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Diagnosis of Borderline Personality Disorder in Adolescence: Issues and Practice

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By

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MSW Clinical Research Paper

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this research was to discover what drives the diagnostic practices of clinicians working with adolescents with a possible Borderline Personality Disorder. The DSM-V allows this diagnosis in adolescents but it is rarely utilized by practitioners for this age group. A qualitative research method was used for the project, in which, participants were interviewed in-person to collect data. There were nine total participants in the Twin Cities metro area, who were all qualified to render mental health diagnoses and worked with adolescents. The interviews focused on the participant's personal practices and experiences with regard to diagnosis of BPD in adolescent patients. Interviews were analyzed using content analysis and coded for accuracy. Emergent themes from the study included a reluctance to diagnose BPD in adolescents, Co-Occurring and Alternative diagnosis, and Risks/Benefits to the diagnosis in this age group. The findings of this study suggest an overall lack of a universal understanding of what Borderline Personality Disorder looks like in adolescence, lack of consistency on how clinicians respond when they encounter it in practice, and deviations from DSM-V guidelines and actual clinical practices.

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Introduction

It's not what you look at that matters, it's what you see (Thoreau, n.d).

Can two social work clinicians look at the same patient, presenting with the same issues and diagnose two separate disorders, or none at all? What drives diagnosing practice, is it based on personal preference or behavioral science? Borderline Personality Disorder (BPD) is a complicated diagnosis at any stage of development, but especially so during adolescence. Adolescence is a time of change and instability, due to this, many clinicians feel that personality is not fully developed yet and will refrain from making a BPD diagnosis at this stage. The Diagnostic Statistical Manual 5 (DSM-V) does allow for adolescent BPD, however, some clinicians do not use this diagnosis for young people.

Social work practitioners work with adolescents in a variety of community, school, clinical inpatient and outpatient settings, so it stands to reason that practitioners may encounter an adolescent with this disorder during their career. Each patient is different and has unique, individual. To be adequately equipped to meet those needs, clinicians must be knowledgeable in a variety of possible diagnoses. Social workers must be also able to examine their own feelings regarding whether diagnosis is appropriate, and if so, which one is most appropriate and weigh them against behavioral theory and evidence to determine the best course of action.

Borderline Personality Disorder

The term 'borderline' was first used by Adolf Stern in 1938 (Shaw & Proctor, pg. 483, 2005). He used the term to describe patients that were more troubled than neurotic, but not psychotic:

> *Stern described a group of patients who 'fit frankly neither into the psychotic or neuropsychotic group' and introduced the term 'borderline' to describe what he observed because it 'bordered on other conditions' (NCBI Guidelines, 2009).*

Psychoanalyst Otto Kernberg coined the expression "borderline personality organization"

in 1975 as an alternative to describe patients who exhibit a:

> *stable, pathological personality organization; their personality organization is not a transitory state fluctuating between neurosis and psychosis (Kernberg, 1975).*

Kernberg went on to attempt to place division between Borderline Personality Organization and the neuroses that often define the disorder. Kernberg used "borderline" to explain the somewhat stable area between neurotic and psychotic personality organization, the middle ground, if you will. In this model, borderline is used to encompass any severe personality disorder. Borderline Personality Disorder was first added to the DSM in 1980 and has since become the most common personality disorder to be diagnosed (Shaw & Proctor, 2005).

Prevalence of Borderline Personality Disorder

Research shows that the prevalence of BPD among the general population is between 1-2% (Van Assel, Dirksen, Arntz, Severens, 2004; Coid, et al, 2009; Korzekwa, Dell, Links, et al ,2008). In the United States alone, this percentage means three to six million people could be suffering from this personality disorder. As troubling as this statistic is, the percentages are much higher among samples taken from a clinical population. According to Korzekwa, Dell, and Links, et al (2008), 22.6% of patients in an outpatient setting were found to have BPD. Research suggests that BPD symptoms begin to appear in late childhood or puberty but help is not usually sought until late adolescence (Newton-Hughes, Clark & Chanen, 2015; Zanarini, Frankenburg, Khera & Bleichmar, 2001).

Clinical Conflict on Early Diagnosis of Borderline Personality Disorder

There is conflict in the mental health community about whether BPD can or should be diagnosed in adolescence. Some mental health practitioners believe that personality is not fully formed in adolescence and so a diagnosis of a personality disorder is not appropriate at this stage of development (Bernstein, et al, 1993; Mattanah, et al, 1995; Laurensenn et al, 2013). Practitioners may also feel conflicted about saddling an adolescent with a lifelong diagnosis that

is poorly viewed in some medical circles and may be transient in nature (Kernberg, Weiner & Ardenstein, 1995; Laurensenn et al, 2013). On the other end of the spectrum, opposing viewpoints point to the fact that BPD is a high risk disorder with ten percent of sufferers dying by suicide, 75% self harming in some way and that earlier interventions lead to improved outcomes for persons with this disorder (Black, Blom, Pfole & Hale 2004; Oldham, 2006; Chanen, et al 2009; Sharp & Tackett, 2013). More research is needed in this area to provide more cohesion in the mental health field when it comes to diagnosing or not diagnosing BPD in adolescence and to discover why or why not some practitioners will use the diagnosis and why some refrain from it altogether.

Therefore, the purpose of this research will explore the factors clinicians consider whether or not to make the diagnosis of BPD in an adolescent patient and their personal practices. This research will present a review of current literature explaining the Borderline Personality Diagnosis, a discussion of temperament and personality, personality development, possible causes, diagnostic instruments to determine presence of the disorder and issues clinicians bear in mind when considering this diagnosis in adolescents. A discussion on the methods that will be used, the population that will be sampled, protection measures for that population, how the sample will be recruited, instrumentation that will be used to collect data, and how data will be analyzed. A research lenses chapter provides the theoretical, professional and personal lenses used in this project.

Literature Review

Before reviewing the literature some clarification of terms that will be used in the rest of the paper is in order. Personality is a unique set of characteristics that are individual to each person and their own patterns of thinking, feeling and behaving (APA, 2015). According to the DSM-V (2012), a personality disorder is "an enduring pattern of inner experience and behavior that deviates markedly from the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to stress or impairment." There are ten personality disorders listed in the DSM-V but for the purpose of this research only one, Borderline Personality Disorder (BPD), will be explored. According to the DSM-V (2012) Borderline Personality Disorder is characterized by "a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity." The DSM-V divides personality disorders into three clusters based on similar characteristics. Clusters A, B and C, borderline personality disorder is a Cluster B disorder. Cluster B disorders are defined by emotional and dramatic behavior (DSMV, 2012). However, it is noted that the cluster classification system has drawbacks and is not always validated (DSMV, 2012).

This chapter will explore the available literature on personality development, borderline personality disorder, models of diagnosis of borderline personality disorder and issues clinicians consider when making this diagnosis in an adolescent.

Personality Disorders and Development

At what age is personality fully developed? Can it change or adapt? Or once set, is there no change? The unique set of characteristics that are individual to each person and their own patterns of thinking, feeling and behaving called personality in adulthood but in childhood and adolescents these traits have historically been described as temperament (APA, 2015; De Pauw & Merviade, 2010). Temperament can be seen in children as early as birth and even in utero

(Rothbart, 2007). Babies to two to three months old show fear, anger and happiness reactions (Rothbart, 2007). Temperament was found to be an significant contributor to a decreased occurrence of behavioral issues (Rothbart, 2007).

Temperament and personality. A study comparing several temperament models of traits to personality models found many similarities between the structure of the traits that were being measured (De Pauw, Mervielde & Leeuwen, 2009). While this study focused on preschool aged children and acknowledged limited consistency for this age range, it proclaimed more reliability for steadiness of traits in school aged and adolescent children (De Pauw, Mervielde & Leeuwen, 2009). Opinions vary among researchers on which domains should be measured and are consistently predictive of future traits. Some researchers have advocated "joint factor analytic studies" for the purpose of integrating cohesion into the language of temperament vs. personality and the wide range of domains in children's temperament models (De Pauw, Mervielde & Leeuwen, 2009).

Personality development in adolescence. Adolescence is a time of change and transformation for all individuals. The World Health Organization defines it as a time of the most human growth and development, preceded only by infancy (WHO, 2015). It encompasses ages ten to nineteen and not only are biological changes happening, but also cognitive and social. It is a difficult period in any child's life, let alone one suffering from a personality disorder.

Theorists have long postulated that the development of ego is essential to personality development. According to Loevinger (1976), ego refers to "an organizing frame of reference that pulls together divergent experiences while simultaneously screening out discrepant information". The ego integrates all of the individual's experiences into a narrative that helps them to organize their sense of self and identity(Syed & Seiffge-Krenke, 2013). Formation of identity has also been theorized to be a crucial task of adolescence (Westen, Betan & Defife,

2011; Klimstra et al, 2010). Identity disturbance is one of the criteria for diagnosis of BPD but little is available on this topic in adolescents with this disorder (Westen, Betan & Defife, 2011; Klimstra et al, 2010).

