

An Evaluation of Clinical Practice Guidelines for Self-Harm in Adolescents: The Role of Borderline Personality Pathology

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Borderline personality disorder (BPD) is associated with high rates of self-harm, suicide attempts, and death by suicide in adults and adolescents. Screening and assessment of BPD in self-harming adolescents could be an important clinical intervention. The aim of this article was to identify whether existing clinical practice guidelines (CPGs) for the care of self-harm in adolescents considered the screening, diagnosis, and/or treatment of BPD. Previous work by Courtney, Duda, Szatmari, Henderson, and Bennett (2018) used Preferred Reporting Items for Systematic Reviews and Meta-Analyses methods to identify 10 CPGs relevant to self-harm in children and adolescents. In this study, the 10 CPGs were reviewed for content about screening, assessment, and/or treatment recommendations for adolescents with BPD. Out of the 10 CPGs, 4 acknowledged the association between BPD and self-harm in adolescents. There was minimal to no guidance provided in the CPGs regarding specific screening, assessment, or treatment strategies for BPD. This may be due to the lack of evidence for efficacy and effectiveness of screening for BPD, thereby limiting the development of guideline recommendations. Studies that examine the impact of screening for BPD in clinical settings are needed. In the interim, CPGs should cite the prevalence of BPD in adolescents who self-harm and reference research showing the benefit of treatment with dialectical behavioral therapy for self-harm and suicide attempts in youth with BPD.

Keywords: borderline personality disorder, self-harm, major depressive disorder, adolescents, clinical practice guidelines

Self-harm is an important indicator of mental health disturbance in adolescents and one of the major reasons for admission to an inpatient adolescent unit in different parts of the world (Cohen, Spirito, Apter, & Saini, 1997). It is a major risk factor for suicidal ideation (SI), suicide attempts, and death by suicide (Ribeiro et al., 2016). Self-harm may or may not involve suicidal intent (Hawton, Saunders, & O'Connor, 2012).

In community samples, the prevalence of self-harm in adolescents is estimated to be between 5% and 10% over a 12-month

period (Madge et al., 2008; Patton et al., 2007) and 17% during the adolescent's lifetime at the time of reporting (Gillies et al., 2018). Clinical prevalence of self-harm is higher; up to 85% of young people experiencing depressive symptoms also report engaging in self-harm (Kovacs, Goldston, & Gatsonis, 1993). Repetition of self-harm is common in adolescents, with 40% of adolescents reporting continued self-harm at 1 year (Heerde et al., 2015) and 15% to 20% of individuals returning to hospital within a year of their previous visit for self-harm (Hawton & Harriss, 2008).

This article was published Online First September 2, 2019.

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This guideline search step of the research was funded by the Cundill Centre for Youth Depression and the Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health. The authors acknowledge and thank Joanna Henderson and Peter Szatmari for their leadership in the guideline search. The authors declare that they have no competing interests.

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Self-harm occurs in the context of many psychiatric disorders. In adolescents, the most common comorbid disorders are major depressive disorder (MDD) and borderline personality disorder (BPD; Haw, Hawton, Houston, & Townsend, 2001). In clinical samples, 40% to 50% of adolescents who self-harm have a diagnosis of MDD (Jacobson, Muehlenkamp, Miller, & Turner, 2008; Nock, Joiner Jr., Gordon, Lloyd-Richardson, & Prinstein, 2006), and 11% to 50% of these adolescents have a diagnosis of BPD (Chanen et al., 2004, 2008; Grilo et al., 1996). Both MDD and BPD have been shown to be among the strongest predictors of self-harm in adolescents, as well as predicting continued risk for suicide attempts in adulthood (Sharp et al., 2012; Weissman et al., 1999; Yen et al., 2003). Given that approximately 50% to 70% of adolescents with BPD have comorbid MDD (Andrewes, Hulbert, Cotton, Betts, & Chanen, 2017; Horesh, Orbach, Gothelf, Efrati, & Apter, 2003), it can be argued that BPD, MDD, or both conditions are highly associated with self-harm in clinical settings.

