Early detection and intervention for borderline personality disorder in adolescence

/ Rano otkrivanje i intervencija za granični poremećaj ličnosti u adolescenciji

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Personality disorders are patterns of maladaptive personality traits that have their onset in childhood or adolescence and have an impact on the individual throughout the life span. Borderline Personality Disorder (BPD) is a very severe but treatable mental disorder. Although BPD has its onset in adolescence and early adulthood, the diagnosis is often delayed. In most cases, specific treatment is only offered late in the course of the disorder and to relatively few individuals. Despite the scientific evidence for the validity of personality disorders in childhood and adolescence, many clinicians remain reluctant to use the diagnosis in young people.

/ Poremećaji ličnosti su obrasci maladaptivnih crta ličnosti koji svoj početak imaju u djetinjstvu ili adolescenciji i utječu na pojedinca tijekom cijelog života. Granični poremećaj ličnosti (GPL) je vrlo težak, ali izlječiv mentalni poremećaj. Iako GPL ima početak u adolescenciji i ranoj odrasloj dobi, dijagnoza se često postavlja kasno. U većini slučajeva specifični tretman se nudi kasno u tijeku poremećaja, a i to relativno malom broju pojedinaca. Unatoč znanstvenim dokazima za validnost dijagnoze poremećaja ličnosti u djetinjstvu i adolescenciji, dijagnosticiranje često ostaje tabu u ovim dobnim skupinama.

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INTRODUCTION

Personality disorders (PDs) are defined as „an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture" (1). This disorder is expressed as the impairment of several aspects of personality, including identity, affect, cognition and social and personal relationships. PDs develop during childhood and adolescence and can have a lifelong course. They are manifested in typical form in early adulthood.

Both major classification systems enable a diagnosis prior to the age of 18 years. While the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) required a minimum age of 16 years (exception: antisocial PD from 18 years), there is no age limit defined in DSM-5 (1). Instead, according to DSM-5´s general criteria of PDs, it is defined theat expression are not better understood as normal for an individual's developmental stage" (criterion G) (1). Diagnosis according to the International Classification of Diseases, 10th revision (2) is possible when the diagnostic criteria are fulfilled prior to the 18th birthday, and the symptomatology is already recognizably persistent, continuous and not situation-dependent. In the German Guidelines on PD (3) it is stated that PDs cannot reliably diagnosed before the age of 14. The Australian Guidelines (4) recommend that, after appropriate assessment, adolescents aged 12-18 years who meet the diagnostic criteria of a Borderline PD should get the diagnosis. The British NICE Guidelines on PD also offer best practice advice on the care of young people with BPD under the age of 18 (5). In comparison to adult populations, the stability of PDs in adolescence are on a similar level (6). Reliability and validity of BPD diagnoses in adolescence is comparable to that in adulthood (7).

In this paper we will focus on Borderline PD. In comparison with other forms of PD there is a huge increase in research examining Borderline PD in adolescents so that there is a more solid empirical basis to rely on. Secondly, Sharp and co-workers (8) have demonstrated in a large sample of inpatients that Borderline PD can be seen as the core („g-factor") of all personality pathology so that, in part, statements about Borderline PD should be representative of other forms of PDs.

RESISTANCE TO THE DIAGNOSIS OF BORDERLINE-PD IN YOUNG PEOPLE

There are some basic misunderstandings regarding the diagnosis of PD under the age of 18:

- Missunderstanding 1: Development only happens in childhood and adolescence and ends up with 18 years.

As it has become clear from many studies in developmental psychopathology, this is not the case, so we do not have to wait until the age of 18 for personality factors to become stable.

- Missunderstanding 2: PDs are not changeable as there are no effective treatment methods, so that the diagnosis of PD is a lifelong destiny.

A large number of longitudinal studies in adult populations suffering from PD have revealed that PD diagnoses are less stable than expected, even without treatment (9). Different therapeutic approaches like DBT, TFP, MBT or SFT have proven to be effective in treating BPD successfully.

- Missunderstanding 3: If a PD is treated successfully in an adolescent patient then this gives the evidence that the diagnosis was wrong.

Longitudinal studies have demonstrated that the presence of PD symptomatology in adolescence leads to major impairments in young adulthood if the disorder is not treated properly (10).

