  - Good sensitivity (.88) and specificity (.73 to .82)
- Borderline Personality Features Scale for Children (BPFSC-11)
  - An 11-item self-report measures which takes under 10 minutes to administer
  - Moderate sensitivity (.74) and specificity (.71)

Guilé et al., 2018; Guilé et al., 2009; Sharp et al., 2014

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Screening of BPD in adolescents

- McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD)
  - A 10-item self-report measure
  - Moderate sensitivity (.68) and specificity (.75)
- Borderline Personality Questionnaire (BPQ)
  - An 80-item, self report measure which takes 10 minutes to administer
  - Moderate sensitivity (.68) and high specificity (.90) in an outpatient sample aged 15-25

Chanen et al., 2008; Poreh et al., 2006; Zanarini et al., 2003

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Screening of BPD in adolescents

- Difficulties in Emotion Regulation Scale (DERS)
  - A 36-item, self report measure which takes under 10 minutes to administer
  - Moderate sensitivity (.69) and specificity (.70) differentiating adolescents with severe history of self-injury in an inpatient sample
- Borderline Symptom List-23 (BSL-23)
  - A 23-item, self report measure which takes under 10 minutes to administer
  - Its initial validation study demonstrated moderate sensitivity to change
  - Demonstrates good sensitivity (.76) and specificity (.83)

Bohus et al., 2009; Charak et al. , 2019; Gratz & Roemer, 2004; Mehlum et al., 2014; Perez et al., 2012; Shen et al., 2023

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Diagnosis of BPD in adolescents

- Childhood Interview for DSM-IV Borderline Personality Disorder (CI-BPD)
  - A semi-structured interview with nine criteria
  - In a sample of adolescent inpatients, the CI-BPD demonstrated good interrater reliability (κ = .89) and agreement with the diagnosis given by clinicians (κ = .34)

Sharp et al., 2012; Zanarini, 2003

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Diagnosis of BPD in adolescents

- Revised Diagnostic Interview for Borderlines (DIB-R)
  - Includes 22 statements pertaining to symptoms of BPD
  - Demonstrates good interrater reliability (κ = .71 to .80)
  - When using a cutoff score of 8, DIB-R demonstrated good sensitivity (.82) and specificity (.80)

Zanarini et al., 1989

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Differential diagnosis from bipolar disorder

- Accurate assessment of the presence / absence of manic or hypomanic episodes is the most important criterion
  - Pay attention to duration (3-4 days met?)
  - Also, consider the general nature of client's close relationships
  - It is possible to meet criteria for both
- One study found that personality measures can differentiate BPD from bipolar disorder with 81-84% accuracy

Bayes et al., 2015; Kernberg & Yeomans, 2013

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Differential diagnosis from bipolar disorder

- The nature of depressed mood also helps differentiate
  - Dysthymia as seen in BPD is more focused on others
  - Dysthymia as seen in BPD will be much more irregular in duration
  - In BPD, more responsive to social environment; in Major Depressive or Bipolar Disorder, much less so
  - Has there been any time when the client was not depressed?
- Finally, consider the overall pattern

Bipolar disorder

Borderline personality disorder

Ehret & Scallon, 2022; Kernberg & Yeomans, 2013

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Differential diagnosis from PTSD

- There is a body of research to demonstrate a relationship
  - Trauma, especially in early life, causes BPD and PTSD
  - The association between childhood trauma and BPD, is due to a genetic predisposition to BPD symptoms
  - Some symptoms of BPD put adolescents at risk for trauma
  - Rates of comorbidity are high: up to 68% of patients with PTSD reporting comorbid BPD; up to 58% of patients with BPD, diagnosed with comorbid PTSD
- What about "Complex PTSD?" (CPTSD)

Bozzatello et al., 2021; Cloitre, Garvert et al., 2014; Cloitre et al., 2019

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Differential diagnosis from PTSD

- Symptom onset in relation to the traumatic event
- Researchers of CPTSD have identified many ways to distinguish CPTSD from BPD:
  - Emotion regulation as emotional sensitivity, difficulty calming when distressed, and chronic numbing? Or emotional lability, uncontrolled anger, self-injurious / suicidal behavior?
  - What about patterns in relational problems?
  - Some of the biggest predictors of BPD (instead of CPTSD) are frantic avoidance of abandonment, unstable relationships, unstable sense of self, and impulsivity

Cloitre et al., 2014; Ford & Courtois, 2021; Kernberg & Yeomans, 2013

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Gender and the diagnosis of BPD

Per *DSM-5*, BPD is diagnosed primarily in women; however, studies have demonstrated that gender differences in population-based samples are not significant

What's going on?