Despite evidence supporting the reliability and validity of BPD during adolescence (Chanen, 2015; Kaess, Brunner, & Chanen, 2014; Sharp, 2016; Sharp & Fonagy, 2015; Sharp, Tackett, & Oldham, 2014), the diagnosis is stigmatized among clinicians. Many clinicians deliberately avoid diagnosing BPD in adolescents with the aim of “protecting” these adolescents from discrimination by other health professionals (Chanen, Sharp, & Hoffman, 2017). However, this practice may propagate negative stereotypes, increase the likelihood of inaccurate diagnosis, and reduce the opportunity for adolescents to be exposed to interventions that have been shown to reduce BPD symptoms and prevent suicide attempts (Andrewes et al., 2017). For instance, up to 76% of adolescents with first-presentation BPD seeking help from adolescents’ mental health services reported engaging in current self-harm, with 66% reporting at least one suicide attempt over the previous year (Andrewes et al., 2017). Because data suggests considerable malleability and flexibility of BPD traits in adolescence (Lenzenweger & Castro, 2005), this is a key developmental period for early intervention (Gunderson et al., 2011; Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010).

Over the past few years, there has been a growing movement advocating for increased screening and early identification of adolescents with features of BPD (Chanen & McCutcheon, 2013; Chanen et al., 2017). Current early intervention programs, such as Helping Young People Early (Chanen, McCutcheon, et al., 2009) and emotion regulation training (Schuppert et al., 2009), have been designed to specifically target adolescents with BPD. These programs are based on randomized controlled trials of psychotherapies, such as cognitive analytic therapy (CAT), which have shown significant, clinically substantial improvement in BPD adolescents, demonstrating “proof of concept” for early intervention in BPD (Chanen, Jackson, et al., 2009; Schuppert et al., 2012). Such initiatives are promising and may help to decrease fears of iatrogenic harm arising from early diagnosis and treatment specifically for BPD (Chanen & McCutcheon, 2008; Chanen et al., 2017). However, it is important to note that no studies have yet tested the efficacy and effectiveness of screening for BPD adolescents.

Given the importance of early diagnosis of BPD and its high prevalence in adolescents with suicidal behaviors, it is reasonable to expect that practice guidelines for the treatment of self-harm in adolescents may address (a) screening for BPD in adolescents who harm themselves and/or (b) referral for diagnostic clarification and

treatment of BPD. Whether or not this evidence has been translated into clinical practice guidelines (CPG) recommendations is unknown. The aim of this article is to review existing CPGs that address the assessment, prevention or treatment of self-harm in children and adolescents for recommendations, or commentary, relevant to the screening, diagnosis, and treatment of BPD or BPD symptoms.

Method

Search Strategy and Selection Criteria

Previous work by Courtney and colleagues (Courtney et al., 2018) used Preferred Reporting Items for Systematic Reviews and Meta-Analyses methods to identify CPGs, practice parameters or committee recommendations relevant to the assessment, prevention or treatment of suicide-related behavior or self-harm in adolescents, defined as persons less than 19 years of age. Eligible documents were appraised by two independent trained reviewers using the Appraisal of Guidelines for Research and Evaluation (AGREE II; Brouwers et al., 2010) tool and designated as being either of minimum ($\geq 50\%$) or high ($\geq 70\%$) quality using three AGREE II domain scores [stakeholder involvement, rigor of development (clinical validity/trustworthiness), editorial independence]. This effort identified 10 documents (Table 1) eligible for consideration in this study (Carter et al., 2016; Cincinnati Children’s Hospital Medical Centre, 2011; Doan, LeBlanc, Roggenbaum, & Lazear, 2012; National Collaborating Centre for Mental Health (U.K.), 2004; Penn & Thomas, 2005; Plener et al., 2016; White, 2014; Working Group of the Clinical Practice Guideline for Prevention & Treatment of Suicidal Behavior, 2012; National Institute for Health and Care Excellence, 2012).

