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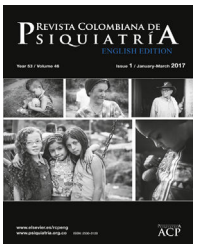

Case Report

Behavioural disorder or borderline personality disorder? The importance of early intervention☆

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ABSTRACT

Diagnosing borderline personality disorder during adolescence is usually controversial. In this paper we present a clinical case in which an outline of the main characteristics of borderline personality disorder during adolescence is summarised. The need of taking into consideration the precursor characteristics of borderline personality disorder in young people is also highlighted. At the same time, other significant behavioural disorders found in young people are emphasized as possible forerunners of a borderline personality disorder diagnosis. Finally, we insist upon the need to implement early intervention programmes for these patients based on current models.

¿Trastorno de conducta o trastorno de personalidad límite? La importancia de la intervención precoz

Palabras clave:
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RESUMEN

El diagnóstico de trastorno de personalidad límite en la adolescencia suele ser un tema controvertido. A continuación se presenta un caso clínico que expone las características habituales de presentación en la adolescencia y se discute además la necesidad de tener en cuenta los factores precursores del trastorno de personalidad límite a la vez que se relaciona la presencia de determinados trastornos de conducta como futuros precursores. Se insiste

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en la necesidad de usar programas de intervención precoz para este tipo de pacientes con los modelos que existen actualmente.

Introduction

The diagnosis of borderline personality disorder in adolescence remains a controversial topic among mental health professionals. In a notable editorial published in May 2016 in the *American Journal of Psychiatry*, John Gunderson commented on the need to develop a care model in the public system for patients with borderline personality disorders. Gunderson began his article with an account of 17-year-old Kevin, who had suffered for years from behavioural disorders associated with a break-up, and reported a wholly characteristic case of borderline personality disorder.[1] However, although authors such as Joel Paris[2] insist on the need to consider the diagnosis in adolescence, in reality, as some studies have suggested, there is a trend towards underdiagnosis.[3] This finding is significant, and a parallel may be drawn between the story of Cinderella, who lost her dress and her carriage when the clock struck 12, and cases of adolescents with a diagnosis of behavioural disorders who have to be diagnosed with another disorder once they reach their 18th birthday. The problem is that, although such diagnoses have weak specificity per se, one might wonder what became of the kappa coefficient[4] in matters of diagnostic reliability in adolescents with psychiatric diseases.

The following is a case report with a typical clinical course of a patient with borderline personality disorder of adolescent onset with multiple prior diagnoses.

In the drafting of this case report, every effort was made to conceal and safeguard the patient's identity. Some elements of the patient's family and personal history were modified without altering the most important aspects of the clinical description, discussion and conclusions proposed.

Case report

A 16-year-old girl living at a centre for minors with behaviour disorders was admitted to the short stay unit after swallowing several razor blades. She had been diagnosed with oppositional defiant disorder[5] at 12 years of age and had been in follow-up by psychology and psychiatry at the centre for minors, to which she had been admitted 10 months earlier.

Notable in the chain of adverse and, in some cases, traumatic events constituting her biographical history was her adoption at 6 years of age along with 2 of her sisters from a home after their biological mother abandoned them when the girl was 2 years old. No father figure information is available. There are no data referring to difficulties in childbirth or any other significant information relating to the first few years of her life. When she was 6 years old, they moved to live with their adoptive family, and, from the start, she showed difficulties in maintaining relationships with her peers and trouble bonding. The girl's adoptive mother reported that the girl had a persistent inability to initiate most social relationships, and that she was incapable of calming the girl whenever she had any type of anxiety. The adoptive mother also reported frequent tantrums and trouble with making friends and playing with other children her age, all accompanied by an excessive tendency to call attention to herself. The data provided were suggestive of disinhibited social engagement disorder.[6] When the girl became an adolescent, coinciding with the separation of her adoptive parents, she had her first serious behaviour problems. First, she ran away from home, became more irritable and oppositional with her family members, exhibited consistent problems at the institution consisting of running away and engaging in sexual promiscuity, and started to make small cuts in her arms. Due to these problems, she started follow-up on a leading mental health unit, where she was first seen at 12 years of age.

Throughout the next year, her behaviour problems increased. She ran away more often and developed relationships with antisocial groups. With increasing frequency, she cut her arms, and also her legs, and she reported chronic feelings of emptiness and a great deal of difficulty in expressing her emotional states. This whole time, her diagnosis of oppositional defiant disorder remained unchanged.[5]

Save for an occasional supermarket theft, there were no data indicative of an antisocial disorder, and at all times her emotional state was predominantly unstable.

A year after these problems began, she was admitted for the first time to the short stay unit. By then, she was 13 years of age. She was admitted for multiple cuts on her arms, marked depressive symptoms and a clinical picture of psychomotor agitation in a context of family conflict.