Borderline Personality Disorder

The DSM-V has nine criteria for Borderline Personality Disorder, five of which must be present to diagnose the disorder. According to the DSM-V (2012), BPD is defined as "a pervasive pattern of instability in interpersonal relationships, self image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

*1. Frantic efforts to avoid real or imagined abandonment. (**Note**: Do not include suicidal or self mutilating behavior covered in Criterion 5.)*

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

*4. Impulsivity in at least two areas that are potentially self damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating. (**Note**: Do not include suicidal or self mutilating behavior covered in Criterion 5.)*

5. Recurrent suicidal behavior, gestures, or threats, or self mutilating behavior.

6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Inappropriate, intense feelings of anger or difficulty controlling anger. (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress related paranoid ideation or severe dissociative symptoms. (DSM-V, 2012)

The DSM-V goes on to state that individuals with this disorder are beside themselves to avoid abandonment, do not deal well with changes and can have huge alterations in personality when

one occurs or is perceived to be occurring. They have unbalanced and extreme relationships and may go from loving someone one day to hating them the next. Their self-image can fluctuate radically and cause them to make big, sudden changes in goals, jobs, opinions, friends, etc. These individuals are impulsive and possibly self destructive in at least two ways, recurrent suicidal behavior or attempts are common. Eight to ten percent of these individuals complete suicide. They may have extreme moods of dysphoria (depression), anxiety and irritability lasting from a few hours to a few days. They may have persistent emotions of feeling empty and frequently display inappropriate anger.

The nine criteria for diagnosis of BPD can be divided into four domains, or sectors of psychopathology, as patients who display symptoms in all these areas can be differentiated from people with other personality disorders (Lieb, et al, 2004). These four sectors are affective, cognitive, behavioral and interpersonal. Affective disturbance consists of "intense dysphoric feelings" with a range of anger, sadness, anxiety, loneliness and meaninglessness, can also be termed as experiencing "aversive tension" (Lieb, et al, 2004). They can alter these moods frequently and intensely, often going through several powerful states in a single day. Criteria numbers 6, 7 and 8 in the above paragraph fit into this category. Disturbed cognition is the second category in this model and it has three levels. The first concerns people who are experiencing worrying but non-psychotic symptoms, such as dissociation and non delusional paranoia. The second refers to people who are experiencing "quasi-psychotic" symptoms, which are delusions or hallucinations that may have some basis in reality but are passing in nature (Lieb, et al, 2004). The third is people who are experiencing actual psychosis with genuine delusions and hallucinations. Severe identity disturbance is regarded as being in the cognitive area because it is "based on a series of false beliefs" (Lieb, et al, 2004). Symptoms that fit into this sector are indicated by criteria numbers 3 and 9 in the above paragraph. The third domain

of behavioral disturbance has to do with people with BPD because of the impulsivity that is a hallmark of the disorder. Behavior that is intentionally bodily self harmful, such as suicide attempts or self mutilation, and more generally impetuous acts, such as substance abuse or binge eating. Symptoms that fit into this sector are indicated by criteria numbers 4 and 5 in the above paragraph. The final domain concerns interpersonal relationships, which are typically extreme and volatile, with fear of abandonment driving them to display desperate efforts in trying maintain closeness (frequent phone calls and physical clinginess) and very turbulent overall features to those relationships (frequent arguments and breakups) with a "reliance on maladaptive strategies that can both anger and frighten others - e.g. highly emotional or unpredictable responses" (Lieb, et al, 2004). Symptoms that fit into this sector are indicated by criteria numbers 1 and 2 in the above paragraph.

BPD often occurs in conjunction with other illnesses. One study found conducted on inpatient, adult BPD patients reported a ninety percent comorbidity rate with anxiety disorders and fifty six percent met the criteria for post-traumatic stress disorder (Zanarini, et al, 1998). There were differences among gender with other disorders but still significant rates of occurrence found. According to Zanarini, et al. (1998) fifty-nine percent of women and eighty-one percent of men met the criteria for a substance abuse disorder, ninety-seven percent of women and ninety-one percent of men met criteria for a mood disorder. This study indicates that conjunction with other Axis I disorders, can be a strong marker for clinicians considering a BPD diagnosis.

According to a study by Wetterborg, Langstrom, Andersson and Enebrink (2015), on adult males with BPD on parole or probation in Sweden also found some significant rates of comorbidity. Researchers used the Mclean Screening Instrument for Borderline Personality Disorder from DSM-V to conduct diagnostic interviews to determine if participants met criteria

for BPD and multiple other instruments to determine presence of other disorders. Out of twenty

seven participants, eleven met the criteria for BPD (Wetterborg, Langstrom, Andersson &

Enebrink, 2015). In order to account for possible gender bias in under diagnosis of males and

reduce risk of false positives, researchers implemented a lower cut off of five positive answers

vs. the seven positive normally used. Of these eleven, ninety percent met criteria for antisocial

personality disorder, eighty-one percent for major depression, seventy-two percent for

substance dependence disorder, seventy percent for attention deficit hyperactivity disorder, and

fifty-four percent for both agoraphobia and social anxiety disorder (Wetterborg, Langstrom,

Andersson & Enebrink, 2015, pp 63-70). These findings point to a high rate of comorbidity with

mental conditions, however, this study did have a low rate of participation and a small sample

size. In addition, recent changes in Swedish law have made it possible for more offenders to be

on probation or parole, instead of in jail, so this may limit generalizing across inmate

populations.

Causes of Borderline Personality Disorder

Opinions on the cause of Borderline Personality Disorder vary between biological (brain

structure) and environmental (traumatic early childhood experiences and dysfunctional

attachment to primary caregiver) or a combination of these factors as the root foundation

(Mosquera, Gonzalez & Leeds, 2014; Furnham & Dadabhoy, 2010; Skodol, et al., 2002).

Several studies have found a decreased frontal lobe volume in persons with BPD (Grant, et al,

2007; Rusch, et. al., 2007; Tebartz van Elst, et al, 2003; Lyoo, Han & Cho, 1998). The frontal

lobes of the human brain support "higher level cognitive processes, comprising executive skills

and working memory" (Stratton & Thompson, 2012). Executive functions include

"decision-making, planning, sustained attention, awareness and insight" (Stratton & Thompson,

2012). The orbitofrontal cortex, an area in the frontal lobes, is an important area in emotional

regulation and impulse control (Rusch, et. al., 2007). It is connected to other areas of the frontal

lobe by white matter circuits. An abnormality in these circuits is related to emotional

disturbances and impulsivity (Rusch, et. al., 2007). Multiple studies have found decreased white

matter volume in people with BPD (Grant, et al, 2007; Rusch, et. al., 2007; Tebartz van Elst, et

al, 2003; Lyoo, Han & Cho, 1998). Impulsivity and unstable emotion regulation are strong

indicators of BPD, leading to the conclusion that the decreased white matter in the frontal lobes

are has a strong association with BPD.

Early experiences have been thought to play a role in lifelong development by many

theorists, including Sigmund Freud (Schore, 2000). A ground breaking theory by John Bowlby

connected both the biological and early environmental experiences to the integration of a

person as a whole. The role of the infant's relationship with the mother, or primary caregiver, is

thought to be extremely vital in understanding how early experiences shape the overall

character of a person (Schore, 2000). Exploring attachment in theory in-depth is beyond the

scope of this research but some basic tenets will be described to help the reader understand the

perspective, as it relates to possible causal factors in BPD. Bowlby theorizes:

> *infants are active in seeking interaction, that the mother's maternal behavior is*
> *reciprocal to the infant's attachment behavior, and that the development of attachment is*
> *related to both the sensitivity of the mother in responding to her baby's cues and to the*
> *amount and nature of their interaction, he lays a groundwork that presents attachment*
> *dynamics as a "reciprocal exchange (Schore, 2000).*

The internal working model of a person is how they expect the world to behave and the

important people in their world to behave, even themselves. The child learns his internal

working model from his attachment to his mother and the relationship between the provides the

co-regulation of the child's internal states of emotion. Attachment has also been described as

"dyadic regulation of emotion" (Schore, 2000).

Maturation of the circuit wiring of the orbitofrontal cortex has been shown to begin to occur at ten to twelve months of age. This research paper has previously described how this area of the brain is central to inhibitory control and impulses, it also coordinates sensory information that allows people to respond to change in their environment as it occurs (Schore, 2000). The orbitofrontal cortex is also connected to the nervous system and "modulates instinctive behavior" (Schore, 2000). There is growing evidence that this area of the brain is specifically affected by the early childhood social experiences of a child (Schore, 2000). As attachment is essentially a regulatory theory, the child gains regulatory function from its interaction with its primary caregiver. When this is well harmonized, you have a child with a secure attachment. When it is frequently disrupted and desynchronized, the child can develop in insecure or avoidant attachment. The dysfunctional development of the neural pathways affects the ability of the child to control and regulate itself (Schore, 2000). These are central behavioral features of a person with BPD.