- Men / boys seek less services for mental health problems than women / girls
- Men having lower willingness to disclose symptoms of BPD
- Bias in our diagnostic procedures, or our application of them

American Psychiatric Association, 2013; Dehlbom et al., 2022; Guilé et al., 2021; Tomko et al., 2014

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Any gender differences in symptoms?

- Men are more likely to demonstrate explosive temperament
- Men are more likely to engage in novelty seeking
- Men are more likely to have comorbid substance use disorder
- Women are more likely to have comorbid eating disorders, mood or anxiety disorders, or PTSD
- In both boys and girls, childhood ADHD or ODD are predictive of BPD symptoms in adolescence

Bottom line: Don't ignore symptoms in adolescent boys!

Guilé et al., 2018; Sansone & Sansone, 2011

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Reducing clinician stigma and anxiety

- Good diagnostic conversations arise from good assessment
  - Practice what you want to say; and don't over-talk
- Check in with yourself about stigma you may hold
  - Remind yourself *and* family, that receiving the diagnosis changes nothing about the client's experience
  - Educate yourself about the nature, causes, and treatability of BPD
  - Remember that personality disorders exist on the continuum of normal personality; it can be viewed as personality development that has gotten "off track"

American Psychiatric Association, 2013; American Psychological Association, 2022; McKenzie et al., 2022; Swales, 2022

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How to deliver diagnosis to clients and families

It can help to borrow ideas from therapeutic assessment:

- Seek to build therapeutic alliance with client *and* family
- Give client and family a chance to voice their questions
- Give feedback to family first; and then to your client with their family present
- Start with "level one" feedback (familiar); move to "level two" (reframing, amplifying); finally, to "level three" (contradictory)

Use the assessment feedback to increase family's empathy for their child, and child's understanding of themselves

Aschieri et al., 2023; De Saeger et al., 2014; Finn, 2007; Tharinger et al., 2009

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Treatment recommendations: Medications

"In the long term, a nonpharmacological approach is preferable. The associated disorders and comorbidities may justify medication"

- A review in 2020 found that research into medications for BPD had declined in more recent years, and that recent results confirmed no benefits
- There is no evidence that medication improves the core symptoms of BPD
  - However, medication may be effective for severe, acute disorders that are comorbid with BPD (like MDD)

Guilé et al., 2018; Leichsenring et al., 2023; Stoffers-Winterling et al., 2020

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Treatment recommendations: DBT-A

- DBT-A is a comprehensive and principle-based treatment which was developed for adolescents in outpatient treatment
  - Teaches skills: Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness
  - Individual sessions, multifamily skills training groups, phone coaching, group supervision of clinicians, family sessions offered
- Randomized controlled trials conducted on adolescents aged 12-18 with self-harm, suicide risk, and borderline personality traits have demonstrated its superiority to control treatments

McCauley et al., 2018; Mehlum et al., 2014

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Treatment recommendations: MBT

- A psychodynamic treatment which draws from attachment theory and cognitive theory
  - Main goal is to strengthen a client's ability to understand their own and others' mental states
  - Can be offered in group, individual, and family format
- Its effectiveness may depend upon its format:
  - One study found that a group-based format was not superior to treatment as usual
  - A second study found that individual plus family format, significantly reduced self-harm, depression, and symptoms of BPD

Bateman & Fonagy, 2009; Beck et al., 2020; Rossouw & Fonagy, 2012

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Treatment recommendations: Other therapies?

