# BPD in Child & Adolescent: Comorbidity

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#### Comorbidity

- Depression (71.4%)
- Anorexia (40.2%), Bulimia (32.9%)
- Alcohol abuse (23.5%), Substance abuse (8.2%).
- Antisocial PD (22.3%), Avoidant PD (21.2%),
- ADHD (may be an indicator of severity)
- These data are similar to that reported for adults

Gender differences in both adolescents & adults

 Predominance of comorbid antisocial personality among boys.

#### Adult BPD is often comorbid with

MDD

• SUD

PTSD

Anxiety disorders

Eating disorders

• Other PDs (*Antisocial PD, Avoidant PD*)

#### Conduct Disorder:

- Conduct disorder is the only axis I disorder
- More prevalent in adolescents with BPD than in those without.
- Common features in BPD & conduct disorders:
- History of physical/sexual abuse
- Early losses

• The **strongest** comorbidity in BPD:

Externalizing disorders

#### The cross-sectional presentation of:

- Mood disorders + externalizing disorders (including ADHD & conduct disorder)
- May mimic BPD
- Adequate treatment of the comorbid disorder
- + a longitudinal perspective
- Needed before arriving at a dual diagnosis.

Differentiation between BPD & mood disorders

Predisposing factors to BPD are a vulnerability to:

Affective dysregulation

Excessive rage

 Childhood presentations of bipolar or dysthymic disorders:

Moody/irritable/affectively labile

Low tolerance for frustration

Explosive anger

# □ Differential Diagnoses:

Mood changes in late school-age/adolescence

May have a diagnosis of mood disorder

### • Particularly

- Exuberant affect
- Loud giggling
- Increased activity
- Disturbed sleep
- Recent onset of angry outbursts
- Decreased attention

#### ■ Manic adolescents:

Do poorly in school because of:

Poor concentration/high-flown thinking

Ends relationships because of:

Irritability/impulsivity.

Acute onset of a depressive episode in a child/adolescent

#### • Characterized by:

- Hypersomnia
- Psychomotor retardation
- Psychosis
- Family history of 2 or more generations with mood disorders
- Is predictive of a bipolar course.

# ☐ History of trauma

Sexual abuse is common in BPD

PTSD

# Repeated traumatization can result in:

 Reenactment, avoidance, dissociation, & hyperarousal

• Influence the child's/adolescent's patterns of:

Coping, relating, & experiencing

Can contribute to the development of BPD.

# **□**Eating disorders:

Particularly bulimia nervosa

Are often part of the clinical picture of BPD.

- In younger children:
- Separation anxiety disorder:
- Should be differentiated from
- The clinginess/distress
- Following separations
- Characteristic of borderline youths

#### Children with uncomplicated anxiety disorders:

do not exhibit:

Impulsivity

Rage

Self-destructiveness

Impaired sense of reality

(typical of BPD)

Differrential Diagnosis:

Schizotypal personality

Schizophrenia spectrum disorders.

#### Schizotypal children present:

- Magical thinking
- Idiosyncratic fantasies
- Transient psychotic episodes
- Unusual perceptual experiences
- Disturbed sense of reality
- Suspiciousness & paranoid ideation

(Are all common typical features of BPD children)

# Schizotypal children:

Have a family history of schizophrenia spectrum disorder

#### • <u>& Present:</u>

• Constricted, flat, or inappropriate affect

Oddness of speech

Discomfort in social situations

• These features contrast with:

• Intense, dramatic affect

Hunger for social response of borderline youths.

• <u>But:</u>

Delusions

Hallucinations

Loose associations

• Are characteristic of schizophrenia

#### Children with a schizoid disorder of childhood

May be absorbed in their own fantasies

Are not distressed by their social isolation

• Do not coerce others:

To play roles

Prescribed by their fantasies

#### **□**Children with

Narcissistic/histrionic personality disorders

Significant overlap with children with BPD.

#### • Narcissistic/histrionic children are:

Self-centered/self-absorbed

Need constant attention

Respond with rage

To rejection/indifference

#### Narcissistic/histrionic children:

Alternate between idealization/devaluation,

Are seductive/manipulative

Express affect with undue intensity/drama

Are preoccupied with fantasies of power/control

#### Borderline children:

- Display much greater:
- Impulsivity
- Self-destructiveness
- Affective instability
- Disturbed sense of reality
- Transient psychotic episodes

