What's in a name? Borderline personality disorder in adolescence

Kirsten Barnicot¹ · Paul Ramchandani¹

Published online: 27 October 2015
© Springer-Verlag Berlin Heidelberg 2015

This issue of *European Child and Adolescent Psychiatry* includes an *ESCAP* (European Society of Child and Adolescent Psychiatry) *Expert Article* on borderline personality disorder (BPD) in adolescence authored by a working group led by Professor Peter Fonagy. This is part of a series of expert articles, the first of which, on anorexia nervosa [8], was published in the October 2015 issue of the journal.

The diagnosis of personality disorder during adolescence has long been controversial, and ICD10 states that it is unlikely to be appropriate before the ages of 16 or 17 years. This expert review addresses some of the key concerns that have been raised; particularly that the longitudinal validity of the disorder (as a categorical construct) is not strong, the evidence base for effective intervention for the disorder itself is still small, though it is developing, and that the diagnosis itself can be experienced as stigmatising. The authors do also helpfully point out the important, but often overlooked, impact of not identifying and offering help to young people experiencing some of the key symptoms of this presentation, though diagnosis is not the only way to access effective services.

Fonagy and colleagues suggest that a key source of reluctance to diagnose amongst clinicians is concern about stigma. Adolescents with a diagnosis of personality disorder report encountering high levels of stigma, to a greater extent than adolescents with other severe mental health conditions, with BPD the strongest predictor of stigma [1]. The impact of this stigma on adolescents with a potentially fragile and negative self-concept—in addition to difficulties

forming trusting therapeutic relationships, often against a background of severe interpersonal trauma—should not be underestimated. As argued by Fonagy and colleagues, avoiding making a diagnosis on this basis could reinforce negative stereotypes of BPD. Nonetheless, this does place a responsibility on the mental health professionals firstly to be sure of the validity and utility of making such a diagnosis, and secondly to do as much as we can to combat the stigma associated with personality disorder.

Fonagy and colleagues highlight two difficulties with our current systems for diagnosing personality disorder that raise questions regarding its validity in both adulthood and adolescence. Firstly, Fonagy and colleagues recommend integrating dimensional factors alongside categorical criteria when making a diagnosis of BPD in adolescents. This reflects a growing recognition of the questionable diagnostic validity of personality disorders as distinct categorical entities. In adults, supposedly distinct personality disorders are often highly comorbid, and factor analyses of personality disorder traits yield inconsistent results, with factor structures that do not resemble the distinct disorders outlined in DSM-5 [4, 9, 11, 13, 15]. The factor analytic structure of personality disorder traits in adolescents has been less well studied, with mixed findings. Using exploratory factor analysis of clinician ratings of DSM-IV personality disorder traits in a sample of 296 adolescent inpatients, Durrett and Westen [3] identified a factor structure resembling the ten DSM-IV personality disorders. Conversely, when a Q-factor analysis—which identifies clusters of similar people rather than clusters of co-occurring items—was applied to the same dataset, very different findings emerged [18]. Borderline personality disorder correlated with two empirically distinct and non-overlapping factors comprising emotional dysregulation and histrionic traits. These findings suggest that the distinctions between personality

✉ Paul Ramchandani
p.ramchandani@imperial.ac.uk

¹ Centre for Mental Health, Imperial College, 7th Floor
Commonwealth Building, Hammersmith Hospital Campus,
London, UK

disorders outlined in DSM-5 may not adequately reflect the true distribution of these presentations in adolescence.

Secondly, Fonagy and colleagues acknowledge that “the categorical stability of BPD in adolescents is relatively low”. In fact, estimates of stability vary widely from study to study. Using a semistructured diagnostic interview in a sample of adolescent inpatients, Mattanah and colleagues found that only 23 % still met diagnostic criteria for BPD 2 years later [12]. By contrast, using a self-report questionnaire with a diagnostic cutoff in a sample of hospital-presenting suicidal adolescents, Greenfield and colleagues found that 76 % still met criteria for BPD 4 years later [5]. These two studies illustrate the extent to which findings can vary between studies according to instrument and sample selection. Findings of low diagnostic stability in adolescent inpatients mirror findings of low diagnostic stability in adults, with just 44 % continuing to meet criteria for BPD after 2 years [6], and 15 % after 10 years [7]. It was partly in recognition of the fact that personality disorders can be transient, like many other psychiatric disorders, that the distinction between Axis I and Axis II disorders was dropped in DSM-5.

What does this mean for the diagnosis and assessment of BPD in adolescents? On the basis of these and other difficulties with making distinct personality disorder diagnoses, ICD-11 is planning to no longer use different ‘types’ of personality disorder in their primary classification system. Instead, personality disorder will be a single dimensional construct, classified according to four proposed levels of severity: personality difficulty, mild personality disorder, moderate personality disorder and severe personality disorder [16]. Severity will be determined by the extent to which the disorder affects an individual’s interpersonal relationships, performance of occupational and social roles, and risk of harming themselves or others. Clinicians may then additionally choose to optionally classify the personality disorder according to five dimensional domains: negative emotionality, disinhibition, dissocial, anankastic and detached. Five very similar personality dimensions were proposed for DSM-5, although with no anankastic dimension and adding a psychopathy dimension [10]. However, this model was considered too unwieldy for clinical use and has been retained only as an idea for further study. In their paper in this edition of *European Child and Adolescent Psychiatry*, Fonagy and colleagues advocate further research on the utility of this hybrid model in adolescents. Whichever approach is favoured, we would argue that any new conceptualisation of personality disorder in adolescents should be evaluated carefully. The ICD-11 model will soon enter clinical practice. It may prove simpler to use and clinical utility is an important consideration for integrating dimensional diagnostic systems into practice [14]. Another potential

advantage of the shift in ICD-11 from a categorical to a severity-based classification is that it implies a diagnosis that is more open to change, with an individual able to transition from one level of severity to another over time. This in-built allowance for fluctuations in severity over time is likely to yield a diagnostic system that is more temporally stable and better reflects the developmental course of personality traits and behaviour over a lifetime. This may also help to address some of the difficulties clinicians have with diagnosing personality disorder in adolescence, as they need no longer feel they are labelling an individual for life [17]. An additional area that warrants more consideration is the involvement of service users in the design and delivery of service. This has a number of potential benefits, including keeping approaches to diagnosis and therapeutic responses in line with what service users find helpful [2].