Data Analysis

Each of the 10 documents was read in detail by two independent raters (KB and JC) to identify each specific mention of BPD or the terms borderline personality “symptoms” or “traits.” Raters categorized each identified instance as being relevant to one or more of the content areas of any of screening, assessment, or treatment of BPD, BPD symptoms, or traits. Raters also noted whether the instance was an evidence-based recommendation or simply a mention in the text without a specific recommendation. Disagreements were resolved through consensus with coauthors.

Results

Four of the 10 eligible CPGs made mention of BPD in adolescents at any point in the document (Carter et al., 2016; National Collaborating Centre for Mental Health (U.K.), 2004; Working Group of the Clinical Practice Guideline for Prevention & Treatment of Suicidal Behavior, 2012; National Institute for Health and Care Excellence, 2012). Two of the four CPGs (National Collaborating Centre for Mental Health (U. K.), 2004; Working Group of the Clinical Practice Guideline for Prevention & Treatment of Suicidal Behavior, 2012) were rated as minimum quality in the previous work by Courtney and colleagues (2018), one met high quality criteria (National Institute for Health and Care Excellence, 2012) and one was rated below minimum quality (Carter et al.,

Table 1
Borderline Personality Disorder Information Within Clinical Practice Guidelines for Self-Harm in Adolescents

Guideline	Organization	Is screening for borderline personality disorder (BPD) recommended/mentioned in the guideline?	Are screening procedures for BPD described?	Are evidence-based recommendations on BPD management/treatment provided?	Other commentary related to BPD?
Self-harm in children over the age of 8 years: long-term management (National Institute for Health and Care Excellence, 2012)	National Institute for Health and Care Excellence (United Kingdom)	No	No	<ul style="list-style-type: none"> Yes; in a separate referenced document for BPD (NICE, 2009). Recommendations include assessment, care planning, management, psychological treatment (DBT); drug treatment is discouraged. 	<ul style="list-style-type: none"> A wide range of psychiatric problems, such as BPD, depression, bipolar disorder, schizophrenia, and drug and alcohol-use disorders, are associated with self-harm (p. 4). During risk assessment, in general, the guideline encourages identification of any psychiatric illness and its relationship to self-harm (p. 8). People diagnosed as having certain types of mental disorder are much more likely to self-harm. For this group, the recognition and treatment of these disorders can be an important component of care (p. 22). Self-harm is considered to be one of the defining features of both BPD and histrionic personality disorder (p. 22).
Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (National Collaborating Centre for Mental Health (U.K.), 2004)	National Institute for Health and Care Excellence (NICE; United Kingdom)	No	No	<ul style="list-style-type: none"> Yes; for people who self-harm and have a diagnosis of BPD, consideration may be given to the use of DBT (p. 69). This should not preclude other psychological treatments with evidence of effectiveness for people with this diagnosis, but not reviewed for this guideline. 	<ul style="list-style-type: none"> BPD is associated with high risks of repeated DSH and suicide (p. 971). The majority of adults (83.9%) and adolescents who present for hospital-treated DSH have an underlying psychiatric disorder (p. 956). Psychosocial assessment by a trained mental health professional may have an effect on DSH repetition rates. Further evaluation is warranted (p. 956).
Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm (Carter et al., 2016)	The Royal Australian and New Zealand College of Psychiatrists (New Zealand, Australia)	No	No	<ul style="list-style-type: none"> Yes; people with BPD who self-harm should be offered psychological therapies that have been shown to reduce the number of repetitions of DSH, such as DBT, CBT, or MBT (p. 970). For children and adolescents who self-harm, consider offering CBT, MBT, or DBT, where suitable (p. 970). Do not rely on group therapy alone to reduce the risk of repetition of DSH in people with BPD who self-harm (p. 970). Do not use pharmacotherapy specifically for the purpose of reducing the risk of repetition of DSH in people with BPD who self-harm (p. 970). 	<ul style="list-style-type: none"> BPD is associated with high risks of repeated DSH and suicide (p. 971). The majority of adults (83.9%) and adolescents who present for hospital-treated DSH have an underlying psychiatric disorder (p. 956). Psychosocial assessment by a trained mental health professional may have an effect on DSH repetition rates. Further evaluation is warranted (p. 956).

