Borderline Personality Disorder in Adolescents:

Lexington Psychiatrist Sheds New Light (and Hope) on a Perplexing Issue

By Dilys Burke

Fits of anger. Impulsive, sometimes risky actions. Difficult relationships. Frequent, abrupt shifts in mood. Black and white thinking. When are these behaviors in teens simply signs of a "typically" stormy adolescence, and when do they point to a more serious and pervasive problem? This is a question that Blaise Aguirre, M.D., a Lexington resident, is called upon to answer on a routine basis. As the medical director for the adolescent DBT residential unit at McLean Hospital, Dr. Aguirre specializes in a condition called borderline personality disorder (BPD), in which extreme and persistent manifestations of these behaviors occur, causing great anguish for adolescents and their families. Untreated, BPD is likely to persist though adulthood, severely disrupting the sufferer's ability to function and impairing quality of life. The rate of suicide attempts, sometimes successful, is high among those suffering from BPD.

Though BPD is more common that disorders like bipolar disorder or schizophrenia, it is less well recognized and often misdiagnosed. It is not uncommon for an adolescent with BPD to have received multiple diagnoses and treatments, only to continue to experience the turbulent symptoms that characterize the disorder. According the Dr. Aguirre, correct diagnosis of BPD is essential because, while psychotropic medications and conventional therapies may help with some of the symptoms, this condition requires highly specialized treatment that focuses specifically on the underlying emotional conflicts and thought patterns that are typical in people with BPD.

BPD – an Overview

What exactly is BPD? Though originally considered a borderline psychotic disorder, it is now recognized that BPD results from disordered emotional and behavioral regulation. It is far more common in females than males, though males do suffer from BPD. According to DSM-IV criteria (DSM-IV is considered the diagnostic "bible" for psychiatric disorders), signs and symptoms include:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation (splitting).
- Identity disturbance: markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two areas that are potentially self-damaging (e.g., promiscuous sex, eating disorders, binge eating, substance abuse, reckless driving).
- Recurrent suicidal behavior, gestures, threats or self-injuring behavior such as cutting, interfering with the healing of scars (excoriation) or picking at oneself.
- Behavioral instability due to a marked reactivity of mood (e.g., intense episodic periods of depression or discontentment, irritability or anxiety usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness
- Inappropriate anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid or delusional thinking or dissociative symptoms.

Because many of these symptoms overlap with those of mood disorders, diagnosing BPD can be complicated. However, experts like Dr. Aguirre understand the sometimes-subtle differences that can help differentiate BPD from other psychiatric disorders.

Although the exact causes of BPD are unknown, research indicates that several factors may contribute to the development of the disorder. Childhood trauma, often in the form of sexual abuse, is common among BPD sufferers. Childhood neglect and/or periods of separation from parents are also common. Growing up in an emotionally invalidating, unsupportive environment may also contribute to BPD. It is important to note, however, that not all children who were neglected or abused develop BPD, and not all BPD sufferers experienced abuse or neglect in childhood. Thus, it is thought that certain biological factors, including genetics and neurological dysfunction, may also play a role in the development of BPD.

Unlike bipolar disorder or depression, symptoms of BPD do not usually respond adequately to antidepressants or mood stabilizers or conventional psychotherapy. For this reason, people with BPD are often perceived as being "untreatable". Moreover, the persistent erratic and self-destructive behaviors associated with BPD can be both frightening and profoundly discouraging. Families, friends, and even professionals may come to view the BPD sufferer as needy, manipulative, and recalcitrant.

Painting a brighter picture of BPD

Dr. Aguirre emphasizes that, while feelings of frustration and discouragement are understandable, it is essential to view individuals suffering from BPD with compassion and empathy. He understands that the patients he treats experience great inner turmoil, often rooted in fear of abandonment and disapproval, as they try to manage their lives in whatever ways that have worked for them, even if they are socially unacceptable and potentially harmful.