Young people presenting with these difficulties, however described, are often amongst the most troubled and vulnerable we see in clinical practice. Fonagy and colleagues have helpfully set out the challenges, and offered some solutions, which should encourage us to review our work with young people and their families. On a personal level, each of us can also continue to fight stigma by challenging negative stereotypes when we encounter them in ourselves and in others, by continuing to educate ourselves to better understand and respond to challenging behaviour and interpersonal dynamics, and above all, to remember to keep each person in mind as an individual.

References

1. Cathoor K, Feenstra DJ, Hutsebaut J, Schrijvers J, Sabbe B (2015) Adolescents with personality disorders suffer from severe psychiatric stigma: evidence from a sample of 131 patients. *Adolesc Health Med Ther* 6:81–89. doi:10.2147/AHMT.S76916
2. Davies J, Sampson M, Beesley F, Smith D, Baldwin V (2014) An evaluation of Knowledge and Understanding Framework personality disorder awareness training: can a co-production model be effective in a local NHS mental health Trust? *Pers Ment Health* 8(2):161–168
3. Durrett CD, Westen D (2005) The structure of Axis II personality disorders in adolescents: a cluster and factor analytic investigation of DSM-IV categories and criteria. *J Pers Disord* 19(4):440–461
4. Ekselius L, Lindstrom E, Von Knorring L, Bodlund O, Kullgren G (1994) A principal component analysis of the DSM-III-R Axis-II personality disorders. *J Pers Disorders* 8:140–148
5. Greenfield B, Henry M, Lis E, Slatkoff J, Guilé JM, Dougherty G, Zhang X, Raz A, Eugene AL, Daniel L, Mishara BL, Koenekoop RK, de Castro F (2015) Correlates, stability and predictors of borderline personality disorder among previously suicidal youth. *Eur Child Adolesc Psychiatry* 24(4):397–406. doi:10.1007/s00787-014-0589-9
6. Grilo CM, Sanislow CA, Gunderson JG, Pagano ME, Yen S, Zanarini MC, Shea MT, Skodol AE, Stout RL, Morey LC, McGlashan TH (2004) Two-year stability and change of

- schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *J Consult Clin Psychol* 72(5):767–775
7. Gunderson JG, Stout RL, McGlashan TH, Shea MT, Morey LC, Grilo CM, Zanarini MC, Yen S, Markowitz JC, Sanislow C, Ansell E, Pinto A, Skodol AE (2011) Ten-year course of borderline personality disorder: psychopathology and function from the collaborative longitudinal personality disorders study. *Arch Gen Psychiatry* 68(8):827–837
 8. Herpertz-Dahlmann B, van Elburg A, Castro-Fornieles J, Schmidt U (2015) ESCAP expert paper: new developments in the diagnosis and treatment of adolescent anorexia nervosa—a European perspective. *Eur Child Adolesc Psychiatry* 24(10):1153–1167
 9. Klonsky DE (2000) The DSM classification of personality disorder: clinical wisdom or empirical truth? A Response to Alvin R. Mahrer's Problem 11. *J Clin Psychol* 56:1615–1621
 10. Krueger RF, Derringer J, Markon KE, Watson D, Skodol AE (2012) Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychol Med* 42:1879–1890
 11. Livesley WJ (1998) Suggestions for a framework for an empirically based classification of personality disorder. *Can J Psych* 43:137–147
 12. Mattanah JJ, Becker DF, Levy KN, Edell WS, McGlashan TH (1995) Diagnostic stability in adolescents followed up 2 years after hospitalization. *Am J Psychiatry* 152:889–894
 13. Morey LC (1988) The categorical representation of personality disorder: a cluster analysis of DSM-III-R personality features. *J Ab Psych* 97:314–321
 14. Polanczyk GV (2014) Dimensionality of childhood psychopathology and the challenge of integration into clinical practice. *Eur Child Adolesc Psychiatry* 23:183–185. doi:[10.1007/s00787-014-0539-6](https://doi.org/10.1007/s00787-014-0539-6)
 15. Torgensen S, Skre I, Onstad S, Edvardsen J, Kringlen E (1993) The psychometric—genetic structure of DSM-III-R personality disorder criteria. *J Pers Disord* 7:196–213
 16. Tyrer P, Reed GM, Crawford MJ (2015) Personality disorder 1: classification, assessment, prevalence, and effect of personality disorder. *Lancet* 385:717–726
 17. Tyrer P (2014) The likely classification of borderline personality disorder in adolescents in ICD-11. In: Sharp C, Tackett JL (eds) *Handbook of borderline personality disorder in children and adolescents*. Springer, New York, pp 451–457
 18. Westen D, Shedler J, Durrett C, Glass S, Martens A (2003) Personality diagnoses in adolescence: DSM-IV Axis II diagnoses and an empirically derived alternative. *Am J Psych* 160:952–966