Diagnosis of Borderline Personality Disorder

Diagnosis is defined as the "the identification of the nature of an illness or other problem by examination of the symptoms" (Oxford University Press, 2015). In psychiatry, when attempting to classify a mental condition, the clinician takes into account many facets, biological, social, behavioral, emotional and historical of a person's life, in order to fully gain a clear understanding of that person's experiences (Alarcon, 2009). For the patient to receive the most suitable care and to have the best outcomes, it is important the appropriate diagnosis be rendered (Alarcon, 2009).

There are various methods of analysis available to clinicians when considering a personality disorder diagnosis. The DSM-V lists nine criteria to look for and also utilizes a screening tool to use in diagnostic interviews. The McLean Screening Instrument for Borderline

Personality Disorder is a ten item, yes or no, self-reported by patient screening scale

(Andre,Vesture & Lobbestael, 2015). It is based on DSM criteria and is one of the most

commonly used diagnostic methods. Each item is worth one point on a ten point scale and a

score of seven or above is indicative of BPD (Andre,Vesture & Lobbestael, 2015). This method

has been demonstrated to have good specificity and sensitivity.

The five factor model (FFM) of personality has also been a useful for many clinicians

when it comes to diagnosis of BPD. It is a set of five broad trait categories of Extraversion,

Agreeableness, Conscientiousness, Neuroticism and Openness to Experience. Neuroticism is

sometimes named by its polar opposite, Emotional Stability, and Openness to Experience is

sometimes named Intellect.

> *Extraverted individuals are sociable and assertive, rather than quiet and reserved. Agreeable individuals are cooperative and polite, rather than antagonistic and rude. Conscientious individuals are task centered and orderly, rather than distractible and disorganized. Neurotic individuals are prone to negative emotions, such as anxiety, depression and irritation, rather than being emotionally resilient. Finally, highly open individual have a broad rather than narrow range of interests, are sensitive rather than indifferent to art and beauty and prefer novelty to routine (Soto & Jackson, 2013).*

The original purpose of the FFM was to provide a comprehensive overview of major personality

traits and aspects (Trull, 2012). However, it came to be seen as having a use in

psychopathology as it represented maladaptive, extremes to personality that are characteristic

of personality disorders. This method has been found to have strong empirical evidence and

cross-cultural replicability and is a useful in assessing for personality disorders (Lyman &

Widiger, 2001).

Considerations in Diagnosing BPD in Adolescents

A recent study by Laurenssen, et al, (2013) found that fifty-seven percent of

psychologists believed BPD could be diagnosed in adolescence. The research also found

sixty-four percent those psychologists who worked with adolescents believed it could be

applied, as well. Of these psychologists, however, only eight percent reported that they do in fact diagnose BPD in adolescents, despite their belief of its existence. Most frequent self-reported explanations for not utilizing the diagnosis included adolescence being an unstable time and that personality disorders at this stage are passing, that the DSM-IV did not allow for diagnosis in adolescents, that the diagnosis is stigmatizing or a combination of all these reasons (Laurenssen, et al, 2013). These are very common themes found in the literature for mental practitioners hesitancy in diagnosis of the disorder in adolescents. Additional studies also point to the stigmatization of the disorder, questions about validity of the diagnosis at this age and lack of knowledge in diagnosing personality disorders as reasons clinicians refrain from making the diagnosis (Courtney-Seidler, Klein & Miller, 2013). There is also a dearth of available literature studies investigating clinician personal practices and the reasons behind those.

Unstable personality features in adolescence. It is beyond the scope of this research to go too far into the debate of what age personality is consistently formed age, beyond what is covered in the temperament vs. personality above section. However, it will provide a brief overview of some of the clinical concerns in this area.

Adolescence is considered by many theorists to be a time of change and conflict related to identity formation and traits that are seen from the age of three on are generally predictive of future behaviors (Westen & Change, 2000). This does not mean that personality is fully formed or absolute by adolescence but it does appear correct that adolescents do have stable personality traits (Westen & Change, 2000). There are many traits and non-personality disorder diagnoses that are predictive of future diagnosis of BPD and clinician could use these to validate a possible diagnosis.

It is a common belief among mental health practitioners that personality lacks consistency and permanence in adolescence and this makes diagnosis of a personality disorder

at this stage of development unreliable (Miller, Muehlencamp & Jacobsen, 2008). While it is a mistake to not consider developmental stage of the patient, when considering diagnosis, many studies have shown the development of personality disorders is evident before the age of eighteen (Crick, Murray-Close, & Woods, 2005; Miller, Muehlencamp & Jacobsen, 2008; Sharp & Romero, 2007). There is cause for some concern as research has shown some adolescents do not retain the diagnosis, but there are also adolescents who maintain the diagnosis (Miller, Muehlencamp & Jacobsen, 2008). A longitudinal study examining the consistency of borderline symptoms between adolescents and middle adulthood found borderline symptoms typically improved over time but those with higher levels of symptoms had more negative outcomes that remained stable as the research sample moved into their twenties and thirties (Winograd, Cohen & Chen, 2008). It appears clear that symptoms for diagnosis are evident in adolescence but clinicians are concerned about the permanency of those behaviors vs. transience.

Validity of borderline personality diagnosis in adolescence. One of the above reasons for hesitancy in administering this diagnosis in adolescents, was the belief the Diagnostic Statistical Manual does not allow for it. The diagnosis was originally developed for adults, which makes some practitioners skeptical of validity in adolescents (Shapiro, 1990). However, the latest version of the DSM-V does allow for its application in adolescents and the criteria has been previously discussed in the paper. Recent studies have focused on using adult criteria to study personality disorders in adolescents (Grilo, et al, 1998; Loranger, et al, 1987). With the exclusion of dependent and passive aggressive personality disorders, researchers found similar rates of occurrence between the adolescent and adult samples. An additional study found similar resemblance between adolescents and adults with a BPD diagnosis, especially in females (Bradley, Conkin & Westen, 2004).

According to Paris (2001), BPD can be diagnosed in adolescents and this is when symptoms first present. BPD also has an average of eighteen for first clinical presentation, with a standard deviation of six years, meaning the range is between twelve and twenty four years of age (Paris, 2001). Most patients are diagnosed after several years of symptoms, leading to the conclusion that onset is in adolescence. The majority patients also express start of symptoms of in puberty (Paris, 2001). From this information, it appears that a diagnosis of BPD in adolescence is both possible and valid.

Stigmatization of borderline personality disorder. An additional reason clinicians have stated for refusal to diagnose BPD in adolescence is the stigmatization that exists in clinical circles for this disorder (Courtney-Seidler, Klein & Miller, 2013; Laurenssen, et al, 2013). Various studies have found that mental health professionals may view this disorder to be associated with manipulation and continual crises in the patient. People with this disorder can be emotionally demanding and have been thought of as "difficult to manage, unlikely to arouse sympathy, annoying, and undeserving of resources" (Aviram, Brodsky & Stanley, 2006). Clinicians have described them as "treatment resistant, demanding and attention seeking" (Aviram, Brodsky & Stanley, 2006). One study found that a BPD diagnosis was enough to change the behavior of nurses working these clients (Gallop, Lancee & Garfinkel, 1989). These patients are viewed with less sympathy by staff and some of the issue may be that clinicians have difficulty separating nature of the pathology from the nature of the person (Aviram, Brodsky & Stanley, 2006). Instead of attributing some of the patient's symptoms to the illness, they see it as a difficulty within the patient. The flaws are attributed to being part of the person's character, instead of the nature of the illness.

Impacts of treatment. This stigma can cause patients to be hesitant in seeking out medical assistance and they feel the negative perception. Patients can feel the lack of empathy

from service providers and this makes them less likely to seek out treatment. Clinicians may

emotionally withdraw from the patient if they feel they are being manipulated and this distance

could damage the therapeutic relationship. This distance can be very harmful to people with

BPD as they have a large fear of rejection and are very sensitive to it (Aviram, Brodsky &

Stanley, 2006). Their fear of abandonment could also cause them to engage in self harm and as

this population has a high risk of suicide, this can also be very detrimental (Aviram, Brodsky &

Stanley, 2006). There is also such a strong negative connotation associated with a BPD

diagnosis that some clinicians will utilize only as a last resort, delaying proper treatment of this

disorder (Aviram, Brodsky & Stanley, 2006). Early diagnosis of this disorder leads to patients

receiving appropriate interventions earlier in the course of their lives. It can prevent some

behaviors from carrying over into later life and becoming permanent (Aviram, Brodsky &

Stanley, 2006).

Summary and Research Question

This literature has explored the BPD, personality disorders, temperament vs. personality,

methods of diagnosis and considerations clinicians have when deciding whether or not

diagnose this behavior in an adolescent. This has provided a basis for continued exploration of

the overall research questions: Why do clinicians who use or refrain from using this diagnosis

with adolescents do so?

