Personality Disorders in Children and Adolescents: Can They Have One?

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Financial Disclosures

- No Financial Disclosure
Case

Patient is a 19 year-old transgendered female to male who presents to the hospital following an overdose of his zoloft 25mg (20 tabs). During the course of his treatment, it is discovered that he has been losing weight, complains of no energy and night sweats. As part of his stay, he learns that he has acute lymphocytic leukemia.

He has been living on his own or with older friends since the age of 17 when he disclosed to his parents that he was transgendered. He is in the process of moving to Flagstaff from Tucson and only temporally is living in Phoenix.

He has a hx of 3 prior overdose attempts, never requiring inpatient psychiatric treatment.

He frequently cuts on his arms as a way to cope

He believe some of the hospital stay do not like him and his care is negatively impacted by their feelings
Objectives

- Review the 3 clusters of personality disorders and the commonly study ones in youth
- Describe treatment approaches to manage borderline personality disorder in adolescents
- Predict long-term outcomes of youth who have a personality disorder as they move into adulthood
What are Personalities?
What are Personalities?

the combination of characteristics or qualities that form an individual's distinctive character.

the sum total of the physical, mental, emotional, and social characteristics of an individual

the complex of characteristics that distinguishes an individual especially in relationships with others.
Personality Disorders (PD)

“An enduring pattern of inner experiences and behavior that deviates markedly from the expectations of the individual’s culture.”

A personality disorder

- deviant from cultural standards
- rigidly pervasive
- onset in adolescence or early adulthood
- stable over time,
- lead to unhappiness and impairment
- maladaptive behavior in at least two:
  1. Affect  
  2. Cognition  
  3. Impulse control  
  4. Interpersonal functioning
Pattern:

- Manifested in cognition
- Affectivity
- Interpersonal functioning
- Impulse control
Pattern:

- Enduring
- Inflexible across a broad range of personal and social situations
- Leads to clinically significant distress or impairment in social, occupational or other important areas of functioning
- Onset traced back to adolescence or early adulthood
### DSM-V Classification

#### Cluster A Personality Disorders

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<tr>
<th>Code</th>
<th>Disorder</th>
<th>ICD-10 Code</th>
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<td>301.0</td>
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<td>301.20</td>
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#### Cluster B Personality Disorders

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#### Cluster C Personality Disorders

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<td>301.6</td>
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<td>301.4</td>
<td>Obsessive-Compulsive Personality Disorder</td>
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#### Other Personality Disorders

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<td>Personality Change Due to Another Medical Condition</td>
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<td>301.89</td>
<td>Other Specified Personality Disorder</td>
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<tr>
<td>301.9</td>
<td>Unspecified Personality Disorder</td>
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Prevalence

- Adults-10-13%
- 50% receiving mental health treatment have a PD
Impact: Experience more..

- Divorce, unemployment, homelessness, accidents, violence, SIB, parasuicidal behavior, attempted/completed suicide, increased need for medical care, hospitalization, visits to the ER, child abuse and neglect, illegitimacy, STD, delayed recovery from medical illness, malpractice suits.
- Impacts the treatment of the primary disorder
Controversies

- Can we make the diagnosis of a PD in a child or adolescent?
- Younger age spectrum may not have enduring patterns of maladaptive behaviors, coping, thinking, feeling or relating yet.
- Development is still fluid—must consider a developmental approach to the investigation of PD to identify, treat and prevent the disorder.
- Empirical data supporting the validity and reliability of the construct and diagnosis of PD in children is lacking.
Controversies

- Most research in youth has been with BPD and antisocial personality
History

- Clinical description in children began in the 1940’s
- Mahler-borderline psychosis
- Ekstein and Wallerstein-rapid and ongoing shifts in ego functioning, reality testing, relationships and defense mechanisms
- Kernberg-limitations in the capacity to differentiate self from others, reliance on primitive defenses and attainment of reality testing, without the achievement of object constancy and identity integration
Borderline Personality

- Frantic efforts to avoid real or imagined abandonment
- Unstable interpersonal relationships altering between extremes of idealization and devaluation
- Identity disturbances
- Impulsivity
- SIB/ideation
- Affective instability
- Chronic feelings of emptiness
- Intense anger
- Transient stress-related paranoia
- Can be Dx in children and adolescents when maladaptive traits have been present for 1 year (2 years adult)
Goldman was the first to adapt standardized adult DSM criteria for BPD in children and adolescents (1)

