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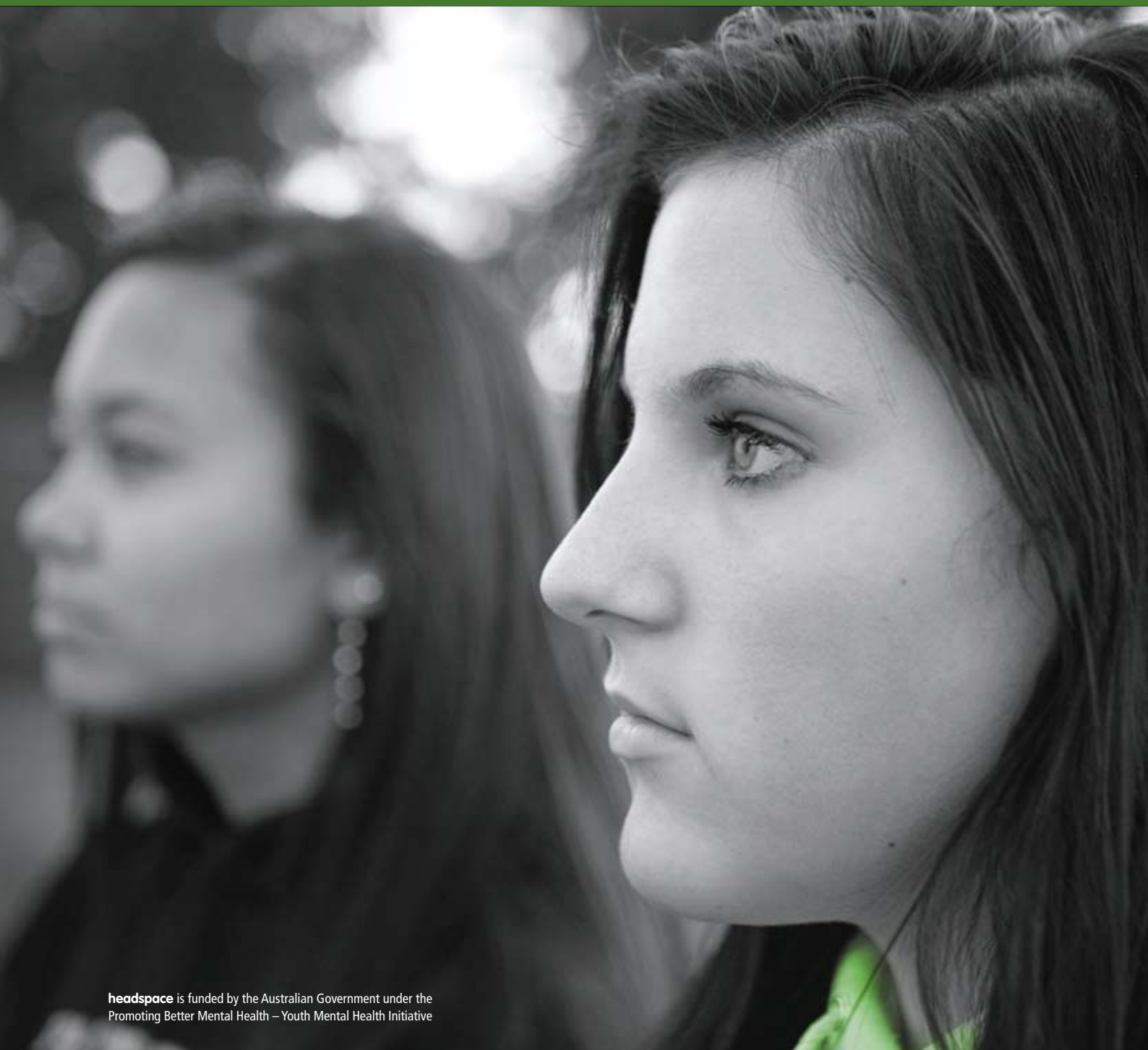
National Youth Mental Health Foundation

Evidence Summary:

Diagnosing Borderline Personality Disorder (BPD) in Adolescence: What are the Issues and what is the Evidence?



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Diagnosing Borderline Personality Disorder (BPD) in Adolescence: What are the Issues and what is the Evidence?

What is a personality disorder?

We all have a unique set of personality traits that characterise us. These are the usual ways that we perceive, think, feel, behave and relate to others and they tend to be consistent across time and situations. **Personality traits become 'disordered' when they are extreme, inflexible and maladaptive, causing significant distress and disruption to an individual's life or to those around them** (e.g. their ability to work, go to school or to maintain relationships).