Methodology

To investigate current practices of diagnosing BPD in adolescents and issues surrounding it, this study used a qualitative design to collect and interpret data. Qualitative data was collected through individual interviews with adolescent clinical treatment providers. A naturalist approach was used in this study as it utilized the qualitative tools of observation, questions and descriptions (Rubin & Rubin, 2005). Qualitative design is especially appropriate for this study because it offers the unique ability to collect and analyze data in a depth and detail not possible in quantitative design (Patton, 2008). Qualitative research permitted the investigator gather more comprehensive information the behavior, actions, emotions of study participants and the reasons behind these. It allowed for adaptability in categories being measured and allowed the researcher to respond to data as it emerged. Qualitative inquiry was also useful because it can specialize on focused areas of the population, as used in this research.

This study utilized in person, individual interviews as the method of data collection. This provided the researcher with an opportunity to gain data from the perspective of the participant and provide context to information accumulated. As practices vary on this topic, it is important to gain plentiful, detailed information from each participant (Fretchtling, 1997). As this is a somewhat controversial topic, an in-depth interview in a quiet environment encouraged the participants to be open with their responses. A more informal quality of process lended the guided inquiry a conversational tone that is characteristic of these types of interviews. This type of interview is suitable for subjects that involve intricate subject matters, when thorough data is wanted and the participants may be busy, important individuals (Fretchtling, 1997).

Sampling & Recruitment

The research project studied clinical practitioners who currently provided services to adolescent patients. Participants were selected through a process of purposive sampling that identified persons who have knowledge and experience in clinical treatment with adolescents. Individual were considered qualified if they were a Licensed Professional Clinical Counselor (LPCC) or if they were licensed clinical social workers. This ensured that the participants were qualified to make diagnoses and were well-informed with diagnostic practices in regard to adolescents.

To identify this sample, the researcher entered 'licensed independent clinical providers' into a google search engine. 'Independent' clinical providers were focused on to reduce risk of coercion from participants agencies or supervisors to participate in the study, and to ensure the voluntary nature of the study and its participants. A public list of clinical providers was retrieved and the researcher then narrowed the list to providers that focus on treating adolescents and using DBT interventions. The researcher contacted possible participants off of this list via telephone. The researcher used a script to explain the study, its purpose, and ask for permission to interview the person being spoken to.

Protection of Human Subjects

All participants were given an informed consent form prior to any interview beginning (Appendix A). The consent form detailed the purpose of the study, the voluntary nature of participation, measures taken for their protection and no interview began until participants gave consent. This research proposal was approved by the Institutional Review Board (IRB) at the University of St. Thomas before any contact was made with potential human subjects.

Once approved, the researcher contacted potential participants and proceeded with recruitment of participants and scheduled individual interviews. Participants were informed of

the confidential nature of the research project, and were able to review the interview questions and consent form prior to the interview. The researcher reviewed both forms with participants prior to the interview beginning and asked questions to ascertain the participants understanding of the forms. Participation in the study were wholly voluntary and participants were informed they could stop the interview at any point. As the study was voluntary, there was no known risk of coercion. Participants were asked if a voice recording device could be used to ensure accuracy of data collected and all agreed. All records of these interviews are stored in a locked file cabinet in the researcher's home and on a password protected computer. Any identifying information was excluded from the study (participant name, name of agency participant works for). All records and documents containing identifying information will be destroyed by June, 2018. Due to the voluntary nature of participation in the study, risks were minimal. Precautions to reduce risk included providing a list of interview questions prior to the interview and making sure participants were aware they can withdraw at any time from the interview. There was some self-disclosure of clinicians' personal practice and viewpoints on this somewhat controversial topic, but all identifying information was kept confidential and should not pose a risk. There were no direct benefits for participating in this study.

Instrumentation

Since this was a qualitative research project, data was collected through the researcher as a human instrument. According to Lincoln and Guba (1985), the researcher as the human instrument brings a set of characteristics that "uniquely qualify the human as the instrument of choice for the naturalistic inquiry." Humans are intuitive and can sense things in the environment that would escape other forms of physical measurement, such as computers. Humans are adaptable and can respond to changes in the interview as they occur, they are able to spot conflicting data and explore it in detail (Peredaryenko & Krauss, 2013). They may, without

thinking, side with subjects in the study or deviate from them, based on their own personal history (Peredaryenko & Krauss, 2013). However, according to Peredaryenko and Krauss (2013), some consider this to be a strength as the "primary purpose of qualitative study is to understand the phenomenon from the perspective of those under study." Too much structure can be antithetical to the nature of qualitative design and one of its strengths is the ability to adapt and be flexible in the interview process.

The literature is varied on methods of designing qualitative interview schedules. For the purposes of this research, the researcher chose to implement several processes in designing the interview schedule. Helpful to the overall design was the "responsive interviewing method" (Rubin & Rubin, 2005). This model treats the researcher and interviewee as two humans, both with feelings, opinions and experiences. Responsive interviewing encourages relationship development between the interviewer and interviewee, as opposed to detachment (Rubin & Rubin, 2005). It encouraged the researcher to adapt and change course, in order to get greater deepness or insights from the participant. This was suitable to the study as the purpose was to understand each clinician's own practice and the issues they consider when deciding to make a diagnosis.

A series of open ended questions, were developed by the researcher and reviewed by the research committee. The questions related to the participants personal practices and experiences with regard to diagnosis of BPD in adolescent patients. Questions were formulated with the intention to discover each participant's personal viewpoint and practices. Questions were asked in a semi structured, or focused interview, format. This allowed not only for exploration of the topic areas but also permitted the researcher to prompt the interviewee, if more information was desired or would offer more insight. This also gave the researcher leeway

to probe the research participant for more elaboration on questions or to explore if a new line of inquiry emerged from answers to the existing questions.

The interview schedule was developed following the six kinds of questions outlined offered by Patton (2008, pp 348-351). Questions focused on interviewee's experience and background, knowledge, opinions, senses and feelings (Appendix B). Interview questions concerned the participants' educational background and experience, the position they currently held, theoretical frameworks most subscribed to, if they had ever worked with clients with a personality disorder, the role of diagnostics plays in their practice, if they would consider diagnosing an adolescent with a personality disorder and why / why not.

Data Collection and Analysis

Data was collected by individual interviews in private settings, such as the clinician's office and chosen by the research participants. Several interviews were conducted in public settings that offered some privacy, such as a neighborhood coffee house. Interviews were all audio recorded and transcribed verbatim. Iterative questioning and probes were used to ensure validity when inconsistencies were detected in participant responses. If incongruent data emerged during the interview process, then falsehood was detected and the researcher chose to dispense with the dubious information. This increased the reliability of the qualitative analysis process. Participants were encouraged to share his or her personal practice and the reasons behind it.The researcher was very close to the data in all aspects of the process. The researcher transcribed, edited and analyzed the data. Extreme diligence was used in preparing the data for analysis. The researcher spent hours transcribing the data and editing it to ensure it was transcribed very appropriately and true to actual occurrence. In analyzing transcripts, a qualitative coding approach using content analysis was utilized. To provide for rigor in the analysis process, the researcher read each interview, without coding, to fully experience each

interview as its own individual occurrence, before engaging in coding. Next, content analysis was used to examine and interpret the data. Content analysis refers to a way of methodically examining and interpreting the data to develop themes in the data and deals with manifest (Padgett, 2008). The interview transcript was carefully examined to find codes and themes, unique to the data. Open coding, which is used to examine the data line by line then summarizing each sentence in a few words, was first used. Axial coding was then used to determine similar codes that occurred at three times in the transcript, and were placed into overarching themes (Padgett, 2008). Each theme was then confirmed with three quotes from the interview subjects. A process called memoing, which involves taking theoretical notes throughout the coding, was also employed. All of these efforts were undertaken to make certain of reliability in transcription and coding.

`   To ensure credibility, the research was examined individually to look for themes consistent, and / or inconsistent, across the population of the sample. Investigator responsiveness, was highly utilized in this study (Graham, 2016). Investigator responsiveness is the openness to seeing nuances in the data and not being stuck on one viewpoint. The researcher did extensive research into the issues surrounding diagnosis of BPD in adolescents and had a strong knowledge of what issues may arise for practitioners considering this. Once themes began to emerge, the researcher looked for data that contradicted the findings in order to account for alternate hypotheses.

Strengths and Limitations

This approach has many strengths to its design. The researcher made the observations, took notes, collected and interpreted the data, which is a strong point as the researcher was very close to the data and knowledgeable about the subject. The interview method allowed participants to describe their experiences in rich detail and in their own words, rather than

limiting their responses to predetermined categories. The researcher did not have a strong viewpoint on the issue and so, was able to critique and analyze the data objectively. This allowed for an actively analytical process to occur during the dissection of the data.