Table 1 (continued)

Guideline	Organization	Is screening for borderline personality disorder (BPD) recommended/mentioned in the guideline?	Are screening procedures for BPD described?	Are evidence-based recommendations on BPD management/treatment provided?	Other commentary related to BPD?
Clinical practice guideline for the prevention and treatment of suicidal behavior (Working Group of the Clinical Practice Guideline for Prevention and Treatment of Suicidal Behaviour, 2012)	Ministry of Health and Social Policy, Galician Health Technology Assessment Agency (Spain)	No	No	Screening/assessment recommendations: 1. Children and adolescents with presence of risk factors for suicidal behavior are recommended to undergo a comprehensive psychopathological and social assessment, paying particular attention to the presence of comorbidity (p. 35). 2. In primary care, it is suggested to implement suicide risk screening programs in adolescents with the presence of suicide risk factors who may need to be referred to a specialist service (p. 34).	
Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care (LeFevre, 2014)	United States Preventive Services Task Force (United States)	No	No	Treatment recommendations: 1. Specific psychotherapeutic treatment is recommended in adolescents: DBT in BPD and CBT in major depression. For anticonvulsant treatment of BPD, carbamazepine is recommended as the first-choice drug to control the risk of suicidal behavior (p. 30).	
Practice Guidelines for Working With Children And Youth At-Risk for Suicide in Community Mental Health Settings (White, 2014)	Ministry of Children and Family Development, British Columbia (Canada)	No	No		

(table continues)

Table 1 (continued)

Guideline	Organization	Is screening for borderline personality disorder (BPD) recommended/mentioned in the guideline?	Are screening procedures for BPD described?	Are evidence-based recommendations on BPD management/treatment provided?	Other commentary related to BPD?
Youth suicide prevention school-based guide—Issue Brief 5: Suicide prevention guidelines (Doan, LeBlanc, Roggenbaum, & Lazear, 2012)	Department of Child & Family Studies, Louis de la Parte Florida Mental Health Institute, USF College of Behavioral & Community Science (United States)	No	No		
Best Evidence Statement: Preventing patient self-harm (Cincinnati Children's Hospital Medical Centre, 2011)	Cincinnati Children's Hospital Medical Centre (United States)	No	No		
Practice parameter for the treatment of youth in juvenile detention and correctional facilities (Penn and Thomas, 2005)	American Academy of Child & Adolescent Psychiatry (United States)	No	No		
Treating nonsuicidal self-injury in adolescents: consensus-based German guidelines (Plener et al., 2016)	Department of Child and Adolescent Psychiatry and Psychotherapy, Central Institute of Mental Health (Germany)	No	No		

Note. DSH = deliberate self-harm; CBT = cognitive behavioral therapy; DBT = dialectical behavioral therapy; MBT = mentalization-based therapy.

2016). Table 1 displays the content of each of these four CPGs relevant to BPD, BPD symptoms, or traits, while further description is as follows.

The most detailed mention of BPD was included in the Royal Australian and New Zealand College of Psychiatrists' Clinical Practice Guideline for the Management of Deliberate Self-Harm (DSH; Carter et al., 2016). This CPG aimed to provide guidance and advice regarding the management of DSH in patients within an evidence-based framework, supplemented by expert clinical consensus. This guideline includes commentary on adolescents as a special population. The guideline acknowledges, "the majority of adults (83.9%) and adolescents who present for hospital-treated DSH have an underlying psychiatric disorder" (p. 956). In terms of assessment, the guideline notes that "psychosocial assessment by a trained mental health professional may have an effect on DSH repetition rates." They note that "further evaluation of BPD is warranted" (p. 956) but do not mention how to screen or diagnose BPD. For treatment, the guideline recommends that in general, people with BPD who self-harm "should be offered effective psychological therapies that have been shown to reduce the risk of repetition of DSH, such as dialectical behavior therapy (DBT), cognitive behavioral therapy (CBT) or mentalization-based therapy (MBT)" (p. 941). In addition, the guideline suggests that pharmacotherapy is not effective for reducing repetition of DSH among people with BPD and should not be initiated unless otherwise indicated for comorbid disorders. Specific commentary regarding treatment for adolescents versus adults is not differentiated. Although many comments regarding BPD were made in this guideline, it did not achieve an AGREE II quality rating (Courtney et al., 2018).

