

Evidence Summary:

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



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Is there a role for early intervention in treating adolescent Borderline Personality Disorder (BPD)?

Interest in diagnosing and treating adolescents with BPD (and other personality disorders/PDs) is a relatively recent development (1). **As research has begun to explore this area, it has become increasingly clear that both sub-syndromal and full-threshold BPD can be reliably diagnosed in adolescence** (see 2). While they often go unrecognised, adolescents with BPD are commonly seen in outpatient mental health services (3-6). They typically report experiencing immense emotional distress and often suffer more impairment than peers diagnosed with other PDs or other mental health disorders (7-9). Some will go on to recover by early adulthood (10-11) but many will experience significant life difficulties for years to come (10,12-13). Adolescents with elevated symptoms of BPD are at increased risk of experiencing a wide-range of negative outcomes as adults. These include meeting the criteria for a diagnosis of BPD as adults, developing substance use or mood disorders, experiencing significant interpersonal problems, distress and a reduced quality of life (14). Importantly, the functional impairments found in adolescents with BPD can persist for decades (13). **There is a compelling case for early intervention for this group (10,14) in order to alleviate the young person's symptoms and distress, and improve their longer-term outcomes.**

What do we know about treating adolescent BPD?

Given the historical lack of attention to treating personality disorders in adolescents, there is a knowledge gap regarding 'what works', both for PDs in general and BPD specifically (15). **As such, there is currently no consensus on which interventions may be considered 'best-practice' for this age group.** There is only one published randomized controlled trial (RCT) for adolescent BPD to date (16). This trial compared Cognitive Analytic Therapy (CAT) to good clinical care (GCC; which consisted of a high-quality, comprehensive intervention) in a group of outpatient clients aged 15 to 18 years. Both treatments were effective in achieving substantial and clinically significant improvement after 11-13 sessions. Few conclusions

can be drawn on the basis of one trial, however the results suggest that early diagnosis of sub-syndromal or full-threshold BPD can be matched with an effective intervention (16).

Other research has focused on providing an adolescent version of Dialectical Behaviour Therapy (DBT), which is a well-known intervention for adult BPD. Adolescent DBT (DBT-A) differs from adult DBT in that it is designed to be delivered over a shorter time-frame (24 sessions over 12 weeks), includes parents in treatment, places a greater emphasis on the family, and focuses on teaching a smaller number of skills using language that is appropriate for an adolescent (17). Preliminary research (17-18) has shown promising results for DBT-A, although more definitive evidence will become available when an RCT evaluating DBT-A for adolescents is completed (19).

What about other therapies that work for adults with BPD?

Given the lack of research regarding what works for treating adolescents with BPD, clinicians may instead rely on using interventions that have only been evaluated with adults with BPD. Until they have been specifically evaluated with adolescents, these treatments should be considered experimental (20). This does not mean that they do not work; rather there is not enough evidence at this stage to say whether they are effective.

A wide range of interventions are used to treat adult BPD and many of these have been shown to be effective. These include cognitive and behavioural-based therapies such as DBT, Schema-Based Therapy (SBT) and Cognitive Behaviour Therapy (CBT); psychodynamic approaches such as Mentalisation Based Therapy (MBT), Transference Focused Therapy (TFT) and Acceptance and Commitment Therapy (ACT); group interventions such as Interpersonal Group Therapy (IGP) and brief skills-training interventions such as Systems Training for Emotional Predictability and Problem Solving (STEPPS) and Manualised Cognitive Therapy. Although the results of clinical trials with adults are encouraging, several systematic reviews of the effectiveness of these therapies have concluded **that there is insufficient evidence to say which particular therapies work best for whom (21-24).**

Reasonable Evidence in adults:
(e.g. a number of rigorous studies show some consistency in results)

- Dialectical Behaviour Therapy*

Limited Evidence in adults:
(e.g. one or more rigorous studies show positive results)

- Cognitive Behaviour Therapy (as an add on to TAU)
- Mentalisation-Based Partial Hospitalisation
- Schema-based Therapy
- Acceptance & Commitment Therapy
- Transference Focused Therapy
- STEPPS (as an add on to TAU)
- Interpersonal Group Therapy

Mixed Evidence in adults:
(e.g. rigorous studies show inconsistent results)

- Manualised Cognitive Therapy

TAU: Treatment as Usual; STEPPS: Systems Training for Emotional Predictability and Problem Solving

* This reflects a greater research interest in DBT; there is no evidence to suggest DBT is more effective than other specialised interventions.