There were also limitations in this design. Since the researcher is an instrument of data collection, she also brings her own set of biases and preconceived notions to the study, which is considered a limitation by some. This was also a relatively small sample size, which makes generalizing results to other populations problematic. There was also a majority of women versus men in the study, which may also influence results. There were only two men respondents and seven women. Given the subjectivity of qualitative data collection and analysis, this design may have lower credibility with more empirically-oriented researchers. But to strengthen its credibility by demonstrating transparency, data on researcher lenses is presented in the next chapter. Inevitably, research is influenced by the researcher who designs the study and interprets the data. What themes are identified and paid attention to, are determined by the researcher and influenced by his or her background. How the language of the participants is interpreted is subject to the researcher's discretion and may have been understood differently by a different researcher with a different skill set or background.

Research Lenses

It is important in any research study to articulate the various lenses used by the researcher. This transparency provides readers with a basis for understanding as well as assessing the credibility of the researcher. Three kinds of lenses and their connection to this project will be articulated: theoretical lenses, professional lenses, and personal lenses.

A good way to think of theoretical lenses is to compare them to the foundation of a home. The foundation gives the strength, integrity and diagram for the structure. Blueprints are drawn up before construction begins, they are broad maps of what the home will look like underneath the cosmetic surfaces of carpet and paint. If part of the building is unsupported, it will sink and weaken the whole home. If it isn't airtight, you will get water in your basement. If the framework is strong, it doesn't matter what storms and elements blow your way, you will be safe because you have a well-built foundation. Similar to how a good base gives strength and improved chances of safety to your home, a clear theoretical framework provides a solid foundation for the research project.Theoretical lenses also help to identify important variables that can affect the phenomenon being investigated, how these may fluctuate and under what conditions these variations occur.

There are many lenses a person may develop throughout their lifetime that will influence the way they look at, interpret and form opinions. People are influenced by their upbringing, culture, job, education and the company they keep. In addition to a conceptual lens, this chapter will discuss how the researcher's professional and personal lens have influenced the study. Professional lenses includes discussion of the researcher's skill and qualifications in research, and personal lenses articulate the researcher's individual history, demographics and feelings that have influenced the way that the data were collected and interpreted.

Conceptual Lenses: Theory of Psychosocial Development

This study utilized the psychosocial theory of human development created by Erik Erikson. Erikson devised eight chief stages of development, "each stage posing a unique developmental task and simultaneously presenting the individual with a crisis that he must struggle through" (Crawford et al,p. 374, 2004). Erikson considered a crisis to be a turning point or opportunity for growth or a "period of increased vulnerability and heightened potential" (Crawford et al,p. 374, 2004p.374). As people resolve these crises, they develop ego strengths that give them the foundation for personality (Crawford et al, 2004). Erikson's eight stages include: Trust vs. Mistrust (age birth to one year), Autonomy vs. Shame and Doubt (ages two to three years old), Initiative vs. Guilt (four to five years of age), Industry vs. Inferiority (ages six to eleven years), Identity vs. Role Confusion (age twelve to eighteen), Intimacy vs. Isolation (young adulthood), Generativity vs. Stagnation (middle adulthood), and Integrity vs.Despair (old age) (Gines, 1998). For the purposes of this research, Identity vs. Role Confusion will be of particular importance given the focus of this research on adolescence.

During this stage, children are confronted with the question of 'who am I' and try many new things / roles. Their task during this stage of development is develop a "coherent sense of self" (Gines, 1998). When this fails to occur, the adolescent becomes trapped in role confusion or negative sense of self or identity (Gines, 1998). According to Crawford et al (2004), using Erikson's theory, the developmental tasks of this age range are to develop an internal sense of well-being through identity consolidation and to establish closeness in long lasting and committed romantic relationships. If adolescents successfully resolve this stage, they emerge with a clear sense of self, principles and their role in their world. Erikson postulated that successful resolution of these crises would provide a platform for later resolution of future crises, he described this process as "epigenetic unfolding of personality" (Crawford et al, 2004). When

these crises are unsuccessfully resolved, individuals are left with a confused sense of self,

social roles and may have difficulty selecting clear vocations or living conventional social norms

(Crawford et al, 2004). According to Crawford (et al, 2004), identity diffusion shares many

characteristics with personality disorders.

Unsuccessful resolution of these developmental crises can also lead to difficulty in

interpersonal relationships. Failure to develop a cohesive sense of self can negatively affect the

individual's ability to make a lasting commitment and instead veer towards isolation (Crawford et

al, 2004). A hallmark of BPD is intense and unstable interpersonal relationships, fluctuating

between extremes of ideation and devaluation. In laymen's terms, a person with this diagnosis

may love you one day and abhor you the next. A roller coaster of emotion is common and this

spills over into relationships.

Professional Lenses

My professional lenses as the researcher are also relevant. It is important that the

researcher of a project of this nature have knowledge and experience in research designs,

methods and interpretation of data, as well as in the subject area. This is important as it lends

credibility to my research project, process and outcome.

I have a bachelor's degree in social work and am a graduate student in the field of

clinical social work. I am knowledgeable in the Diagnostic Statistical Manual IV and V and have

been trained on how to use these as aids in diagnosing of psychological conditions. I have been

trained in qualitative and quantitative research methods and engaged in multiple research

projects of both kinds during my scholastic education and presented the findings to groups of

my peers. I have worked on individual and group research projects during the last five years. I

am able to identify areas that need further research and settle on a scope for my research. I can

gather information that is available on a given topic and describe gaps in the available

information that cause limitations to the research. I am able to access multiple kinds of data and methods of retrieval of these sources. I can interpret the data retrieved and assimilate it into logical cohesion of similarities and differences. I understand the importance of using reliable data and credible sources to base my research on. Data collected is only as good as your source and it is the responsibility of the researcher to use trustworthy references. Citation of material and sources is important to insure ethical practices and professional integrity. I also have experience presenting research and have witnessed presentation of research findings on multiple occasions.

I also have experience working professionally through employment, internships and volunteer positions with many clients who have a mental disability or illness. I am able to adapt to working with persons of differing needs to accomplish a goal. I have worked with one person who was diagnosed with Borderline Personality Disorder and this person was a middle aged female. While this has given me some familiarity with the population and diagnosis, I do not feel this experience has caused any undue bias with the population. However, I do feel this experience has given me some unique information and understanding on the characteristics of the disorder. I believe that my knowledge, training and experiences with research and persons with psychological disorders has trained me to think in a certain way. In the same way a medical doctor can look at symptoms and diagnose a physical illness, my education has trained me to look at behavior and diagnose psychological conditions.

Personal Lenses

My personal history also influences the way I think about behavior, the framework of my lenses and strengths or limitations I may bring to the research. I am a Caucasian, thirty - three year old female living in a small upper Midwestern city. I am not aware of anyone I know on a personal level that has a diagnosed personality disorder. I have always lived in a small town.

This may limit my outlook and experiences, however, I have frequently worked and gone to college in larger communities with populations of over one hundred thousand, located within a hundred miles of my home. My hometown could accurately be described as predominantly Caucasian farming community and this may limit my interactions with diverse populations. I do not have any adolescent children but I have multiple nieces and nephews currently in this stage of development so I feel I have some knowledge and insight into this population. I was also once an adolescent myself! I was also raised in a single parent household and am the youngest child in my family. My socioeconomic status is currently middle class. The conceptual theory I feel most fits with my personal beliefs is attachment theory. I think the origins of behavior are a combination of genetics and experiences. I believe that people may be biologically more predisposed to certain behaviors but environment and experiences are also a factor on the likelihood of expression and permanency those behaviors.

I was raised in a Judeo / Christian household and this is the basis for many of my personal beliefs. I am knowledgeable in Protestantism, Judaism and Catholicism but lack specific knowledge on many eastern and middle eastern religions. I am very interested in history and am very well informed on western European history, segments of Egyptian and Russian history, the Israel / Palestine conflict. I tend to focus more on specific persons in history and that helps me to understand events in a more complete context. My political viewpoint is more of an Independent, but I lean toward conservative end of the spectrum. I enjoy learning about opposing viewpoints on many issues and think many forms of truth are subjective and relative to person and circumstance. I see multiples sides of topics and appreciate learning about differing perspectives because it helps me to understand people and behavior better.

Findings

This study investigated the practices of clinicians who work with adolescents and issues they encounter when working with an adolescent who may have a personality disorder. This chapter will focus on the themes found in the interview transcripts after the data analysis process was completed. These three themes discuss will include reluctance to diagnose adolescents with BPD, alternative and co-occurring diagnoses that clinicians may consider and beneficial/harmful, effects that may accompany a BPD diagnosis in adolescence.

Description of Participants

All participants were outpatient therapists who provided therapeutic counseling to adolescent clients among their client caseloads. Some treated a range of ages and some focused their practice exclusively in the adolescent age range. All participants had previously worked with clients with a diagnosis of Borderline Personality Disorder. The study had nine total participants, these participants held a variety of credentials ranging from Licensed Marriage and Family Therapist (LMFT), Licensed Independent Clinical Social Worker (LICSW) and Doctor of Psychology (Psy. D.). There were seven females and two males interviewed with experience in working years ranging from four to seventeen. Two had significant experience working with clients with a BPD diagnosis and the rest were had somewhat limited exposure to clients with this diagnosis.