Beside those misunderstandings, there is the concern that a diagnosis of PD in childhood

and adolescence might lead to severe stigmatization later in life (11). This has to be taken as a serious concern as long as mental health professionals do not acknowledge the empirical facts about the changeability of the disorder in treated as well as in untreated populations (12). Thus, as informed mental health professionals, it is our duty to fight against these prejudices and the stigmatization of young people who are suffering severely.

DEVELOPMENT OF PERSONALITY AND PERSONALITY DISORDERS

The development of personality as well as personality disorders has to be understood from a life-span perspective where the foundations are set in childhood and adolescence (13, 14). Current concepts focus on transactional approaches that describe the constant interplay of constitutional and environmental factors. From the beginning, the individual plays an active role in this process. In contrast to widespread beliefs, the perception of adolescence as a phase of life where turmoil, i.e. constant troubles with oneself and others, is present in all adolescents, is not supported by developmental research (15). It is possible to distinguish adolescent crises, which are frequent in this age period and that are not associated with a higher load of mental problems, from identity diffusion which is seen as one of the core constructs of severe personality pathology (16). In the newly developed model of PD that was presented in DSM-5 Chapter III (1) the essential features of a personality disorder are defined as significant impairments in personality functioning manifesting in impairments in self-functioning (identity, self-direction) and impairments in interpersonal functioning (empathy, intimacy).

The period of adolescence is seen as a particularly vulnerable phase for the development of BPD (17), and in recent years BPD has been described as a developmental disorder with onset in adolescence around age 13 (18, 19). The first symptoms of BPD can be already detected at an earlier age. In an English birth cohort (20), 6,330 11-year-old children were interviewed in respect to symptoms of Borderline psychopathology. These data were compared with 34,653 adults from an American community sample: 3.2% of the children (3.6 % girls, 2.8% boys) met DSM-IV criteria for BPD in comparison to 5.9% of the adult population (6.2% women, 5.6% men). Children and adults presented with very similar rates of chronic emptiness, physically self-damaging acts and stormy relationships. While children reported to be angry and moody more often than adults, other BPD symptoms like paranoia or dissociation, serious identity disturbance, impulsivity and frantic efforts to avoid abandonment were more common in adults. In comparison with boys, the 11-year-old girls showed more mood reactivity and symptoms of interpersonal dysfunction like unstable relationships or concerns of being abandoned, whereas boys described more engagement in physically self-destructive acts and impulsive behaviour.

Generally speaking, the first symptoms of BPD appear in late childhood, are clearly manifest in adolescence and have their peak in early adulthood.

The stability of PDs does not differ markedly between adolescents and adults, and is rather low when measured categorically. In a longitudinal study of Chanen et al. (21), a PD was rated at both times of measurement in 55% of the cases. Only in 14.6% of the cases, a PD that could be confirmed at baseline was no longer present at follow-up. In another 19.8% of the cases, a PD was rated only at the second measurement. In 74% of cases the rate of meeting criteria for a PD diagnosis at one or both times of measurement was high and comparable to findings in adult populations. The stability

was higher in girls compared to boys, and in severely disturbed inpatients compared with less disturbed outpatients. The highest dimensional stability was found in antisocial and schizoid symptoms (22).

LONG-TERM OUTCOME OF EARLY STARTING PD

Adolescents with early-onset personality disorders have a high risk of major impairments in adult life. Those impairments comprise educational and academic failure, a broad range of interpersonal difficulties as well as severe mental health problems in addition to PD. In the Children in the Community (CIC) Study, an epidemiological sample of 778 children and adolescents from New York State (23), 83% of patients with a PD diagnosis in adolescence suffered from adverse outcomes in early adulthood: 59% had any Axis I psychiatric disorder, 37% numerous difficulties in interpersonal relationships, 24% poor educational achievement (school failure), 42% serious acts of physical aggression toward others, and 14.5% had attempted suicide. Those associations remained significant after controlling statistically for co-occurring Axis I disorders or for corresponding problems during adolescence.

