

BPD in Children and Adolescents

Following is an interview with Blaise Aguirre, MD., the medical director of the new Adolescent Dialectical Behavioral Therapy Center at McLean Hospital, Belmont, MA. He is a child and adolescent psychiatrist recognized for his work in the treatment of BPD. He is also the author of Borderline Personality Disorder in Adolescents (Fair Winds, 2007, Beverly, Mass.).

Randi Kreger: There is a great deal of conflicting information about whether or not children and teens can be diagnosed with BPD. What does the official Diagnostic Statistical Manual say? And what do you say?

Dr. Aguirre: The DSM *does* allow for a BPD diagnosis in childhood if the patient has had the symptoms for more than a year. Some clinicians tend to overlook this. I have seen children as young as 13 meet criteria for the diagnosis. Parents often identify BPD beginning at puberty, when some start acting out.

Many of the BPD kids on our unit at McLean are referred because they begin injuring themselves: cutting, burning, branding, and piercing. They do it to regulate their emotions, mostly anxiety and anger.

Some of the kids are referred because of ongoing thoughts of suicide or after they have made an attempt. I am sure that some of these children had difficulty regulating their emotions prior to age thirteen, however, I have not seen cutting before age 12.

Kreger: How does one go about diagnosing a child? Are there any tests?

Dr. Aguirre: Right now, the diagnosis is made using the DSM, although increasingly clinicians look for a series of problems in these areas: dealing with emotions--especially anger—having chaotic relationships, being confused about their identity and values, practicing self-harm, being overly impulsive, feeling empty, and presenting with cognitive impairments such as irrational beliefs, paranoia, and dissociation. Using these criteria, I don't

know of any other childhood conditions other than BPD where they are all affected.

Also, we know that in some cases BPD runs in families and we plan to include genetic testing in our future research. We also want to study the question as to which criteria best help in making the diagnosis of BPD in adolescents. We eventually hope to develop a standardized interview that will help clinicians distinguish BPD from normal adolescent behavior. In the future we also hope to see whether advanced imaging techniques can help identify brain differences in these children.

Kreger: How should parents work with clinicians to obtain a diagnosis?

Dr. Aguirre: As with any specific diagnosis, the more a clinician is familiar with the symptoms, the more likely they are to recognize the condition. Because kids can't drive or might not be sexually active, I include other impulsive and disruptive behavior such as skipping school, so called "hooking up," and sneaking out at night.

Adolescents who have had more than a year of symptoms often come to us with chronic thoughts of suicide; marked self-loathing; self-injury; relationships characterized with overidealization/devaluation; and stark black and white, all-or-nothing type thinking.

Their abandonment fears are profound. Many recognize that they test their partners to no end to get them to prove that their partner loves them, which they know can be very destructive to their relationships

Kreger: How do you tell the difference between BPD and other disorders?

Dr. Aguirre: There is a lot of comorbidity [overlap] between BPD and other childhood disorders. The main differences are the degree of self-destructive behavior, the degree of self-loathing, and the unremitting thoughts of suicide.

Self-loathing is pretty unique to BPD; self-injury is very rare in Oppositional Defiant Disorder or Conduct Disorder, although it may be seen in Clinical

Depression. The impulsivity in Attention Deficit Hyperactivity Disorder is sometimes similar to the impulsivity in BPD.

Although adolescents with BPD can be aggressive, this is not a common presenting symptom to our unit. Often when the BP adolescent is aggressive, they feel ashamed or remorseful after the event. The child with Conduct Disorder generally does not care at all (or at least does not appear to care) if they have hurt someone.

Kreger: Is there anything parents can do for children at risk? For example, increasing validation? [empathizing with the child's feelings without agreeing that their facts are correct]

Dr. Aguirre: Validation is clearly important. The best early intervention is predictable and consistent caregiving. Caregivers need to be aware of how the environment may be invalidating.

For example, there might be a mismatch between how the caregiver sees the world and how their child sees the world. The most important thing is to close this gap. A way to reduce the gap is not to blame either parent or child, but to recognize the problem and work with a family therapist who is familiar with BPD dynamics.

Kreger: What resources can parents find locally for help? How do they find a psychiatrist who believes that their child isn't just a "bad kid" or going through a phase?"

Dr. Aguirre: This is a particularly hard question. Unless they are experts at working with this group, many therapists and psychiatrists don't like working with individuals with this diagnosis because it means years of treatment and a lot of frustration.

We often have the problem of not having adequate resources in the kid's local community upon discharge from our unit. I think the diagnosis will become more accepted, especially with the amount of self-injury taking place, and more and more clinics will offer services that treat self-destructive adolescents.

Parents need to tell clinicians they're evaluating that they have read up on BPD, and that the diagnosis as described most closely fits their child's behavior.

Kreger: How should parents respond to the implicit or explicit accusations that they must have been abusive?

In many of the cases we see, there is no evidence that parents have been abusive. Mostly, parents have tried the best they could. However in some cases, there has been clear sexual and physical abuse.

We work from a "no blame" perspective, believing that a child and their family have gotten to where they are because of their past and their biology. Dwelling on the past has not been shown to help treat BPD. We work on current symptoms. The major difference is if the patient has Post Traumatic Stress Disorder, then the trauma work must also be addressed.

Kreger: How are medications handled?

Dr. Aguirre: Many kids referred to us have been hospitalized many times. Often, at each of these hospitalizations the treating psychiatrist is presented with a single part of the whole picture: we call this the "admitting symptom." For example, the patient is "depressed," "manic," "anxious," or "psychotic."

For each of these symptoms, past psychiatrists had added a medication. In subsequent hospitalizations, medications have seldom been removed, so we see kids on all the meds from previous hospitalizations.

Often, our approach is to be clear as to the clinical criteria that make the diagnosis of depression or psychosis. And then if there is no clear sense that these diagnoses are correct, we gradually remove the medication. Often, the problem behavior began after a relational conflict, and unfortunately there is no medication that heals broken relationships.