The CPG with the next most detailed mention of BPD was the "Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior" by Spain's Working Group of the Clinical Practice Guideline for Prevention & Treatment of Suicidal Behavior (2012). This guideline contains recommendations regarding assessment, prevention, and treatment of suicidal behavior in primary and secondary health-care settings and received a minimum quality rating (Courtney et al., 2018). The guideline recommends "paying particular attention to the presence of comorbidity" (p. 8) and conducting a "comprehensive psychopathological and social assessment" (p. 7) when assessing adolescents who self-harm, similar to the process for adults. It mentions that BPD and antisocial personality disorder are the most common comorbid personality disorders in people who self-harm (p.56). There was no guidance regarding screening or diagnostic tools specifically for BPD. However, treatments are discussed for patients with BPD who engage in self-harm, specifically DBT for both adolescent and adult patients. It is also stated that "[f]or anticonvulsant treatment of BPD, carbamazepine is recommended as the first choice drug to control risk of suicidal behaviors" (p. 5). It should be noted that this specific recommendation was given a grade of C by the guideline authors, as it was based off of one systematic review (Ernst & Goldberg, 2004).

The guideline by NICE and National Collaborating Centre for Mental Health focuses on the short-term management and secondary prevention of self-harm in primary and secondary care (National Collaborating Centre for Mental Health (U.K.), 2004). Acknowledging the association between self-harm and mental disorders, the guideline specifically mentions "self-harm is con-

sidered to be one of the defining features of both BPD and histrionic personality disorder" (p. 22). Beyond this, no mention is made of specific screening or assessment of BPD in persons who engage in self-harm. In terms of assessment, the guideline recognizes personality disorders as a predictor of high risk of fatal or nonfatal repetition of self-harm and mentions that people with personality disorders might "need a long-term strategy for treatment and help in specialist services" (p. 159). The guideline recommends treatment of BPD using DBT for individuals aged 8 years and over (p. 69) based on evidence from one randomized controlled trial (Linehan et al., 1991).

NICE also published a CPG for the long-term management of self-harm in children over the age of 8 years (National Institute for Health and Care Excellence, 2012) as a follow-up to the previously mentioned document. This CPG, NICE Clinical Guideline 16 (National Institute for Health and Care Excellence, 2012), focused on the treatment of self-harm within the first 48 hr of a self-harm incident. These were the only guidelines that received a high quality AGREE II rating (Courtney et al., 2018). Acknowledging that BPD is associated with self-harm, the guidelines direct the reader to a separate document for its management and treatment (National Institute for Health and Care Excellence, 2009). There is no other mention of screening or assessment procedures for BPD adolescents within this guideline.

Discussion

BPD is known to be an important comorbidity—or primary disorder—which influences both the severity and treatment responsiveness of self-harm in adolescents (Andrewes et al., 2017; Sharp et al., 2012; Yen et al., 2003). Our aim in this report was to identify whether CPGs relevant to self-harm contain recommendations—or commentary—relevant to the screening, assessment or treatment of adolescents with BPD.

Among the 10 self-harm CPGs identified in previous work (Courtney et al., 2018), we found that only four made any mention of BPD (Table 1). Within these four guidelines, there is no guidance regarding specific screening or assessment recommendations for BPD in adolescents. However, there is commentary that recognized that "self-harm is considered to be one of the defining features of both BPD and histrionic personality disorder" (National Collaborating Centre for Mental Health (U.K.), 2004, p. 22). More generally, the guidelines acknowledge that "people diagnosed as having certain types of mental disorder are much more likely to self-harm. For this group, the recognition and treatment of these disorders can be an important component of care" (National Collaborating Centre for Mental Health (U.K.), 2004, p. 22).