Is there a role for medication in treating adolescent BPD?

There is no compelling evidence for the use of medications to treat adolescent BPD. Medication should never be used as a primary treatment for adolescent (or adult) BPD (25). While it is evident that a wide range of medication is used to treat adults with BPD the evidence-base for their use is limited (26). Indeed multiple medications are often prescribed to patients at the same time (25-27), which is ill-advised as it leads to an increased risk of harmful and potentially serious side effects (27). Overall, high quality research on the role of medication is needed before any conclusions can be drawn that help inform clinical practice.

Can it ever be harmful to treat BPD? In adolescents as well as adults?

Perhaps the most concerning aspect about the current status of treatment for BPD in all age groups is the gulf that exists between 'what works' and the reality of 'treatment as usual' for this client group (16,28).

It is well recognized that treating adolescents with BPD can cause considerable stress and strong emotions in clinicians (29). It is important that clinicians are aware of, and able to manage, these emotions in a supportive environment as individuals with BPD are usually highly sensitive to rejection. Moreover, individuals with BPD often struggle with interpersonal relationships – including with therapists – and may find it difficult to remain engaged in therapy (30-31). In the absence of specialised training and support, self-harming and other impulsive behaviour is often misinterpreted by clinicians as deliberate misbehaviour or 'manipulation'. Such an interpretation is neither accurate nor helpful (20).

In fact, young people with BPD are usually very ineffective manipulators; it is the transparency of their actions that makes them so provocative and so poor at getting what they need (32). **These behaviours can be more helpfully understood as unhelpful coping mechanisms in the face of emotional distress (29).**

Research indicates that across a range of clinical settings, staff attitudes towards clients with BPD have traditionally tended to be negative and critical (30). **Such attitudes are likely to lead to unempathic and unhelpful responses toward clients (30) and tend to escalate behavioural disturbance (33). It is only when these attitudes exist that 'treatment' may be considered harmful.**

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

At the core of improving outcomes for young people with BPD is the need for appropriate compassionate treatment. This is perhaps more important than promoting any one particular therapy. At this stage of evidence and knowledge, any thoughtful, structured approach that is based on a sound knowledge of BPD is potentially helpful, whatever its theoretical underpinnings or technical approach (24-25). A common element to many effective treatments for BPD is adopting a non-blaming approach to understanding the individual. In order for this to be possible **adequate supervision and support for the therapist are essential (20,22,27).**

Professionals who work with clients in the context of a limited number of sessions need not attempt to tackle the wide array of symptoms associated with BPD. Nor should they assume that the task at hand is to somehow 'change the young person's personality'. Instead, **efforts should be focused on targeting some of the immediate stressors in the young person's life**, including self-harming behaviour, suicidal ideation, turbulent family environments or high levels of anxiety or depression. There is evidence to suggest that by targeting co-occurring disorders and supporting clients to cope with current stressors in their lives, treatment can lead to significant improvements within a relatively short-time frame (34). **It is also important that every effort is made to support a young person to maintain or regain their ability to function at work or school and in their social relationships as independently as possible (29).**

Other Resources

NICE guideline: Borderline Personality Disorder: Treatment and Management (in both adults and adolescents) (<http://www.nice.org.uk/Guidance/CG78>)

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

Tips and techniques for engaging and managing the reluctant, resistant or hostile young person (http://www.mja.com.au/public/issues/187_07_011007/mcc10287_fm.html)

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