A 20-year longitudinal study on 736 adolescents (mean age at intake 13.7 years) (24) revealed that patients with comorbid Axis I and Axis II diagnoses had significantly poorer outcomes than those with Axis I disorders only. They explain these results with the hypothesis that the presence of personality pathology could interfere with normal maturation and socialization processes in adolescence. The explanations of Sharp and Fonagy (17) take the same direction: „From a developmental psychopathology perspective, the evidence is consistent with the assumption of a range of bidirectional aggravating interactive processes, whereby BPD symptoms increase and are increased by poor life adaptation at least in terms of social relationships, which in turn can generate, and be further worsened by, internalizing and externalizing disorders. To put it quite broadly, the profile of problems characteristic of BPD is likely to generate a negative, bidirectional interaction between the person and his/her social environment where the supportive, resilience enhancing properties of the social environment are negated, leaving the individual exceptionally vulnerable to both social and biological risk.“ (17).

Taking together the results from different epidemiological and longitudinal studies, the longitudinal outcome of BPD is very loaded: patients with BPD are persistently high users of health services who are constantly in psychiatric outpatient treatments over many years, interrupted by periods of inpatient treatment (25); 60%-70% of patients with borderline personality disorder make suicide attempts, the rate of completed suicide is between 8% and 10% (26, 27) and it is estimated that more than 30% of individuals who die by suicide previously suffered from PD (28). Patients with BPD show severe and persistent functional disability (29) as well as vocational and work problems like academic failure, lower levels of qualification and much higher unemployment rates (30). Individuals with higher levels of early adolescent BPD symptoms score consistently lower in role function, social function and life satisfaction (31).

THE SOCIETAL COSTS OF BPD

Borderline-PD causes enormous suffering in the patients and a high amount of burden for families, partners and children. Therefore it is, without any doubt, an ethical imperative to provide these patients with the best therapy that is available (32). But for a modern society it is not only an ethical question to establish

effective services for the treatment of patients with BPD, it is also reasonable from an economic point of view.

The prevalence of BPD in the general society is judged to be around 1-2%. Because of the enormous suffering of BPD patients, about 80% of them seek for therapeutic help. It is estimated that about 15% of all patients in psychiatric or psychotherapeutic hospitals in Germany fulfil the criteria of BPD, either as first or second diagnosis. Thus about 15% of all costs that are spent in Germany for the treatment of mental disorders are used for the care of BPD patients (about 3 billion €) (33); 90% of the total medical costs are due to inpatient treatment. While the disorder starts in childhood and adolescence, the first psychiatric inpatient treatment of a patient with BPD is on average around age 24. At this age the probability to be readmitted to a psychiatric hospital in the next ten years is about 80% (33).

If we do not look only at the medical costs, the picture gets even more dramatic, as the majority of costs assignable to BPD are due to indirect costs (mainly work-related disability). In the Netherlands, the total costs of BPD are estimated to be 2.2 billion € per annum, or 16,852 € per patient with BPD. Only 22% of these costs are directly related to healthcare (34). In another cost-of-illness study investigating the economic burden of BPD on society (35), the Human Capital Approach was used to estimate the value of all potentially lost production due to BPD. Productivity costs accounted for almost 42% of total costs, with the largest part due to work disability.

As a consequence of these results it has to be stated that the economic burden of BPD on society is completely underestimated. These costs are far higher than those that would be needed to establish effective treatment facilities for BPD patients.

EARLY DETECTION AND PREVENTION FOR BPD IS URGENTLY NEEDED

In this article, we have described how BPD leads to harmful outcomes and high individual and societal costs. A rational course of action would be to support every effort that is focused on early detection and prevention of such a harmful disorder. However, reality draws a different picture all over the world. The norm is to ignore the BPD diagnosis before the age of 18, which leads to a delay in adequate treatment. Not providing young patients with BPD with disorder-specific treatment approaches increases the probability of a chronic and harmful course of the disorder over the whole life-span. This comes along with enormous suffering as well as enormous costs.

In 2014, Andrew Chanen, Carla Sharp and Perry Hoffman started an initiative to change this situation. Together with other experts in early detection and prevention of BPD, they founded the Global Alliance for Prevention and Early Intervention for BPD (GAP) (36). The main goal of this GAP initiative is to support both clinical and research activities that help improve early detection and effective intervention for BPD. Moreover, a focus will be put on the intensive inclusion of families of young patients with BPD at all stages of assessment and intervention. Finally, the initiative wants to move away from the competition to find the „best“ treatment (the so-called „horse-race“ approach) to instead improving access to a variety of evidence-based treatments.

Detection, prevention and early intervention for borderline personality disorder should become a public health priority.

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