Table: 1

Participants Gender, Years of Practice and Licensure

Gender	Credentials	Years in Practice	Theoretical Frameworks
Male	Doctor of Psychology	11	Used a variety of perspectives
Female	LMFT	4	Systems
Female	LMFT	7	Addlerian
Male	Doctor of Psychology	13	Humanism
Female	LICSW	4	Attachment
Female	LMFT	6	Social Learning
Female	Doctor of Psychology	9	Behaviorism
Female	LMFT	17	Psychodynamic
Female	LICSW	9	Social Constructionist

Varying Educational and Theoretical Backgrounds of Participants

The participants held a wide variety of degrees and licensures. All were outpatient mental health providers but the variety of their educational degrees and institutions at which these degrees were earned makes it understandable that they would have diverse frameworks they operationalize in practice. The subjects were all professional, educated, and experienced individuals in the field of mental health..

Each respondent had different experiences, history, and philosophy than the others. One respondent marketed herself as a secular therapist, while another had a background in Christian counseling. One respondent had earned an undergraduate degree in women's studies, while another had a bachelor degree in aeronautical engineering. One respondent stated:

> *I am trained as an Adlerian [refers to Alfred Adler] in my philosophical work. I do identify as an Adlerian and practice as an Adlerian. Although, I might classify myself as more of an eclectic practitioner, heavily influenced by Adlerian framework. He was very influenced by the psychodynamic framework but he was more moderate [than Freud] when it came to the psychodynamic approach. I think...Adler took very much of a social work perspective and he met people where they're at.*

Another respondent indicated she felt systems theory most fit her theoretical perspective and a third indicated that with some client presentations the theoretical framework most appropriate was obvious and with others the respondent would utilize multiple theories in their therapeutic approach. No two respondents answered the question the same way or used the same theoretical frameworks.

Observational Data

Seven of the nine interviews were conducted in the respondent's offices and two were conducted in small restaurants, close to the respondent's place of work. Most of the environments were quiet and the participants gave full attention to the interviewer. One restaurant was quite noisy and the participant seemed distracted during the interview process. Eight of the participants seemed very comfortable and were easy to maintain the line of questioning with but one participant appeared nervous and took about ten minutes before she appeared comfortable. All appeared to be being honest and answering questions to the best of their ability. They all appeared knowledgeable in diagnostics and were detailed in their answers.

Theme 1:

Reluctance to Diagnose Adolescents with BPD

This theme emerged when the majority of respondents displayed extreme reluctance to diagnose Borderline Personality Disorder in the adolescent population. The participants reported they had never diagnosed an adolescent with a personality disorder or BPD- this includes the two clinicians with significant experience working with clients with a personality disorder-.six of the nine were emphatic that they would not consider the diagnosis in someone

under the age of eighteen but several responded they would consider it, provided the client was

seeing them on an ongoing basis, had for some time and the symptoms the client displayed

could not be attributed to other causes. One respondent stated:

> *Generally, in my practice, I would never diagnose an adolescent [with Borderline Personality Disorder]. I have diagnosed nineteen year olds [with Borderline Personality Disorder], in fact, two. I did not hesitate and for whatever reason, that seemed to be a good threshold, they were out of high school for over a year.*

This quote represents the nature of the comments made by participants indicating they would

not consider a BPD diagnosis in someone under the age of 18. Several clinicians' reported they

would consider the diagnosis in someone under 18, if all other criteria was met, and even then

very carefully. One participant reported:

> *I think one needs to be cautious to ensure that the behaviors are pervasive and not of an normal adolescent nature...it is important to know something about the background of an adolescent and have collateral information…..... On the other hand, if the criteria is met under the diagnostic methodology, then yes, I think it should be given.*

Several clinicians' reported they would be more likely to consider the diagnosis if the patient

came from a stable family life and had no history of trauma. One respondent stated:

> *I would generally use post traumatic stress disorder than that [BPD]. Maybe consider it as a possibility but I would probably not diagnose it …. I worked in residential [settings] in the past and I could see now how some of those kids could be diagnosed with a personality disorder. But, really, to me borderline is pretty strongly a trauma disorder, so I would focus on the trauma and the post traumatic [stress disorder].*

Participants gave multiple reasons for their hesitancy in diagnosing an adolescent

with BPD: environmental factors and family history, transient nature of identity formation in

adolescents and lack of stable personality feature in adolescence.

Environmental trauma and family history. Participants discussed environmental

factors and family history as important criteria when pondering the diagnosis. Several

respondents noted that 'disruption in attachment' and a history of trauma is seen in adult

patients. A chaotic family life with history of trauma to the client and other family members was

frequently mentioned by participants as something they look for to guide their diagnosing

practices. The following is a statement from one participant:

> *I also look at the history of trauma, this particular young lady had a history of sexual*
> *trauma, her grandma committed suicide, her mother was a victim of sexual trauma.*
> *There is kind of a system of family dysfunction or disruption in attachment or*
> *vulnerability.*

Family history was very relevant to participants when they were considering how to categorize a

patient. Respondents reported being more likely to consider the diagnosis in an adolescent who

came from a very stable family life because then the turmoil the adolescent was displaying

could not be attributed to the family or home life. One respondent reported:

> *If there was nothing going on in the family, I would probably be more inclined to*
> *consider it. You always want to make sure that it [symptoms] can't be attributed to other*
> *causes.*

While another respondent stated:

> *I'd probably consider it more strongly in the context of their family, or if there was an*
> *absence of any trauma [in their history]. If it seemed to be a really stable family versus a*
> *lot of chaos. So that would make me think about more, if it was a really stable family and*
> *this kid was engaging in a lot of this relationship 'I love you, I hate you' sort of traditional*
> *borderline stuff. really, really cautious diagnosing a personality disorder in an adolescent*

An additional respondent stated:

> *To know something of [the adolescent's] early childhood and whether or not the*
> *Borderline features could be attributed to some other transient factors before making the*
> *diagnosis...so there are a lot of 'ifs' in there to consider before doing so.*

Several respondents discussed feeling that if the adolescent was in a chaotic environment,

the environment would show itself in the his or her behavior, thus, mirroring some of the

common symptoms of BPD. However, if the family environment was stable and the behavior

could not be accounted for by some sort of upheaval in the family dynamic, they would be more

likely to consider BPD as a possible likelihood.

Transient nature of identity formation in adolescents. Respondents displayed concern about the instability of identity features in adolescence. They expressed concern that some of the identity features their clients were displaying were not permanent. Six respondents mentioned that teens are highly influenced by their peer groups, and that peers influence their decision-making. Respondents also noted how adolescents are heavily influenced by media, celebrities and current social trends. One respondent stated:

> *The symptoms of Borderline [Personality Disorder] describe a lot of what it is to be a fifteen year old girl...in our culture. I think when one is out high school or their parents house is when identity is more formed.*

Participants reported that some features of BPD have become more common in today's culture and these trends make it difficult to distinguish to identify BPD symptoms. Additional respondents offered that:

> *It's even difficult because a lot of things like cutting and self harm, that used to be really big indicators of borderline have become a lot more common. A lot of teenagers engage in those kind of behaviors. Suicidal behavior, in my experience, is really common too.*

And another participant stated:

> *One needs to be very careful that the behavior cannot be attributed to normal adolescent variability..*

Lack of stable personality features in adolescence. Respondents reported that personality was largely unstable during adolescence. Seven felt personality to be somewhat stable around the ages between eighteen to mid-twenties. Respondents were of the opinion that personality, like identity, was predominantly thought to be fluid at the adolescent age.. Several participants stated they thought personality changes are ongoing and occur until death. One respondent stated:

> *The key parts of a person's personality, I would say, are formed pretty early. I would say [they are] pretty stable by eighteen, it might vary a little bit because there is still develop going on but usually around that area.*

Several respondents indicated they felt there are always exceptions to the rule and should be considered on a case-by-case basis. One respondent stated:

Generally, without special circumstances, [I consider personality to be stable by age] eighteen. Particularly, eighteen and out of high school. But I'm sure there are variables, I've seen very mature sixteen year olds, I've also seen very immature twenty four year olds. But if I had to give a hard number, I'd say eighteen...and in terms of diagnosing, I do hold onto that. And I'm rarely diagnosing a personality disorder in anyone under [the age] of eighteen. Perhaps it's arbitrary but it's just a practice that has been pretty natural for me.

One respondent was unsure and thought personality changes could ongoing throughout life,

stating:

I do not know and we do not know but I think science has theorized it's more around the age of mid-twenties [that personality becomes stable]. I don't think personality is set in stone like that, I think it's a lot more fluid and complex.

Several respondents also display this viewpoint but also reported the youngest age a

personality is stable enough for a diagnosis is eighteen. Four respondents reported stable

personality features were something they assessed over time and continued contact with the

individual. While most respondents did give an actual age number, they generally indicated the

stability of personality formation in a client something they assessed on an individual basis with

clients and could not be applied broadly.