- Abandonment- “Fear that the therapist will not be at the next appt or refusing to leave the house while the parent is at work”
- Disturbance in self-perception and self-presentation-gender identity or roles, friendships, school or career plans. “Running for class president despite having no friends.”
- Unstable interpersonal relationships-Distortion of the relationship “Teacher described as a friend, inability maintaining friendships”

Controversies
Epidemiology

- Rates vary depending upon the setting
  - 43% in inpatient settings
  - 3-46% in community settings
- Suicide rates up to 10%
Etiology

- Genetic
  - 11.5% morbidity risk in 1st degree relatives
  - Twin studies-35% dizygotic and 7% for monozygotic pairs
  - Link to affective disorders and substance abuse in 1st deg. Rel
  - Link to impulse-control disorders
  - Link to ADHD and learning disorders
Etiology

- Biological
  - Reduced serotonergic neurotransmission in cortical inhibitory area (prevent the dampening of aggression)
  - Bilateral increases in activation of the amygdala-increased reactivity to emotionally relevant stimuli
  - Increased left amygdala activation to facial expressions of emotion
  - Reduced amygdala and hippocampal volume
  - Dysfunctional fronto-limbic network-underlying impulsive aggression, affective instability and hyperreactivity to loss or frustration
Etiology

- Psycho-Social
  - Adverse and traumatic experiences, neglect, separation, serious parental psychopathology
  - Disruptions in early relationships
  - Mothers reward passive-dependence and ignore or reject autonomy
  - Inability to evoke the memory of a comforting parental image under distress
  - Inability to self-soothe resulting in an inner sense of emptiness and reliance on transitional objects (drugs, food, sex)
  - Limited mentalizing capacity
Mentalizing

- Process by which we make sense of each other and ourselves, implicitly and explicitly
- Attentive to the mental states of those we are with, physically and psychologically
- Self-agency, autobiographical narrative, social reciprocity and empathy, self-regulation, affect modulation, capacity to play and symbolize
- Operationalized by researchers investigating theory of mind
What is Mentalizing?

- It is the imaginative mental activity that enables us to perceive and interpret human behavior in terms of intentional mental states (needs, desires, feelings, beliefs, goals, purposes, reasons).
- Understanding the behavior of others in terms of their likely thoughts, feelings, wishes and desires is not a constitutional given—it is a Developmental Achievement.
What is Mentalizing?

- Ability to do this is shaped by early attachments (how our subjective experience was mirrored by a trusted other)
- Quality of the affect mirroring impacts the development of the affect regulative process and self-control
- CAPACITY FOR MENTALIZATION
Mentalization

Prefrontal/controlled

Posterior cortex and subcortical/automatic

Arousal/Stress
What leads to BPD

- Infants with a hypersensitivity to social cues (mentalization)
- Increased arousal or affective dysregulation
- Parents who share similar genetic vulnerabilities
- Parental disposition to respond to their children’s hyperarousal and signs of distress with hyperarousal and distress
- Low threshold for the triggering of the arousal system with a concurrent inhibition of the frontal and prefrontal structures involved in mentalizing in response to mild stimuli
What leads to BPD

- Uncanny sensitivity and reactivity to other people’s mental states
- Exquisite capacity to know the right buttons to push to evoke responses from others
- Dramatic intensity of their responses to interpersonal events
- Self-centeredness and utter disregard for other people’s feelings
Impairment of Social Cognition

- Affect regulation
- Attentional control (strong links to the regulation of affect)
- Impulse/frustration issues
- Mentalization
- Dual arousal system impacted (stress facilitates automatic metallization, it inhibits controlled mentalization)
  - Mild arousal optimizes the prefrontal cortex
  - Excessive stimulation shuts off the prefrontal cortex and the posterior cortical (parietal) and subcortical (amygdala, hippocampus and striatum) - automatic functions take over
Clinical Evaluation

- Difficult temperament
- High activity level, poor adaptability, negative mood
- Problems settling into rhythmic patterns of sleep and feeding
- Cranky and hard to soothe
- Often have ADHD, conduct, separation anxiety or a mood disorders
- Distorted sense of reality, vivid fantasy world
- Unstable relationships with peers, intense and dramatic
- Promiscuity in girls
Clinical Evaluation

