Borderline Personality Disorder in Adolescents: Ubiquitous or Specific?


The authors sought to identify diagnostic criteria that are relatively specific to borderline personality disorder in severely ill adolescent inpatients and that may predict a stable borderline personality disorder during this turbulent time. Twenty-one adolescent inpatients with borderline personality disorder were contacted 2 years after the index hospitalization (baseline). Seven of these patients met criteria for borderline personality disorder at follow-up. The ability of baseline criteria for borderline personality to predict the diagnosis of borderline personality disorder at follow-up was determined. Criteria for borderline personality disorder were sensitive for the stable disorder but not very specific. Without follow-up data, the diagnostic significance of symptoms of borderline personality disorder in adolescents appears uncertain.

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A number of empirical studies have sought discriminating diagnostic features for borderline personality disorder in adult populations (1). Despite evidence supporting that borderline personality disorder can be meaningfully diagnosed in adolescence (2), the diagnostic efficiency of DSM-III-R criteria for borderline personality disorder in adolescents has not been explored. The fact that, as Masterson (3) has noted, inconstancy and turbulence can be characteristic of adolescence tempers the degree of confidence afforded a diagnosis of borderline personality disorder in a young patient. Given the considerable fluidity in adolescent disorders and in adolescence itself, can the clinician derive diagnostic and prognostic significance from the presence of particular symptoms of borderline personality disorder for adolescents with this disorder?

To address this issue, we considered three questions. First, are there diagnostic criteria that are relatively specific to stable borderline personality disorder in adolescent inpatients with substantial comorbidity of behavioral and affective disorders? Second, do any of the diagnostic criteria predict a stable diagnosis of borderline personality disorder at 2-year follow-up? Third, for patients with borderline personality disorder at baseline and at follow-up, how stable is each symptom?

METHOD

The study group consisted of 21 adolescent inpatients with borderline personality disorder (11 females and 10 males) at the Yale Psychiatric Institute. These patients were part of a larger study of outcome in severely ill adolescents. The patients were contacted for in-person follow-up 2 years following discharge. At the time of their index hospitalizations, the patients ranged in age from 15 to 19; their mean age was 17 years. Symptoms were assessed at baseline by using the Personality Disorder Examination (4), which was repeated at follow-up by raters who were blind to baseline diagnosis. Diagnoses were statistically derived on the basis of whether patients met five or more of the eight DSM-III-R criteria for borderline personality disorder. Weighted kappas, computed to determine interrater reliability for a diagnosis of borderline personality disorder, were determined by independent ratings of 26 patients at baseline and 20 patients at follow-up. Kappa values were 0.84 at baseline and 0.80 at follow-up.

Baseline axis I diagnoses were determined by using the Schedule for Affective Disorder and Schizophrenia for School-Age Children—Epidemiologic Version (5) for patients under the age of 18 or the Structured Clinical Interview for DSM-III-R—Patient Version (6) for patients 18 and older. Axis I comorbidity was high: 18 (86%) of the 21 patients had a concurrent baseline diagnosis of major depression, and nine (43%) had a diagnosis of dysthymia. Conduct disorder was diagnosed in 11 (52%) of the patients.

RESULTS

Seven of the 21 subjects were diagnostically stable: they met criteria for borderline personality disorder at baseline and at follow-up.

Four sets of conditional probabilities were calculated for seven of the eight DSM-III-R diagnostic criteria for borderline personality disorder and are presented in table 1. The eighth criterion, frantic efforts to avoid abandonment, was not assessed in an earlier version of the

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<table>
<thead>
<tr>
<th>Symptom</th>
<th>Positive Predictive Power (%)</th>
<th>Negative Predictive Power (%)</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>Number of True Positives</th>
<th>Number of False Positives</th>
<th>Number of True Negatives</th>
<th>Number of False Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstable relationships</td>
<td>20</td>
<td>60</td>
<td>33</td>
<td>43</td>
<td>2</td>
<td>8</td>
<td>6</td>
<td>4</td>
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<tr>
<td>Impulsiveness</td>
<td>28</td>
<td>33</td>
<td>71</td>
<td>7</td>
<td>5</td>
<td>13</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Affective instability</td>
<td>32</td>
<td>50</td>
<td>86</td>
<td>7</td>
<td>6</td>
<td>13</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Inappropriate, intense anger</td>
<td>35</td>
<td>100</td>
<td>100</td>
<td>7</td>
<td>7</td>
<td>13</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Suicidal threats or gestures</td>
<td>33</td>
<td>100</td>
<td>100</td>
<td>14</td>
<td>6</td>
<td>12</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Identity disturbance</td>
<td>47</td>
<td>100</td>
<td>100</td>
<td>43</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Emptiness or boredom</td>
<td>35</td>
<td>100</td>
<td>100</td>
<td>7</td>
<td>7</td>
<td>13</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

*Symptom present at baseline; diagnosis present at follow-up.
*Symptom absent at baseline; diagnosis absent at follow-up.