It has long been assumed that both personality and personality disorders (PDs) are stable and enduring in their course from the end of adolescence (1). However, the evidence suggests otherwise (1-3). In fact, both normal and disordered personality remain relatively fluid over the first three to five decades of life. **This widespread misunderstanding reinforces the inaccurate belief of many health professionals that PDs cannot be diagnosed until adult life and that they are 'untreatable'.** This belief is especially common among clinicians in relation to borderline personality disorder (BPD), the most common and severe PD in clinical practice (4).

Is it permissible to diagnose PDs in adolescents?

Mental health professionals often believe that the current diagnostic systems in psychiatry (e.g. DSM-IV-TR; 5) do not allow them to diagnose PDs prior to age 18. This is incorrect (6). **DSM-IV-TR (5) allows for the diagnosis of PDs in adolescence if the symptoms are severe enough to persistently interfere with the individual's daily functioning for one year or longer.**

What is BPD and how prevalent is it in adolescent populations?

BPD is characterised by a pervasive pattern of emotional instability, poor impulse control, difficulty managing interpersonal relationships and disturbed self-image (5). Clinical signs of the disorder include unstable moods, impulsive aggression, chronic suicidality, repeated self-injury, and interpersonal chaos (7).

Research suggests that BPD is not uncommon in adolescents. **It has been argued that it is primarily a disorder of young people, as BPD traits in young people appear to be at least as high, if not substantially higher, than in adults (2).** In community settings, BPD is estimated to affect about 3% of adolescents (4), while in clinical settings it is higher, ranging between 11% (of adolescent outpatients) to 49% (of adolescent inpatients; 8).

While adolescents with BPD might seek professional help, there is often a considerable delay between the onset of symptoms, help-seeking behaviour (9) and recognition of the disorder (10,11). Controversy about diagnosing BPD in this age group and the stigma that surrounds the disorder contribute to **low detection rates and reluctance among clinicians to diagnose in adolescence** (6,12). When adolescents do come into contact with mental health services, personality disorder is infrequently assessed, resulting in the majority of cases of BPD going unrecognised. As a result the opportunities for intervention are often lost (4,13). **Ignoring the possibility of BPD as a clinical reality among adolescent clients might hamper effective clinical treatment (6,14-15).**

Can BPD be distinguished from 'normal' adolescent behaviour?

The stereotype of adolescents being moody, disruptive and difficult to deal with might lead to the inaccurate perception that all young people have BPD traits. **It is the number and pervasiveness of the problems that distinguishes BPD from normal adolescence.** The associated level of pain and desperation and the high suicide risk lie far outside the experience of a typically 'stormy' adolescence (16). **With training, mental health professionals can distinguish between normal development and the characteristics of BPD (6).**

Is it valid to diagnose BPD in adolescence?

Much of the controversy surrounding diagnosing BPD (and other PDs) in adolescence has centred on concerns as to whether it is valid to diagnose PDs in adolescence. A diagnosis of adolescent BPD has strong concurrent validity (i.e. it is associated with high levels of current distress and impaired functioning), divergent validity (i.e. it can be reliably measured on more than one scale) and construct validity (i.e. the features of BPD diagnosis in adolescents are comparable to those of adults; 6,17). The evidence relating to the predictive validity of the diagnosis (i.e. the stability of the diagnosis over time and the associated long-term functional outcomes) is less clear (6). **While the diagnosis itself is relatively unstable over time when measured categorically (i.e. present/absent), it is predictive of significant negative functional outcomes well into adulthood.**

Research studies consistently report that the majority of adolescents will not maintain a diagnosis of BPD over a 1-3 year follow-up (6,17). It must be noted that this finding is not unique to adolescent BPD as recent evidence suggests that BPD is not particularly stable in adult samples either (6,12,18-20). Furthermore, methodological limitations of these studies and the fact that many of the participants were receiving treatment must be taken into account (6). It is possible they reflect a positive response to treatment rather than diagnostic instability.

A 20-year longitudinal study provides strong support for the argument that borderline symptoms in adolescence cannot be considered a developmental stage that passes (16).