- Shyness and fears of rejection in boys
- Bulimic binges or drugs for soothing and comfort
- Self-mutilation
- Child diagnostic interview for borderline patients (C-DIB)
- Borderline personality features scale for children and adolescents (BPFC-C)
Differential Diagnosis

- Comorbid with Depression, substance use, PTSD, anxiety and eating disorders.
- See high rates of conduct disorder.
- Bipolar disorder
- Disruptive Mood Dysregulation Disorder
- Emerging narcissistic or histrionic personality disorders
Course and Prognosis

- Few longitudinal studies have shown consistent findings
- Risk for suicide, substance abuse
- Mellow in middle age
Treatment

- Repeated crises results in multiple systems and treatment modalities (hospital, RTC, IOP, juvenile justice, OP, special education)
- Treatment is controversial
- Crisis management-no outcome data
- Require extended treatment with multiple interventions
- No data on RTC outcomes
Treatment

- Family and individual psychotherapy
- DBT decreases parasuicidal behavior
- Mentalization based treatment (MBT)
  - Individual and group therapy focused on helping patient to identify and interpret mental states, both in themselves and others in order to promote a sense of the self as the agent of behavior, based on underlying mental states
Treatment

- DBT-core issue is emotional dysregulation
- MBT-core issue is an impairment in mentalization producing a related disturbance in self-coherence and self-agency
Treatment

- Establish a collaborative relationship with the parents
  - Support parental competence and mindfulness, empathy and mentalizing abilities
- Collaborative relationship with the patient
  - Enhance the child sense of self-control
  - How to observe their own internal states without becoming overwhelmed
  - Break down experiences into smaller bits
- Recognize your own emotional reactions
Treatment

- Pharmacotherapy
- Oxytocin
  - Interpersonal hypersensitivity (threat hypersensitivity and negative bias) is associated with bottom-up emotional generation
  - Affect dysregulation is an abnormal top-down process
  - Alterations in the social reward and empathy domains
  - Oxytocinergic system involved in these domains
Oxytocin

- May improve adaptive social approach behavior
- Normalize top-down processes
- Mesolimbic circuit improving social reward experiences
- Modulating brain areas involved in cognitive and emotional empathy
Outcome

- Developmental antecedents of adult BPD
- Surveyed parents of adult patients with BPD
  - Females—“promiscuity, verbal outbursts, impulsivity, suicidality and self-harm”
  - Males—“substance abuse, aggression, impulsivity, suicide attempts and self-cutting” (Siever et al. 2002)
- 88% of adult patient achieve remission
Outcome

- Younger age, no prior psychiatric hospitalization, no childhood sexual abuse, less severe childhood verbal, emotional or physical abuse; higher degree of childhood competence; no family hx of mood or substance use; no PTSD
Case

Patient is a 19 year-old transgendered female to male who presents to the hospital following an overdose of his zoloft 25mg (20 tabs). During the course of his treatment, it is discovered that he has been losing weight, complains of no energy and night sweats. As part of his stay, he learns that he has acute lymphocytic leukemia.

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Summary:

- Borderline Personality Disorders can be diagnosed in Adolescents
- Causes for BPD are still not well understood
- Genetic and Environmental factors likely involved
- BPD is under diagnosed or misdiagnosed
- With treatment, BPD can improve over time
Which of the following personality disorders is in Cluster C?

- Schizoid
- Antisocial
- Borderline
- Obsessive-Compulsive T
- Schizotypal
You follow a 15 year-old female with a 1 year history of cutting. She has never been on psychotropic medication and reports feeling “better when I cut.” The most appropriate treatment recommendation would be:

- Start a SSRI to target her depression
- Refer for inpatient psychiatric hospitalization
- Start an atypical antipsychotic
- Refer for insight oriented therapy
- Start mentalization based treatment T
Which of the neuroimaging findings is associated with Borderline Personality Disorders?

- Reduced amygdala and hippocampal volume
- Increased serotoninergic transmission in the cortical inhibitory areas
- Increased Dopaminergic transmission in the Cerebellum
- Decreased Serotoninergic transmission in the Nigrostriatal pathway
- Increased amygdala and hippocampal volume