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Borderline Behavior in Adolescence: An Adjective in Search of a Treatment

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In 1985, Akiskal et al.¹ described borderline personality disorder (BPD) as “an adjective in search of a noun.” They proposed that BPD, once thought to be a prodromal form of schizophrenia, is an indistinct psychopathologic syndrome that has more in common with major affective disorders than with psychoses. Gunderson et al.² challenged this position, arguing that the patterns of cooccurrence of BPD and mood disorders are inconsistent and the illness courses dissimilar. Partly as a result of these debates, we have learned a great deal about BPD in the past two decades. Currently, there is broad agreement that BPD is frequently comorbid with Axis I disorders, in particular depression, bipolar disorder, substance abuse, and posttraumatic stress disorder; often associated with childhood physical and sexual abuse; associated with severe and persistent psychosocial impairment and a high risk for self-harm over time; and one of the most difficult disorders to treat, despite the considerable progress that has been made with manual-based psychotherapies such as dialectical behavior therapy and transference-focused psychotherapy.

More recently, BPD traits have been described in adolescents, although the continuity between adolescent and adult BPD has not been adequately investigated. The two articles in this issue of the *Journal* represent the first large-scale randomized trials of psychosocial treatment for BPD in youth, using methods drawn from psychodynamic psychotherapy (mentalization) and dialectical behavior therapy or cognitive-behavioral therapy (Emotion Regulation Training [ERT]).

Rossouw and Fonagy³ compared mentalization-based treatment for adolescents (MBT-A) with treatment as usual (TAU) for 80 participants (mean age = 14.7 years, 85% female) who had intentionally harmed themselves within the prior month. The participants did not have to meet *DSM-IV* criteria for BPD, although 73% did. Virtually all (97%) had significant depressive symptoms at entry. The MBT-A consisted of weekly individual sessions for 1 year, with monthly family therapy sessions interspersed; the average number of sessions was 20.

Mentalization refers to the ability to understand and predict thoughts and feelings in oneself and others. Deficits in mentalization ability are believed to be associated with failures in early attachment.³ In adolescents vulnerable to BPD, significant stress leads to increases in emotional arousal, which further affects the youth’s ability to make sense of interpersonal events. The result is an increase in self-defeating thoughts, leading to more significant depression, social withdrawal, and an urgent desire to escape. Self-harming behavior becomes a solution with a dual purpose: to distract oneself from pain and to reconnect with the outside world. MBT-A includes education on the link between mentalization and self-

harm and the development of a behavioral crisis plan for the youth and family members. Otherwise, the treatment is psychodynamically inclined, with exploratory individual sessions to help the adolescent understand the kinds of social experiences and resulting mental states that contribute to self-harm.

The authors found that MBT-A was more effective than TAU (sessions of psychosocial support) in decreasing self-harm and depression. Notably, only 33% of the participants in MBT-A continued to meet the full BPD criteria at 12 months; in comparison, 58% of those in TAU maintained their diagnosis at 12 months. The effects of treatment on self-harm were mediated by an increased ability to mentalize and a decrease in attachment avoidance.

This study is important for a number of reasons. First, it foreshadows a growing trend to pitch pediatric treatments toward specific problem areas (e.g., self-injurious behavior, aggression, mood instability) instead of *DSM-IV* diagnoses. The greater focus on dimensional behavior as a means of defining clinical groups may help expand treatments to larger populations of youth who have clinically significant symptoms but are on the “border of borderline.” Second, it suggests that a risk factor for self-harm—the inability to mentalize—can be measured in youth and a specific treatment applied to improve it. In the future, we may be able to intervene early with youth who are identified as vulnerable to self-harm based on their level of mood lability and difficulty in labeling emotions in themselves or others.

Two additional issues warrant consideration. First, as the authors aptly point out, depression is a key risk factor for self-harm. To what extent do treatments such as MBT-A operate through changing depressed mood and cognitions as opposed to altering the internal self-regulatory processes believed to be central to BPD? The strong association between self-harm and depression with future suicidal behavior suggests the importance of stabilizing current mood as a means of preventing suicide, an objective that is at once obvious but frequently forgotten in practice. Second, adolescents in MBT-A were almost twice as likely (63% versus 33%) to receive family-based sessions than those in TAU. Indeed, recent studies have found that family intervention can be effective in treating depression and bipolar disorder in adolescents.^{4,5} Individual or group models of treatment may be strengthened by adding occasional (e.g., once per month as in the present study) sessions of family psychoeducation to increase the use of mentalization or other emotion-regulation strategies.

The multisite study of ERT in the Netherlands examined a group treatment that included sessions of cognitive restructuring, mindfulness, psychoeducation, and social skills training.⁶ The study was conducted at four mental health centers and involved 109 adolescents with BPD (73%) or subthreshold BPD (27%), most of whom (62.4%) were also depressed. Participants were randomly assigned to ERT groups (19 2-hour sessions over 6 months, with an average attendance of 12.1 sessions) or TAU. Although no outcome differences between the ERT and TAU groups were observed, there is much clinically useful information to be derived from this study. First among these is the low rate of remission in the sample: decreases in symptoms and an improvement in quality of life were found between the two treatment conditions, but only 19% of the ERT group and 12% of the TAU group were fully remitted from their borderline PD symptoms by 6 months.

It is likely that there are subgroups of adolescents with BPD traits who do not have full symptom remissions. In the study by Schuppert et al.,⁶ poor prognostic indicators included higher levels of depression at baseline, more symptoms of attention-deficit/hyperactivity disorder, and a history of physical or sexual abuse (present in 55% of the sample). Once again, we see the powerful impact of depression on the course of BPD. Few of the subjects

(about 30%) were taking medications at baseline, and one wonders whether initiating pharmacologic treatment to gain control over depression, attention-deficit/hyperactivity disorder, or anxiety symptoms before initiating the skill-training groups might have improved the degree of response in ERT.

The discrepancy in findings between these two large and well-designed trials is somewhat puzzling. The two studies contained similar proportions of adolescents with established BPD diagnoses, comorbid depression, and substance misuse. Possible explanations for the differential efficacy of MBT-A may include, but are not limited to, the group format of ERT, which may not be optimal for teens with severe depression and borderline traits; the greater availability of family sessions in MBT-A; the longer duration and greater frequency of MBT-A (an average of 20 sessions in 1 year versus 12 in 6 months); and differences in the intensity, content, or monitoring of the TAU protocols.

The two studies are innovative in testing manual-based interventions for adolescents with a range of problem behaviors that, in a prior era, might have been deemed untreatable or written off as time-limited teenage angst. When we begin to consider the implementation of these treatments in community settings, we need to acknowledge our uncertainty in how to recognize borderline symptoms in adolescents, whether these symptoms are different from those in mood disorders, and the lack of data on the continuity of the diagnosis into adulthood. Nonetheless, these investigators have identified clear targets for treatment, along with reliable means of assessing change mechanisms and clinical progress. These features increase the likelihood that community therapists will incorporate these novel interventions in diverse settings that serve youth at risk for self-harm.

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