Fear of client stigmatization or labels. All nine participants reported the fear of their

client being stigmatized by a BPD diagnosis. Participants reported individuals with this diagnosis

are viewed *emotionally demanding* and can be a *rollercoaster* to work with. Five participants

reported that this a lifelong diagnosis and should not be arbitrarily applied to a patient because it

could influence health care treatment they receive for the rest of their lives. One respondent

stated:

The stigma of what it [a BPD diagnosis] means carries over when they see other providers, it may affect how her providers treat them. What people would think of them because of that diagnosis.

Another study participant commented:

One needs to be careful to avoid putting a diagnostic label on someone, that can be stuck to them...like velcro.

Respondents' feared that a diagnosis of BPD could lead to clients being poorly treated by other health care providers in the future. Instead of practitioners listening objectively to the patient's symptoms, they may categorize them as just seeking attention or being manipulative, due their diagnosis. They expressed concern this could lead to patient's not getting needed treatment and being marginalized.

Study participants also expressed concerns that an adolescent may begin to define themselves by their diagnosis. One respondent stated:

For a young person, this [diagnosis] can be daunting. The feeling that this isn't going to get better, for the rest of my life I have to live with this, and that feeling can be hopeless.

As identity formation is very crucial at this stage of development, multiple practitioners reported they felt that giving a diagnosis to one so young could cause the adolescent to begin to define their sense of self by that title. One respondent stated:

I think sometimes diagnosis can become a crutch or become a client's identity.
If an adolescent begins to view his or herself as just what their diagnosis entails, it could spill over into the rest of their lives. It can distort their reality and they can see everything that happens to them, or that they do through a lens of their illness.

This participant described adults as generally having a sense of self formed and being able draw on this past grounding to orient themselves about what they know to be true, about themselves. Further stated by the participant, an adolescent does not have this advantage, they are still *questioning everything about what is true and real about them*.

Theme 2:

Co-occurring Disorders and Alternative Diagnoses

All respondents reported common diagnoses that they have seen in BPD patients, or patients they suspected as having BPD. Depression, anxiety and self-harm attempts were the most common diagnoses that emerged from the participants. One respondent described the

following symptoms in an adolescent patient she was treating that she suspected may have

BPD. The respondent stated:

> *Self harm, suicide attempt, difficulty in managing a romantic relationship, and that difficulty was breaking up and getting back together, breaking up and getting back together, breaking up and getting back together, sabotaging the romantic relationship…..Primarily, I'm going to give her a depression, anxiety or post traumatic stress [diagnosis].*

This particular respondent also described her client having a *love/hate* dynamic to her personal

relationships. Multiple respondents used similar language and descriptions when they were

describing symptoms that are indicative of possible BPD. Eight respondents also described

these clients as having very black and white thinking and language. This love/hate dynamic was

reported in nearly all of the interviews as a symptom the practitioners saw in clients with BPD.

The following are all statements from various participants:

> *Extreme relationship thinking, like really black and white kind of language.*

> *A lot of emotional dysregulation, a lot of love/hate relationships, and very black and white thinking.*

> *Telling the significant other one day 'I hate you' and the next day 'I love you.*

A history of trauma is also a common denominator in this population and

several participants mentioned this is something they look at when considering at diagnosis of

BPD. Several respondents reported using a diagnosis of Post Traumatic Stress Disorder as a

possible co-occurring disorder. One respondent mentioned using Adjustment Disorder as a

possible alternative to BPD.

Theme 3:

Benefits/Risks of Early Diagnosis

Respondents were questioned about what the impact of early diagnosis would have on a

patient. Themes that were discovered in the responses ranged from early diagnosis being

beneficial because the patients could receive effective treatment in a more complete context

and that could improve outcomes for the patient. One respondent stated:

> *I think what makes a difference is obtaining the most effective treatment sooner, rather than later. If the diagnosis can be given sooner, than treatment can begin sooner.*

Respondents reported an additional benefit that of early diagnosis discussed was that families

would receive support and understanding for issues they are experiencing. Some people may

be relieved when they receive a diagnosis as it helps them know they are experiencing a real

issue and there are interventions available that may help improve their situation. One

respondent stated:

> *Having the diagnosis could help an adolescent or adult get the help that they need also help them feel that the severity of what they are dealing with is being understood and taken seriously. It could be a benefit for families dealing with this to know that it is a real thing and recognized. And it could help be a push for services for them, like, telling them your kid needs to be in therapy and that there is a way to make it better.*

Harmful possible effects to early diagnosis were mainly concerned with the 'what if' of a

misdiagnosis. Respondents reported BPD is a lifelong diagnosis and adolescence is a time

change so it's possible for an adolescent to be misdiagnosed. A misdiagnosis could have a lot

of far-reaching negative effects on one's life. One respondent stated:

> *In adolescents it's just...unsure, moving forward there is not a lot you can predict. Families can change and the right person at the right time can influence them.*

This respondent was also discussing how sometimes situational issues can make someone

appear to be suffering from an illness, when they are just responding to their environment.

Participants reported there are both benefits and risks that can result from diagnosing

one so young with a serious disorder. The respondents stressed the importance of clinicians

being mindful of these effects when they come into contact with a potential case and taking their

time with their diagnostics.

Discussion

The purpose of this study was to explore if therapists were utilizing the diagnosis of BPD in adolescence and the reason behind the decision. The findings of this study support many of the themes found in existing literature. In this discussion, first I will interpret the findings of this study, compare and contrast to existing research, then determine implications for social work practice and future research on the topic of diagnosis of BPD in adolescence.

Findings Consistent with the Literature

Most of the practitioners interviewed would not consider the diagnosis in an adolescent, consistent with the existing literature (Laurenssen, et al, 2013). Several did respond that they would consider it, but only under specific circumstances. Reasons identified for the clinicians qualms about utilizing this diagnosis in adolescence were overall very consistent with existing literature (Laurenssen, et al, 2013). Namely, that personality is not yet stable in adolescence so a personality disorder diagnosis in this population is very risky and it is a lifelong diagnosis that has stigma associated with it (Miller, Muehlencamp & Jacobsen, 2008). Respondents did not want to diagnose an adolescent with BPD when it may be transient and associated with the stage of development they are at. Consistent with the literature, respondents' identified the belief in the existence of BPD in adolescence but due to the serious nature of the diagnosis, would not utilize in this age group (Laurenssen, et al, 2013).

As previously discussed in the literature review, identity formation is a major developmental task of adolescence (Westen, Betan & Defife, 2011; Klimstra et al, 2010). This is the stage of life when children are discovering who they are, what fits and what doesn't. Identity formation is very important because it serves as a lens through which these individuals view their personal experiences to find purpose in the direction of their lives (Crawford et al,p. 374, 2004). Adolescent theorists commonly theorize that early adolescence is a time of unstable

sense of self (Brinthaupt and Lipka, 2002; Harter, 1999; Shaffer, 1996). For individuals on the

bridge between childhood and adulthood, adolescence is a time to try new things, put on

identities for a little while then cast them off when they realize they don't fit. This is perfectly

normal behavior and does not signify that one is suffering from a personality disorder, however,

it is also defining criteria for one suffering from BPD (Miller, Muehlencamp & Jacobsen, 2008).

The dilemma for practitioners comes when it is time to decide what is just normal teen angst vs.

what is a pervasive pattern of behavior, indicative of a personality disorder (Crick, Murray-Close,

& Woods, 2005; Miller, Muehlencamp & Jacobsen, 2008; Sharp & Romero, 2007). This was an

issue many respondents identified as being a concern and a reason for lack of diagnosis in this

population.

Respondents identified benefits and risks to utilizing this diagnosis in adolescence.

These were overall very consistent with the literature, as well (Courtney-Seidler, Klein & Miller,

2013; Laurenssen, et al, 2013). Participants' feared the clients being labelled and receiving poor

treatment from having been given a diagnosis that has a stigma. A BPD diagnosis can be

viewed negatively in some medical circles (Courtney-Seidler, Klein & Miller, 2013; Laurenssen,

et al, 2013). They have been described by behavioral health care workers as "difficult,"

"treatment resistant," "manipulative," "demanding," and "attention seeking" (Gallop & Wynn,

1987; Nehls. 1998; Stone, Stone & Hurt, 1987; Fraser & Gallop, 1993). A previous study has

documented persons with BPD being told that doctors had no help to give them and there was

no point in them going into the hospital (Bonnington & Rose, 2014). If someone was subjected

to this treatment when they are young, it could prevent them from seeking help later in life.

Respondents identified many co-occurring disorders with patients with BPD, which is

very consistent with the literature (Zanarini, et al, 1998). Anxiety, depression, self-harm attempts

and PTSD were strong indicators of possible BPD, revealed in the interviews and literature

(Zanarini, et al, 1998). These are important considerations for clinicians to pay attention to when they are treating an adolescent with one of these diagnoses because they could be indicative of a possible personality disorder.