It is also important to realize that there *is* effective treatment for BPD. Dialectical Behavioral Therapy (DBT) is a therapeutic approach to BPD that was developed by Marsha Linehan, Ph.D., director of the Behavioral Research and Therapy Clinics at the University of Washington in Seattle. Recognizing that people with BPD suffer from emotional and behavioral dysregulation, Dr. Linehan developed an approach to therapy that specifically targets key characteristics that are common among BPD sufferers. These include: Emotional vulnerability, self-invalidation, unrelenting crisis, inhibited grieving, active passivity, and feigned confidence.

Since its introduction in 1993, DBT has been shown to effectively reduce suicidal and self-injurious behaviors, dropouts from treatment, psychiatric hospitalizations, substance abuse, anger, and interpersonal difficulties in people with BPD. These findings are scientifically supported by MRI studies showing that BPD sufferers who improved on DBT had less activity in the parts of their brains that are associated with high levels of arousal.

A Snapshot of DBT

Through a combination of regular individual sessions with a DBT-trained therapist, group skills training, and phone consultations, DBT helps people with BPD balance both the acceptance and change that is necessary for them to live a more normal, productive, and happy life.

During weekly individual therapy sessions, patients review behavioral issues that have come up for them since their last session, and prioritize them according to how concerning they are. Those that are most concerning (such as self harm and suicidality) are dealt with before moving on to behaviors that are of less concern. In addition to identifying and addressing these issues, the therapy deals with issues that impact quality of life, such as depression or substance abuse, with the goal of helping the patients improve the overall quality of their lives.

Patients with BPD also attend weekly group skills training sessions during which they learn four specific skills that will help them deal more effectively with their lives. They include:

- **Mindfulness** – The goal of mindfulness is to balance the "emotional mind" (the mental state that is controlled by current emotions), with the "reasonable mind" (the mental state that is governed, sometimes excessively, by rationalization and logic) to achieve a "wise mind" that integrates the two states in a balanced way.
- **Interpersonal effectiveness** – This focuses on the development of effective social skills, such as assertiveness and dealing with interpersonal conflict that will help patients achieve specific goals in a way that neither disrespects the other person or the patients.

Moody, impulsive and self-destructive, teens with BPD often jump from one crisis to another.

•**Distress tolerance** – Patients with BPD tend to experience profoundly painful reactions to life's circumstances. Distress tolerance skills help them learn to deal with life's stressors effectively through acceptance of themselves and their current circumstances.

•**Emotional regulation** – To help BPD patients deal with intense and fluctuating emotions, emotional regulation skills teach them how to identify and manage their emotions rather than become overwhelmed by them.

As-needed phone consultations with their therapists are another important part of DBT. The point is to help patients deal with real-life issues effectively, as they arise, rather than resorting to maladaptive or destructive behaviors. Patients are encouraged to call when they need help using their DBT skills during a crisis or conflict. Moreover, therapists "contract" with their patients that they call *prior* to engaging in self-injurious or suicidal behavior.

Finally, because BPD affects not only the patient but family members as well, family involvement in DBT is strongly encouraged. In adolescents, parents need to learn how to change old patterns of response to their children that precipitate or reinforce maladaptive behaviors. Thus, it is recommended that parents participate in intake sessions with their child and meet regularly with their child's treatment team. Participation in DBT support groups and group DBT sessions can also be very helpful.

Under the direction of Dr. Aguirre, McLean Hospital, located in Belmont, MA, offers a 28-day residential program for females from age 13 to 20 in the 3East Residential Unit. The program provides round-the-clock care and an intensive DBT curriculum. A typical daily schedule consists of daily goals groups, DBT skills instruction, individual therapy, relational dilemmas groups, expressive therapy, DBT homework and tutoring time, along with group outings and trips to McLean's fitness center. A stay of at least 28 days is recommended; this allows staff to establish the most effective plan to help patients successfully achieve treatment goals and allows patients and their families to learn the DBT strategies and techniques that need to be assimilated into the patients' lives.

For patients who would benefit from a longer stay, there is a residential step-down program that helps patients integrate their DBT skills into their daily lives. Patients may either attend the Arlington School (an accredited high school located on the McLean campus) or the 3East day program, depending on their needs.

McLean also offers a day program for both females and males for those who live in the area or for those attending the step down residential program. Again, the focus is on DBT as it relates to emotional regulation, interpersonal effectiveness, and academic/vocational support.