Each CPG referenced the use of psychotherapy, specifically DBT to treat self-harm in adolescents with BPD. DBT is one of three evidence-based treatments for BPD symptoms in adolescents (Panos, Jackson, Hasan, & Panos 2014; Linehan, 1993), with the other two being CAT and MBT (Bateman & Fonagy, 2008, 2009, 2010; Clarkin et al., 2001; Ryle & Kerr, 2002). These latter two therapies were mentioned in two of these four CPGs (Table 1).

One CPG (National Institute for Health and Care Excellence, 2012) specifically referenced readers to the NICE Clinical Guideline 78, a detailed guideline for treatment of BPD (National Institute for Health and Care Excellence, 2009). Referring to another

guideline is appropriate considering that the management of BPD is multifaceted and complex.

Each of the four CPGs notes that pharmacotherapy is currently thought to be ineffective in relieving core symptoms of BPD and is not recommended as a treatment. One CPG (*Working Group of the Clinical Practice Guideline for the Prevention & Treatment of Suicidal Behavior, 2012*) recommended the use of carbamazepine for prevention of suicidal behaviors (p. 5) based on evidence rated as Grade C according to the Scottish Intercollegiate Guidelines Network (SIGN) Grades of Recommendation (*Harbour & Miller, 2001*). This grade is given to a body of evidence consisting of “well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal” (*Harbour & Miller, 2001*).

We recommend that developers of CPGs for adolescent self-harm consider the following suggestions in future guideline iterations:

1. Given the prevalence and predictive role of BPD in self-harm severity in adolescents (*Andrewes et al., 2017; Chanen & McCutcheon, 2013; Sharp et al., 2012*), all guidelines regarding the care of self-harm in adolescents should make mention of BPD as a common comorbidity, citing comorbidity rates.
2. Given reported positive outcomes in studies on DBT, CAT, and MBT, guideline developers should review and appraise the controlled clinical trials assessing treatment

Table 2

Selected Validated Screening and Assessment Measures for Adolescent Borderline Personality Disorder

Measures	Number of items; response format	Administration and scoring time	Psychometric properties
Screening tools			
MSI-BPD (<i>Chanen et al., 2008; Gardner & Qualter, 2009; Noblin, Venta, & Sharp, 2014; Zanarini et al., 2003</i>)	10 items; yes/no clinician-reported scale	NA	Internal consistency: .73–.78 Sensitivity: .71–.90 Specificity: .75–.93 Diagnostic accuracy: .73–.83 NPV: .89
BPFS-C (<i>Chang, Sharp, & Ha, 2011; Crick, Murray–Close, & Woods, 2005</i>)	24-items; self-reported scale	NA	Internal consistency: .76–.88 Sensitivity: .85 Specificity: .84 Diagnostic accuracy: NA
BPFS-C-11 (<i>Sharp, Mosko, Chang, & Ha, 2011; Sharp, Steinberg, et al., 2014</i>)	11-items; self-reported scale	NA	Internal consistency: .85 Sensitivity: .740 Specificity: .714 Diagnostic accuracy: .80
BPQ (<i>Chanen et al., 2008; Poreh et al., 2006</i>)	80 items; true/false self-reported scale	NA	Internal consistency: .92 Sensitivity: .68 Specificity: .90 Diagnostic accuracy: .85 NPV = .91
BSL-23 (<i>Bohus et al., 2007</i>)	23 items; self-reported scale	NA	Internal consistency: .935–.936 Sensitivity: .90 Specificity: .93 Diagnostic accuracy: NA
Assessment measures			
CI-BPD (<i>Zanarini, 2003</i>)	Nine items; clinician interview	30–45 mins	Internal consistency: .81 External validity: associates with PAI-BOR ($r = .66$), BPFS-C, clinician diagnosis ($\kappa = .34$), internalizing and externalizing problems
PAI-BOR (<i>Morey, 2007</i>)	20 items; self-report scale	15 mins	Internal consistency: .85–.87 External validity: associated with range of other BPD relevant pathology, CI-BPD
SCID II (<i>First, 1997; First, Williams, Benjamin, & Spitzer, 2016</i>)	Nine items for BPD; clinician interview	30 mins	Internal consistency: .71–.94 External validity: associates with the BPQ ($\kappa = .57$) Diagnostic accuracy: .80 NPV: .89
DIB-C (<i>Guzder, Paris, Zerkowitz, & Feldman, 1999; Greenman, Gunderson, Cane, & Saltzman, 1986</i>)	24 items; clinician interview	30 mins	Interrater reliability, $k = .72$