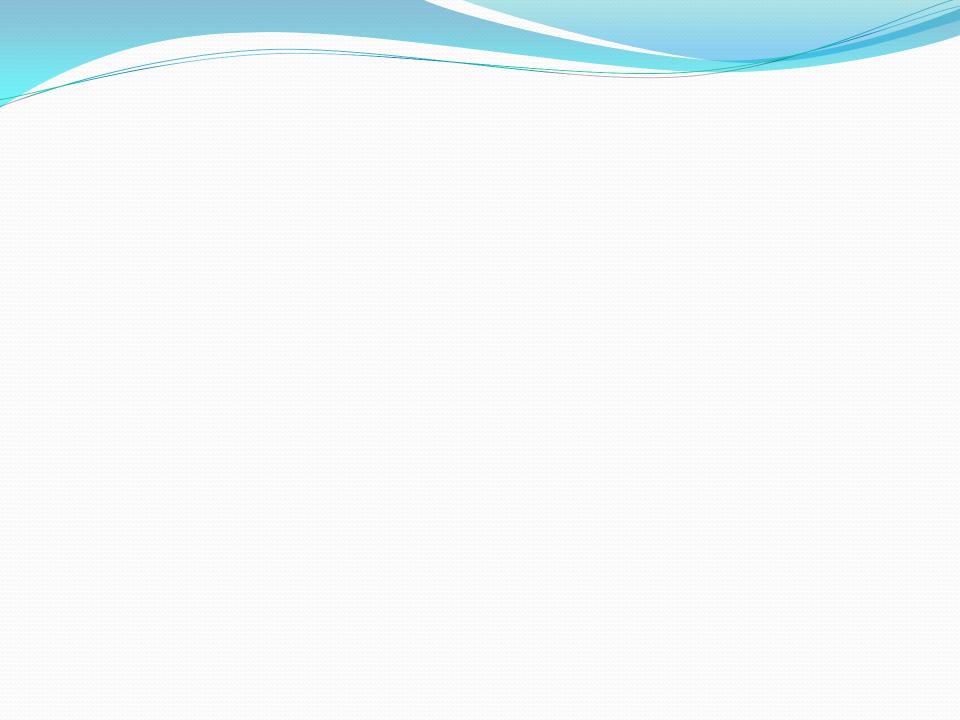
# ■ADHD (uncomplicated by BPD):

• Does not include:

Self-destructiveness

Unstable relationships

Fragile sense of reality



- Course & Prognosis
- Inconsistent findings
- Limited evidence of:
- Developmental continuity of BPD symptoms
- From adolescence into adulthood

- Most support a developmental trajectory:
- There are **primary disturbances**
- That give rise to cooccurring internalizing & externalizing symptoms
- Which interfere with normal personality development
- Lead to dysfunctional patterns of coping/relating.
- → lead to adolescent BPD
- & develop into adult BPD.

 Adolescence/young adulthood with BPD are marked by:

Affective dyscontrol

Interpersonal storms

Impulsive behavior

Self-destructive behavior

Most notable during late adolescent/young adult:

Family dysfunction

Occupational impairment

Suicide risk

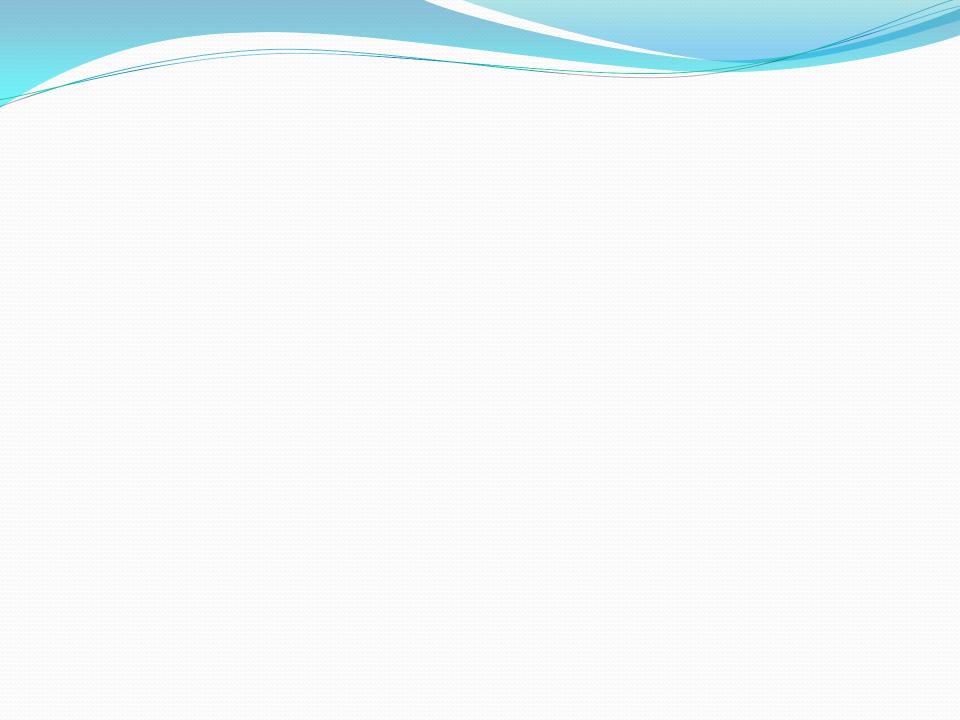
Substance abuse

# □ During middle age:

Symptoms' intencity decrease

• 

Can have greater stability in their relationships.



The most common disorders cooccurring with adult BPD:

Avoidant PD

Dependent PD

Narcissistic PD

Antisocial PD

Paranoid PD

This differentiation is supported by:

 Genetic, epidemiologic, & follow-up studies of adult BPD

That discriminate

BPD

• From the schizophrenia-schizotypal spectrum.