Personality Disorder Examination, resulting in missing ratings for 13 of the 21 subjects; the analyses were therefore not performed for this criterion.

Positive predictive power is the conditional probability of receiving a diagnosis of borderline personality disorder at follow-up given the presence of the symptom at baseline. Negative predictive power is the conditional probability of not receiving the diagnosis at follow-up given the absence of the symptom at baseline. Sensitivity indicates the probability that, given the presence of a diagnosis of borderline personality disorder at follow-up, the symptom was present at baseline. Specificity indicates the probability that, given the absence of a diagnosis of borderline personality disorder at follow-up, the symptom was absent at baseline.

Sensitivities (percent of patients with borderline personality disorder at follow-up who met the criterion at baseline) were high (mean=84%), but specificities (percent of subjects with criterion at baseline uniquely associated with borderline personality disorder diagnosis at follow-up) were low (average=18%).

For the subgroup of seven patients who were diagnosed with borderline personality disorder at both baseline and at follow-up, the stability of each symptom was assessed by determining whether the symptom was either present or absent at both points in time. The most stable symptoms in this stable subgroup were emptiness or boredom (100% agreement) and inappropriate, intense anger (86% agreement), followed by affective instability (71% agreement), identity disturbance (71% agreement), and suicidal behaviors (67% agreement). The least stable were unstable, intense relationships (50% agreement) and impulsiveness (57% agreement).

DISCUSSION

There was minimal diagnostic efficiency of symptoms over time in this study group. Prospectively, the presence of any particular symptom provided a poor index of whether the diagnosis would be stable over a 2-year period. (This conclusion cannot be extended to the abandonment criterion, for which diagnostic efficiencies could not be calculated.) The absence of four symptoms—inappropriate, intense anger; suicidal behaviors; identity disturbance; and emptiness or boredom—accurately predicted that a patient would not have the diagnosis at follow-up. The significance of this finding is uncertain because of the small number of subjects, but it may be a fruitful consideration for future investigations.

Borderline personality disorder was stable over the 2-year follow-up period for only 33% of the study group. There have been few studies that offer data for comparison. Links et al. (7) found that 60% of adult inpatients diagnosed with borderline personality disorder had a stable diagnosis after 2 years. In a community-based sample of adolescents, however, Bernstein et al. (8) found generally low rates of persistence of personality disorder diagnoses over 2 years. For moderate and severe borderline personality disorder, persistence rates were 29% and 24%, respectively.

Even for the stable patients with borderline personality disorder in the present study, there was considerable fluidity of symptoms in the syndrome. Chronic feelings of emptiness or boredom and inappropriate, intense anger were the most stable symptoms in this group.

Criteria for borderline personality disorder generally were sensitive for the stable disorder in this group of behaviorally and affectively disturbed adolescent inpatients with borderline personality disorder. Specificity, however, was low. Identity disturbance and unstable relationships, which appeared to be the most specific criteria, may alert clinicians more than other criteria for borderline personality disorder to the presence of stable borderline personality disorder in severely disturbed adolescents.

Overall, however, without follow-up data the diagnostic significance of symptoms of borderline personality disorder in adolescents is uncertain. As Masterson (3) urged, trends in nosology have moved away from such relatively nonspecific diagnoses as adjustment reaction of adolescence toward the application of greater specificity in diagnostic descriptions. Our data suggest that for acutely ill adolescents, less specific diagnostic constructs may have greater temporal validity. Patterns
of symptoms and behaviors precipitating an inpatient admission may transiently resemble borderline personality disorder without signaling the presence of an enduring syndrome. For such patients, diagnoses of identity disorder along with depression or conduct disorder when warranted may best capture what is clinically salient, both currently and prognostically.

REFERENCES