- Reviews describe other therapies like Emotion Regulation Training (ERT) and Cognitive Analytic Therapy (CAT)
  - Psychotherapy does decrease BPD symptoms and non-suicidal self-injury in adolescents, but effects are not maintained
  - Existing studies demonstrate so much bias that it's difficult to draw conclusions; and specific treatments are not often superior to treatment as usual
- DBT and MBT are the only standalone treatments which currently are evidence supported in adults
  - And these findings have low confidence, require replication

Jørgensen et al., 2021; Stoffers-Winterling et al., 2022; Wong et al., 2019

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Treatment recommendations: The MOBY study

- A group of researchers compared two service models and two forms of individual psychotherapy for early intervention treatment of BPD in youth aged 15-25
  - Helping Young People Early (HYPE) + Cognitive Analytic Therapy
  - HYPE + Befriending
  - Youth Mental Health Service (YMHS) + Befriending
- Results: All three interventions were equally effective in restoring psychosocial functioning
  - Raised questions about what the "essential" parts of treatment are

Chanen et al., 2015; Chanen et al., 2022

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Treatment recommendations: Essentials

- A solid treatment model for understanding BPD
- Clinical case management
  - This includes hospitalization when necessary
  - But also keeping client out of the hospital, when *not* necessary
- And finally, treatment of co-occurring problems
  - SSRI's, behavioral activation therapy for co-occurring depression
  - Mood stabilizing medication for co-occurring bipolar disorder
  - Antipsychotics for acute crisis symptoms

Beck et al., 2020; Chanen et al., 2022; Leichsenring et al., 2023; Rossouw & Fonagy, 2012; White, 2022

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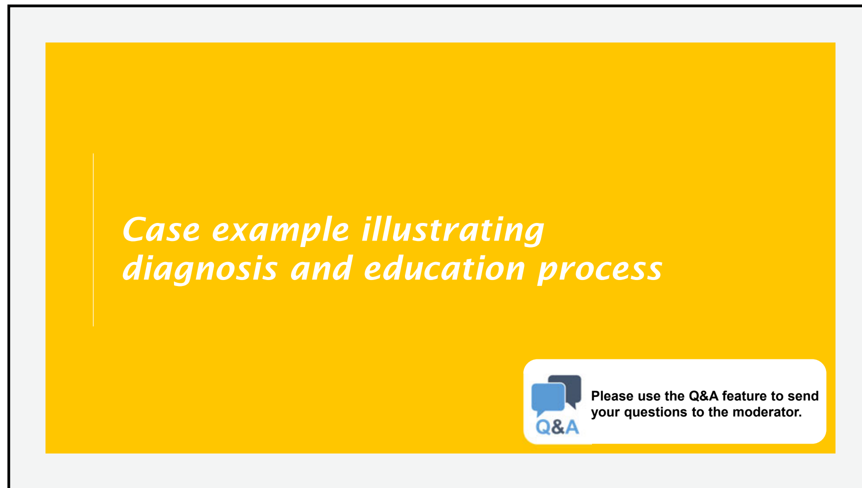

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Case example: Maya

A: 14, adolescent
D: Admitted with several
D: No developmental or acquired
R: Non-religious
E: White, not Hispanic or Latino
S: Heterosexual
S: Middle class
I: Not indigenous
N: Born in the United States
G: Girl, pronouns she/her

The diagnoses that Maya admitted with were:

- Disruptive Mood Dysregulation Disorder (DMDD)
- Generalized Anxiety Disorder (GAD)
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder (ASD)
- Nocturnal Enuresis (bedwetting)

She endured joint pain and seasonal allergies

Parents are married, biologically related to Maya

Mom is college-educated and works in healthcare

Dad is high school-educated and works in business

Maya was in the 9th grade and completing classes online

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Case example

- Maya had three previous inpatient stays prior to coming to residential
- Had also attended two Partial Hospitalization Programs (PHP) in between two inpatient stays
- Presented with chronic suicidal ideation: “Nothing will ever get better. The inpatient team recommended I come here.”
- Self-harm with sharp objects, such as broken glass and broken pens
- Multiple past medications:
  - Anxiolytics: Buspar (buspirone)
  - Antidepressants: mirtazapine
  - ADHD: Concerta (methylphenidate), guanfacine, Vyvanse (lisdexamfetamine)
  - Antipsychotics: Abilify (aripiprazole), Rexulti (brexpiprazole), risperidone
  - Various others: metformin, propranolol
  - *None of these medications had helped*