Benefits to early diagnosis, identified by participants, were getting helpful interventions and support for the individual and family early on. Research has shown that early interventions improve outcomes for those with BPD (Aviram, Brodsky & Stanley, 2006). Respondents felt early diagnosis could also normalize the situation for the family and let them know that they are not alone in what they are going through. The families and adolescents could learn healthy ways to deal with the illness and its symptoms sooner and learn what to pay attention to (Aviram, Brodsky & Stanley, 2006). BPD sufferers would learn how utilize and operationalize therapeutic tools in a more timely manner, leading to improved quality of life (Aviram, Brodsky & Stanley, 2006).

Unexpected Findings

Multiple participants mentioned family history as an important factor when considering a BPD diagnosis. While that was not unexpected, one of the things in practitioners mentioned looking for was a surprise. Stability of the family unit of the adolescent patient was a strong indicator that clinicians' considered when examining the patient's potential for BPD diagnosis. If the family provided a steady, non-chaotic environment for the patient, with little upheaval, respondents were more likely to consider the diagnosing the adolescent with BPD. The justification for this practice is that if a family is experiencing frequent variability and instability, it will naturally be seen in the individual's behavior. However, if family issues are not the root cause of the behavior then it is more likely that a mental disorder is causing the symptoms, thus, making a diagnosis of BPD more reliable for this age group.

While there are many valid concerns when considering this diagnosis, there also seemed to be a lot of fear based decision-making leading diagnostic practices for adolescents with potential BPD. Participants expressed multiple concerns about diagnosing an adolescent with this lifelong label. Concerns included that adolescents are experiencing symptoms that will not be permanent and just of normal adolescent instability, also a fear of labeling a client with a diagnosis that is poorly viewed in some mental circles. Several participants expressed that if a client received poor treatment from medical staff, they feared it could prevent a patient from seeking help in the future. Respondents feared giving out this diagnosis because of how it could affect the patient's future and the possibility of a misdiagnosis.

Implications for Social Work Policy and Research

This study presents the perspectives from licensed clinicians about their use of BPD diagnosis with adolescents. This study shows the overall lack of a universal understanding of what Borderline Personality Disorder looks like in adolescence and how clinicians should respond when they encounter it in practice. It highlights the inconsistencies between the literature that says a diagnosis is possible and the overall clinical practice that does not generally recognize its existence. In evaluation of the outcome of the study, the researcher finds the results are congruent to the literature of there being a need for more research and clinical education to better prepare clinicians to meet the needs of adolescent individuals who may be suffering from BPD.

In order to continue to broaden the knowledge base related to BPD in adolescents, future research should focus on discovering the differences between transient personality traits and borderline features. One of the main issues clinicians reported during this study was not knowing if the traits being displayed were permanent or temporary, due to the client's stage of development. Further research into identifying ways of determining the stability of personality

features in adolescence would be helpful to practitioners. Future research should also focus on having larger sample sizes and exploring differences between men vs. women participants, as this was sample only had two males and this could have skewed the results.

Further research is needed on this topic so that a consistent policy can be developed in the social work clinical setting so that practitioners have more a guideline when considering this diagnosis. Further research into how BPD appears in adolescence would also be helpful and provide mental health practitioners with a clearer of how it presents in adolescents and what to be cautious for when considering this diagnosis. If a cohesive policy was implemented among the profession, it could lead to be more patients getting the help they need sooner. Earlier interventions could improve overall outcomes among patients with this diagnosis.

The findings also highlight that current DSM-V guidelines do not always carry over into actual clinical practice. Clinicians in actual practice may deviate from what the establishment acknowledges is possible or appropriate and what the practitioner in practice feels is fitting for the individual patient. This practice can be viewed as very honoring to the individual and supportive of social work values. Social workers have a duty of care to clients they are serving and may consider when assigning a diagnosis, if it is in the patient's best interest,.If the diagnosis could cause the patient harm, such as keeping them from getting a job or causing them more stress and anxiety, that may well be reason for a clinician to withhold a diagnosis. Clearly, there are risks and fears accompanied with a Borderline Personality Disorder and practitioners must consider all of factors these when considering it.

Conclusion

Borderline Personality Disorder is a serious and pervasive illness that is acute implications for its sufferers. It is a complicated diagnosis that needs extremely careful consideration, before being utilized. This qualitative study has examined the implementation of this diagnosis in adolescence to explore clinicians personal practices and found varying reasons for its use, or lack thereof. Overall the study found that the issues clinicians consider in BPD diagnosis is very consistent to the existing literature. Inability to determine the consistency of the symptoms in adolescence, use of alternative diagnoses and co-occurring diagnoses, and fear of possible risks of the diagnosis all play a role in whether or not clinicians utilize the diagnosis in adolescents. Some of the hesitancy in diagnosing BPD in adolescence appears to be fear based, on the part of clinicians. Fear of treatment the client may receive from other providers and fear of misdiagnosing a person with a serious, lifelong disorder. More research is needed to develop a consistent adolescent assessment tool for clinicians and to improve understanding of how the BPD presents at this stage of development.

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Appendix A—Consent Form

Diagnosis of Borderline Personality Disorder in Adolescents: Issues and Practices
I am conducting a study on Borderline Personality Disorder in adolescents and the diagnostic practices of clinicians who work with these persons. I invite you to participate in this research. You were selected as a possible participant because you work with adolescents in a clinical treatment setting and are qualified to render this diagnosis. Please read this form and ask any questions you may have before agreeing to participate in this study.
This study is being conducted by: Rebecca Denaway, a graduate student at the School of Social Work, University of St. Thomas / College of St. Catherine and supervised by Dr. Mari Ann Graham, PhD, LCSW, a professor at the school of social work.
Background Information:
The purpose of this study is to gain a better understanding of the diagnostic practices of clinicians who work with adolescents and the issues that surround this diagnosis. There is a lack of research into this area and some conflict exists of among clinical practitioners. In addition, this information may potentially be used to better prepare clinicians who work with adolescents who may have this disorder**.**
Procedures:
If you agree to be in this study, I will ask you to do the following things: participate in an in-person interview lasting no longer than an hour and a half, and allow the interview to be audio-recorded.
Risks and Benefits of Being in the Study:
This study has no risks to participants.
This study has no known benefits to participants.
Confidentiality:
The records of study will be kept confidential. Any published report will not contain any identifying information of participants. The participants will not be identified by name or agency of service. All records and transcripts of this interview will be kept on a password protected computer and in a locked storage cabinet in the researcher's home. All records of this interview will be destroyed no later than June 20[th, 2016.]
Voluntary Nature of the Study.
Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with St. Thomas. If you decide to participate, you are free to withdraw at any time up to the end of the interview process. Should you decide to withdraw, data collected about you will only be used with your permission. You are also free to skip any questions I may ask.
Contacts and Questions:
My name is Rebecca Denaway. You may ask any questions you have now. If you have any questions later, you may contact me at any time. You may contact my university chair, Dr. Mari Ann Graham. You may also contact the University of St. Thomas Institutional Review Board at 651 - 963 - 5341 with any questions or concerns.
You will be given a copy of this form for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and for my interview to be audio-recorded. I am at least 18 years of age.

_____	_____
Signature of Study Participant	Date

_____
Print Name of Study Participant

_____	_____
Signature of Researcher	Date

Appendix B -- Interview Schedule

Background / Demographic Questions

1. What is your educational and professional background?

2. Can you tell me about the position you currently hold?

3. What are the demographics of the clients you currently serve? (age, gender, race)

Knowledge Questions

4. How were you trained in diagnostics?

5. What role does diagnostics play in your current position?

6. What conditions have you diagnosed?

7. Tell me about your about experience working with clients with a personality disorder.

8. What experience do you have diagnosing personality disorders?

Opinion and Values Questions

9. Please describe the theoretical framework you use most in practice

10. What age do you consider personality to be fully formed and what factors signifies this to you?

11. How do you typically diagnose personality disorders? (models, etc.)

12. What is your opinion about diagnosing personality disorders in adolescents? Please elaborate and give examples, if possible.

13. What is your opinion on diagnosing Borderline Personality Disorder in adolescents? Please explain your rationale as fully as you can.

14. What factors would you bear in mind if considering this diagnosis in an adolescent?

Experience and Behavior Questions

15. Can you tell me about a time when you worked with an adolescent client you felt had this disorder? What symptoms did the client display? Was the client diagnosed with BPD? If not, did you diagnose him or her with it? Or mark it as a rule out? What actions did you take?

Feeling Questions

16. What personal feelings do you have about this issue of diagnosing adolescents with Borderline Personality Disorder?

17. Have you ever diagnosed an adolescent with this disorder? Why or why not?

18. What do you think is most complicated about diagnosis of the disorder in adolescents?

19. How do you think diagnosis or lack of diagnosis affects long term outcomes for adolescents? What is beneficial and what is harmful?

20. Is there anything I haven't asked that you'd like to tell me about in relation to this topic?