BPD in Child & Adolescent: Comorbidity

Elham Shirazi, MD
Board of General Psychiatry
Board of Child & Adolescent Psychiary

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*.

- **<u>Adult BPD is often comorbid with</u>**
- 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**

- **<u>The cross-sectional presentation of:</u>**
- 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

- **<u>Childhood presentations of bipolar or dysthymic disorders:</u>**
- 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

- **<u>Repeated traumatization can result in:</u>**
- Reenactment, avoidance, dissociation, & hyperarousal
- **<u>Influence the child's/adolescent's patterns of:</u>**
- 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)

- **<u>Differrential Diagnosis:</u>**

- 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

- **& Present:**

- Constricted, flat, or inappropriate affect

- Oddness of speech

- Discomfort in social situations

- **<u>These features contrast with:</u>**
- Intense, dramatic affect
- Hunger for social response of borderline youths.

- **But:**
- 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.

- **<u>Narcissistic/histrionic children are:</u>**
- 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

- **<u>Most support a developmental trajectory:</u>**
- 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

- **<u>Most notable during late adolescent/young adult:</u>**

- 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.