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Case example

Parents reported that Maya

- Used screens excessively for social media and gaming
- They had attempted to take away her phone due to Maya sending “nudes” to a boy
- She was angry and upset about having her phone taken away, so they gave it back to her
- She struggled to maintain friendships due to “drama” or becoming too “clingy” and has frequent disputes with friends
- She quit her club volleyball team because she felt teammates “bullied” her
- She switched schools due to her perception of being bullied; currently at school where her mom works

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Case example

Parents report that

- Maya would not comply with expectations of chores or homework
- She had severe emotional outbursts when parents try to implement consequences
- Her bedroom and personal items were extremely disorganized, and that she was "*not capable of starting something on her own. We feel that every time we try to discipline her, we will be back in a place like this.*"
- She had multiple medication trials with behavioral side effects to some
  - For example, reported that Zoloft made her "*berserk for the whole summer*"
  - Sent nude photos while on Rexulti
  - Lamictal caused rash and hives – allergy identified
  - Vyvanse increased her anxiety
  - Mirtazapine made her sleepy

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Case example

- Admission assessment scores were indicative of:
  - Mild depression
  - Significantly low activation
  - Moderate social anxiety
  - High anxiety sensitivity
- Maya began engaging in residential treatment:
  - Mindfulness exercise to begin each morning
  - 12.5 hours of "individual assignment time" per week (CBT focused)
  - DBT group five days per week
  - Experiential therapy five days per week – opportunities for behavioral activation, community integration, teamwork and assertive communication with peers
  - Individual sessions with therapist which focused on DBT skills and effective communication

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How BPD was diagnosed

BPD criteria were reviewed with parents first, then all together:

- A pattern of unstable and intense interpersonal relationships – arguments with close friends, believing she is bullied
- Impulsivity in at least two areas – cutting hair, sending "nudes," reports of eloping from home
- Recurrent suicidal behavior, gestures, threats – threatening to kill self on social media, recurrent inpatient hospitalization
- Affective instability – arrived with DMDD diagnosis, observed
- Chronic feelings of emptiness – self-reported by Maya
- Inappropriate, intense anger – observed toward peers, family, and treatment team

American Psychiatric Association, 2013

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Delivery of diagnosis and psychoeducation

BPD diagnosis was conveyed to parents first, then to Maya

- Parents strongly held the belief that Maya had ASD, referencing neuropsychological testing at age 9
- Maya did present with sensory sensitivities and social difficulties; however, language development was normal, and she demonstrated social reciprocity
- Maya had been treated in a clinic for ASD, which offered multi-disciplinary interventions; difficult to tell which had most benefit

Parents were open to the team's recommendation of a DBT-specific program and began to investigate options near their home

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During treatment

- Medications were tapered down to just an SSRI and Concerta
- Concerns about polypharmacy, including metabolic syndrome, weight gain, and tardive dyskinesia were discussed
- Maya was provided with DBT skills and CBT-based interventions, including behavioral activation strategies
- Parents had voiced treatment goals of "increase distress tolerance, learn how to manage emotions"
- Parents were provided with education about use of DBT skills and behavioral activation
- Screen use was discussed – restrict certain apps, set limits on use

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During treatment

- The harm of "splitting" was discussed with parents, as it applies to behavioral management, general expectations, and treatment
- Parents were taught the importance of not accommodating
- Treatment team taught parents how to set age-appropriate limits
- Parents were asked to reflect on their own ability to tolerate Maya's distress
- Maya was taught DBT interpersonal effectiveness skills; and parents received this education, in addition to education on validation
- Maya was taught "radical acceptance"

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During treatment

- Maya was also taught emotion identification strategies, and effective problem-solving
- Parents and Maya were taught strategies to avoid repeated hospitalizations, including DBT distress tolerance skills
- Goals for future were discussed, including taking a part-time job
- Parents noticed an increase in skill use and assertive communication
- Eventually, decision was made to pursue depression-specific PHP after discharge to continue:
  - Receiving combination of DBT and CBT services
  - Weekly family sessions to support skill use and application