As it was impossible for her parents to manage her behaviour, the minor protection system took over her care and placed her at a centre where her behaviour could be better managed. In her first year of admission, despite improvement in her depressive symptoms, her tendency to cut herself persisted, because, as she verbalised, the cuts made her feel better. She had persistent problems in relating to her peers, swinging quickly from forming close relationships with particular people to getting angry with them and wanting no further contact with them. Sometimes, after problems arose in her relationships, she had a tendency to pull out her hair, and on one occasion she ended up swallowing a stone, in a manifestation of her chronic attention-seeking behaviour, and visiting the emergency department.

In the following year, although a certain amount of improvement was achieved at the centre where she resided, she had persistent marked emotional instability, showed

problems with impulse control, sporadically cut her arms and once ran away from the centre for 2 or 3 days, during which she consumed cannabis and alcohol. Ultimately, in the past year, her behaviour problems worsened due to problems with family reunification, and she ingested 3 razor blades following a conflict with her adoptive mother, for which reason she ended up being admitted to the short stay unit.

Her family dynamics were always characterised by significant emotional invalidation and a great deal of conflict between the separated parents, although her sisters continued to live in that setting with those dynamics and only had mild behaviour problems. As of her admission, she exhibited marked emotional instability; she ended up swallowing a bottle cap, requiring not only gastroscopy but also close monitoring. She showed notable difficulty with recognising and expressing her emotions, as well as difficulty with relationships and marked impulsivity. She expressed chronic feelings of emptiness, which she sought to allay by cutting herself.

Given the girl's signs and symptoms, a diagnosis of borderline personality disorder was suggested, despite her age. The seriousness of her signs and symptoms and the longitudinal course of her pathological behaviours and affective instability confirmed the diagnosis of borderline personality disorder. Nevertheless, several personality tests were done to refine the clinical approach and psychological and diagnostic assessment. Notable among them is the Spanish version of Borderline Symptom List 23 (BSL-23).[7] In addition, the patient's social cognition was assessed using the *Ḿovie for the Assessment of Social Cognition*(*Ḿ*ASC),[8] which confirmed her tendency towards hypermentalising responses.[9] This was highly consistent with studies linking social cognition abnormalities to borderline personality disorder.

Review of the subject

Despite the recommendations of some authors,[2] there are very significant difficulties with making a diagnosis of borderline personality disorder in adolescents. The data indicate that adversities in childhood, both in school and at home, especially in a predominantly invalidating environment, are risk factors for borderline personality disorder.[10] There are few follow-up studies of residents of centres for minors, but the results on personality are very conclusive.[11]

Various studies have also indicated that affective dysfunction, hostility and interpersonal conflict in oppositional defiant disorder and impulsivity in attention-deficit/hyperactivity disorder may point to early development of borderline personality disorder.[12] Other studies have also referenced an inability to form a secure bond with a caregiver.[13] Reports of physical abuse and sexual abuse and derivative abnormalities in recognising emotions[14] as well as social cognition abnormalities may be other precursors to borderline personality disorder.[15] To conclude, other studies have cited a wide range of psychiatric disorders in family members of patients with borderline personality disorder,[16] especially in mothers already diagnosed with borderline personality disorder, and the need for intervention for this patient profile.[17]

Discussion of the subject and conclusions

Attachment problems from an early age, along with problems with identity formation in adolescence, marked by serious problems with social cognition, promoted the onset of borderline personality disorder; an invalidating family environment also acted as a catalyst.

Currently, it is known that diagnosis of borderline personality disorder in adolescence is reliable and valid,[18] as in adults, with similar incidence rates between these two population groups.[19] We find it necessary to pursue early intervention strategies in this type of patient, using some of the models that have provided evidence in this age group.[20] The need for early intervention is based on the major comorbidity and mortality[21] associated with a diagnosis of borderline personality disorder and on the significant deterioration of social functioning and quality of life in children and adolescents with this diagnosis, comparable to that seen in those with other serious mental disorders.[22] It is also known that certain personality traits are more flexible and mouldable in adolescence, rendering early intervention more appropriate.[23] The disadvantages of early intervention include the stigma[24] that the diagnosis carries at such an early age and self-stigmatisation[25] by patients. However, an incorrect diagnosis not only impedes suitable treatment but also could promote polypharmacy.[21]

The approach to abilities in dialectical behaviour therapy[26] for reducing self-destructive behaviours and the use of therapy techniques based on mentalisation[27] are two approaches from which our patient might have benefited. The approach to identity diffusion in transference-focused psychotherapy is also not to be overlooked.[28]

We believe it is necessary to conduct a suitable study of precursors to borderline personality disorder in situations in which it could be clearly evaluated whether behaviour problems are the starting point for a personality disorder, especially in adolescence, and identity could be seen to be particularly damaged.

Harking back to the Cinderella parallel in the introduction, we would rather precious time for intervention not have been squandered once the clock strikes midnight.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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