BPD during adolescence defines a group of young people with more severe symptoms and lower levels of functioning than those with other types of personality disorder or no PD (14). The negative outcomes associated with elevated BPD symptoms in adolescence appear to persist well beyond the adolescent years extending to a wide range of functional and clinical outcomes. Higher levels of BPD symptoms in early adolescence are predictive of increased risk of a diagnosis of BPD in adulthood, developing Axis I disorders, experiencing significant interpersonal problems, distress and reduced quality of life through the 20s and 30s. These problems occur independent of adolescent Axis I disorders and persist even after individuals no longer meet criteria for BPD (16).

Regardless of whether or not the diagnosis of BPD is maintained into adulthood, adolescent BPD warrants intervention. Adolescents with elevated BPD symptoms are at current risk of suicidal behaviour and report intense emotional pain and distress (21-22). Moreover, while remission of the BPD diagnosis is common in the transition to adulthood, this does not necessarily imply full recovery - there is often a need for ongoing support even when a young person no longer meets diagnostic criteria (7).

Can a diagnosis of BPD in adolescence be harmful?

Another controversial aspect about diagnosing BPD in adolescence is the risk that a diagnosis – or label - will 'stick' and haunt the person long after the symptoms have ended (23). Unfortunately a diagnosis of BPD can still lead to rejection by the health system (24), as clients are often seen as "too difficult". For this reason, health professionals might have legitimate concerns about stigma and 'labelling' an adolescent with BPD (2,4,23). **These concerns should encourage better education and training of professionals but should not prevent mental health professionals from assessing borderline symptoms in adolescents and diagnosing BPD where appropriate (2,4,6), as accurate diagnosis is necessary for appropriate intervention.**

In the absence of appropriate assessment, adolescents with BPD either go without treatment or are misdiagnosed. Substituting other diagnoses (eg. adjustment disorders, bipolar disorder) is inappropriate and unjustified (14) and is likely to lead to the application of inappropriate interventions (12,16). Without appropriate intervention, adolescents with BPD are likely to experience persistent difficulties that have major developmental effects, increasing their sense of despair and hopelessness.

What is the prognosis for adolescents with BPD?

Although BPD is prospectively associated with major problems and a suicide rate of 10% (21), even after individuals no longer meet criteria for the diagnosis, evidence suggests that the natural tendency of BPD is toward improvement (25) and psychotherapy can speed up this process. Furthermore, effective specialised treatments for BPD in adolescence are now emerging (15).

What does this all mean for mental health professionals who work with young people?

The available evidence indicates that the BPD diagnosis is as reliable and valid in adolescents as it is in adults (2,6). A carefully conducted and appropriate diagnosis of BPD, based upon the DSM-IV-TR criteria, assists the clinician, the client and his/her family and significant others to make sense of what can be a confusing and distressing situation and also helps to plan appropriate interventions to reduce the current and future problems associated with the disorder. **As adolescents might move out of the diagnosis it is important to re-evaluate them regularly to see if the diagnosis is still appropriate** (23).

Clinical experts recommend that when young clients present with symptoms suggestive of BPD, it is necessary to weigh the potential benefits of a diagnosis against the potential risks of early stigmatization, and that the appropriate response to stigmatisation is improved training for professionals (2). A diagnosis of BPD should not be made in order to exclude individuals from care. **Where a diagnosis is made, caution should be exercised to ensure that it is accurate.** There is concern that some clinicians regard BPD as a convenient diagnosis for clients who are simply difficult to treat. **Clinicians must conduct appropriate assessments, particularly avoiding labelling all adolescents who self-harm as having BPD.**

It has been argued in the literature on adult BPD that if a diagnosis is made there are compelling reasons to openly discuss the BPD diagnosis with the client and to provide both the client and his/her family with accurate psycho-education to dispel any myths they might have (7,20,24,26). A randomised controlled trial found that psychoeducation led to short-term symptomatic improvements in adults (27). In the absence of any such evidence specific to adolescent BPD, clinical experts have advised that a diagnosis should be openly discussed and psycho-education provided to adolescents and their families (28).

Other Resources

www.neabpd.org: A useful American website featuring articles, video and audio commentaries from several leading international experts on BPD

www.bpddemystified.com: Another useful American website

'BPD and Young People':
http://tc.oyh.org.au/InformationResources/factsheets
A factsheet for young people and their families/carers

'Engaging and managing an unwilling or aggressive young person': http://mja.com.au/public/issues/187_07_011007/mcc10287_fm.html practical tips for professionals working with young people on how to manage challenges in engagement and treatment

'A Complete Guide to Understanding and Coping When Your Adolescent Has BPD' http://www.amazon.com/Borderline-Personality-Disorder-Adolescents-Understanding/dp/1592332870

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