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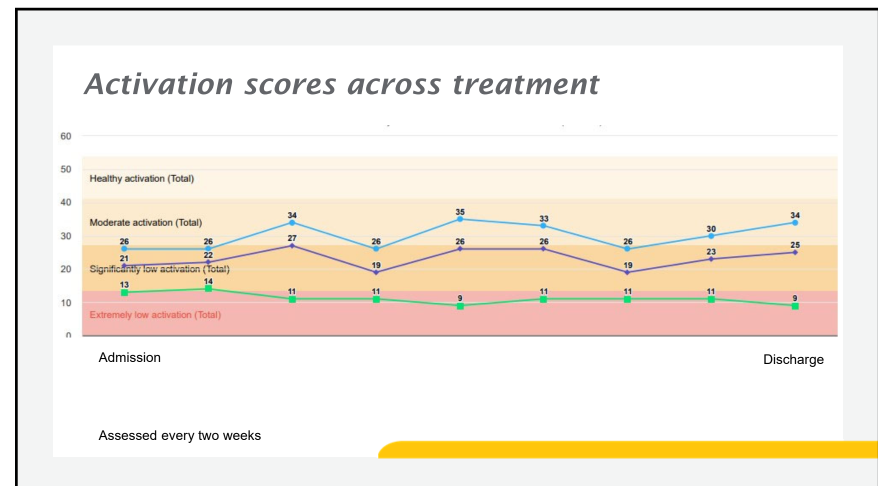

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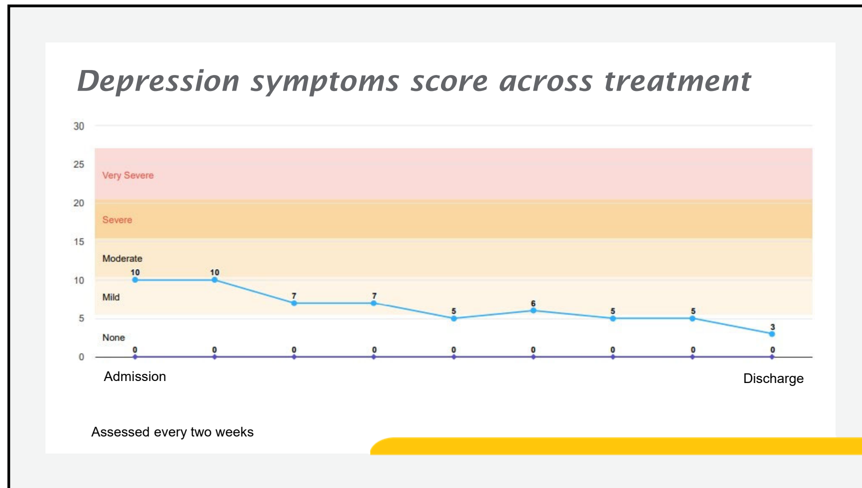

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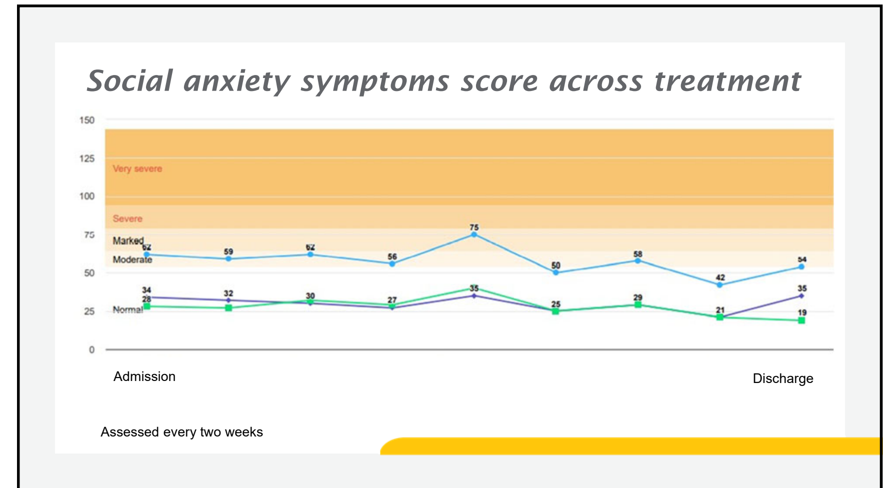