All staff members associated with the 3East program are highly knowledgeable about BPD and trained in DBT. The prevailing attitude among staff is one of compassion, caring and pride in offering the specialized treatment patients need to live effectively with this challenging disorder.

McLean's Program for Adolescents with BPD

Where to Turn for Information and Help

Though BPD is not widely a recognized diagnosis in adolescents (see boxed inset for more information about diagnosing BPD in teens), evidence indicates that the signs and symptoms of BPD in adolescents are consistent with adult BPD. Thus, while there are not many sources that specifically address adolescent BPD, the following organizations, accessible on the Web, provide general information about BPD that can be useful:

The National Institute of Mental Health

http://www.nimh.nih.gov

The National Alliance on Mental Illness

http://www.nami.org.

The National Education Alliance for Borderline Personality Disorder

http://www.borderlinepersonalitydisor-

A Brief Bio of Blaise Aguirre, M.D.

Dr. Aguirre received his doctorate in Medicine at the University of Witwatersrand in Johannesburg, South Africa. In the U.S., he completed his General Psychiatry Residency at the Boston University School of Medicine and his Child Psychiatry Residency at Boston Medical Center. In 2000, after serving as a staff psychiatrist and consultant in a number of different area hospitals and clinics, Dr. Aguirre began working at McLean Hospital as a staff psychiatrist for their Transitional Care Unit, and as a consulting psychiatrist for the McLean-affiliated CNS Pathways Academy and Klarman Eating Disorders Center. In 2007, he pioneered and became medical director of the newly developed Adolescent Dialectal Behavioral Therapy Center at McLean Hospital. Since its opening, the unit has been a resounding success, with adolescent females coming from all over the world to obtain specialized treatment for BPD. He also wrote the first and only book on BPD in adolescents, which has received wide acclaim among consumer advocates, clinicians, and families.

Dr. Aguirre's interest in BPD was sparked by a friend he had known in the past with a psychiatric condition that seemed to defy diagnosis and resist treatment. Though he eventually lost touch with this friend, he never forgot about her suffering and difficulty in dealing with her condition, which he realized was BPD. He has always had great compassion for this difficult-to-treat population and has committed his career to helping adolescence with BPD achieve successful outcomes and improve their lives through the intensive, targeted treatment program offered at McLean Hospital.

Dr. Aguirre currently resides in Lexington, MA with his family.

The Debate Over Diagnosing BPD in Adolescents

Whether or not BPD can or should be diagnosed in children and adolescents has been a matter of great controversy within the psychiatric profession. Historically, there has been great reluctance to diagnose BPD in children and adolescents, in part because their personalities are still developing and in part because some of the characteristics of BPD are similar to those associated with a "typically" difficult adolescence. However, it is well recognized that symptoms of BPD often begin to occur during adolescence, and that its roots are planted in childhood. Moreover, although the DSM-IV diagnostic manual characterizes BPD as an "adult" condition, it also states*: "To diagnose a personality disorder in an individual under 18 years, the features must have been present for at least 1 year."*

As a psychiatrist who spent most of his career working with children and adolescents, Dr. Aguirre recognized that some of the more difficult patients he encountered in this age group seemed to have many of the characteristics of BPD. Furthermore, whereas these patients had not responded adequately to traditional treatments, they seemed to respond well to BPD-specific therapies, especially DBT. This convinced him of the importance of recognizing and correctly diagnosing BPD in adolescents. Since opening the adolescent borderline Disorder unit at McLean Hospital, Dr. Aguirre has witnessed innumerable cases in which adolescent patients have improved significantly after having been properly diagnosed and treated for BPD.

Despite ample evidence supporting the diagnosis and treatment of BPD in adolescents, the issue remains controversial among psychiatrists. Thus, many patients who might be helped by DBT are being misdiagnosed and are not getting the treatment they need. To help put the debate to rest, Dr. Aguirre and his associate Dr. Mary Zanirini (also a Lexington resident) are conducting a study at McLean Hospital that will help confirm the existence of BPD in adolescents, and distinguish those traits that characterize BPD from those of normal adolescence.