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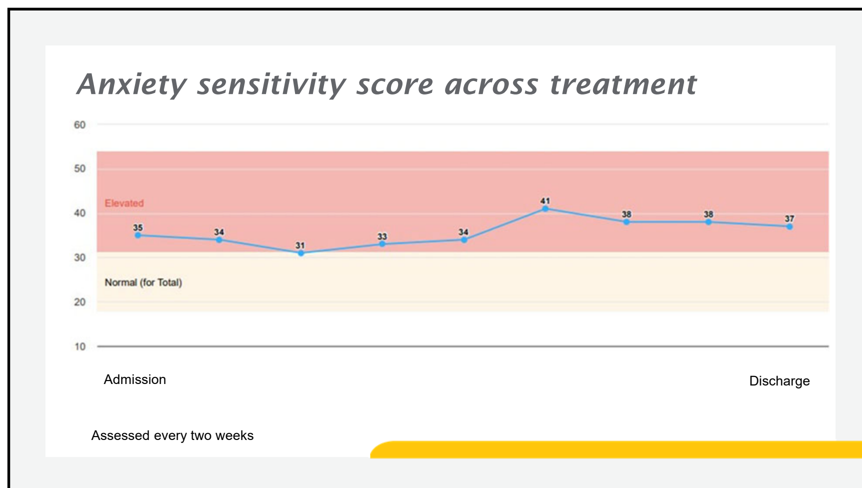

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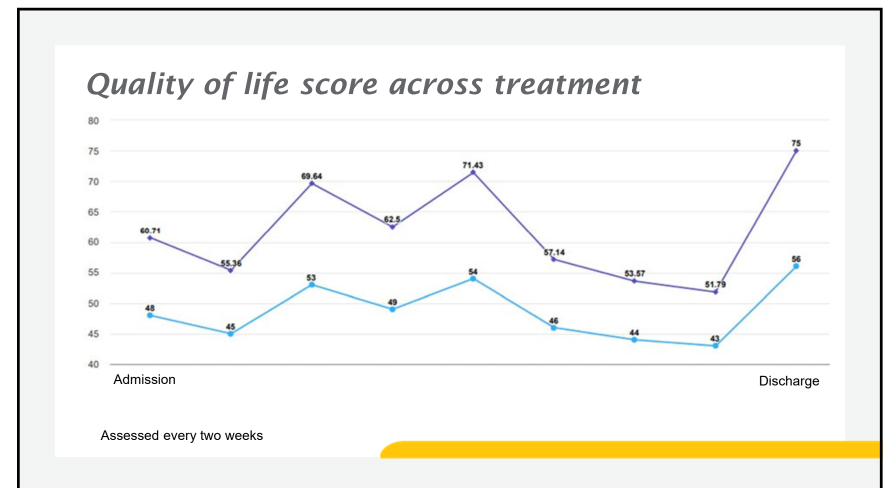

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Treatment approaches

- We used a combination of:
  - Thorough assessment based on history, behavioral observations, and interviewing Maya and family
  - Delivery of results in a manner consistent with therapeutic assessment principles
  - DBT, particularly the skills portion
  - Reducing polypharmacy and associated risks
- Are there other approaches we could have taken?
  - Discharge to a DBT-adherent outpatient provider (or MBT provider if DBT not accessible)

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How dimensional approach could be used

- Both the *ICD-11* and *DSM-5* alternative model begin with determining level of impairment from personality dysfunction
  - Ranges from 0 (little to no impairment) to 4 (extreme impairment)
  - Next, we look at pathological personality traits
    - Maya probably would have rated high for Negative Affectivity, Disinhibition, and Antagonism
  - Next, we establish whether the impairment is pervasive and stable
  - Finally, whether there are alternate explanations
- Describe difficulties in terms of not having developed a sense of her own and others' goals and motivations in the same way as peers

American Psychiatric Association, 2013; American Psychological Association, 2022; Swales, 2022

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Key take-home messages

- Validated measures exist to aid in diagnosis of BPD in adolescents
- When conveying a diagnosis of BPD, check your own anxiety / stigma
- Remember that diagnoses can be confusing, and clients or families may have strong preferences for certain diagnoses
- Provide assessment feedback in a therapeutic manner, starting with information that is most familiar
- Psychoeducation is important for both client *and* family
- Recommend medication only as-needed for co-occurring conditions; polypharmacy is not evidence-based
- DBT-A and MBT have the most research support

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