Note. NA = not available; MSI-BPD = McLean Screening Instrument for BPD; BPFS-C = Borderline Personality Disorder Features Scale for Children; BPQ = Borderline Personality Questionnaire; BSL = Borderline Symptom List; CI-BPD = Childhood Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* Borderline Personality Disorder; PAI-BOR = Personality Assessment Inventory–Borderline Features; SCID-II = Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders* Disorders–Axis II Disorders; DIB-C = Diagnostic Interview for Borderline Personality Disorder–Child Version; NPV = Negative Predictive Value.

of adolescents with features of BPD and subsequently make corresponding clinical recommendations.

Research Questions for Future CPGs

At present, there are no prospective trials evaluating the predictive validity, benefits, or harms of screening for BPD in adolescents who engage in self-harm. Future research is needed to determine the impact of screening, diagnosis and treatment of adolescent BPD in the context of primary outcomes such as clinical efficacy, as well as patient satisfaction and clinician acceptability. A key research question for self-harm CPG developers to consider going forward is as follows: “For adolescents who present with a history of self-harm, does screening for borderline personality disorder improve outcomes?”

To conduct this research, it is important to recognize that several screening measures have been validated for BPD in adolescents, and further research is needed to determine which of these measures are most useful in which settings. For example, there are several self- and clinician-report scales advocated for screening of BPD in adolescents (Table 2). Two instruments that do not require clinician training to administer include the McLean Screening Instrument for BPD (Zanarini et al., 2003), the Borderline Personality Features Scale for Children (Chang, Sharp, & Ha, 2011; Crick, Murray–Close, & Woods, 2005), and its shorter 11-item version (BPFSC-11; Sharp, Mosko, Chang, & Ha, 2011; Sharp, Steinberg, Temple, & Newlin, 2014). The Borderline Personality Questionnaire (Poreh et al., 2006) has been shown to achieve the best balance of the desired properties in a screening instrument such as high sensitivity (the true positive rate) and high negative predictive value (probability that a negative test means the person does not have the condition; Chanen et al., 2008), but its length (90 items) might preclude more widespread clinical application. Another research question is “Which measures have the most robust evidence for screening and diagnosing BPD in adolescents?”

One post screening intervention for adolescents who screen positive for BPD should include a diagnostic assessment, ideally, using a structured diagnostic instrument (see Table 2 for examples). These tools require training or advanced clinical skill. Clinicians should consider psychiatric referral for adolescents with suspected BPD, given their need for specialized services in most cases.

There are also several personality trait measures that will avail the assessment of BPD traits consistent with the *Diagnostic and Statistical Manual of Mental Disorders, –Fifth Edition*, Alternative Model of Personality Disorders (American Psychiatric Association, 2013). These measures include the Personality Inventory for *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, (De Clercq, Decuyper, & De Caluwé, 2014), the Dimensional Inventory of Personality Symptom Item Pool (De Clercq, De Fruyt, Van Leeuwen, & Mervielde, 2006), the Five Factor Borderline Inventory (Mullins-Sweatt et al., 2012), and the Personality Diagnostic Questionnaire – 4 (Bagby & Farvolden, 2004). Other than the Personality Inventory for *Diagnostic and Statistical Manual of Mental Disorders, –Fifth Edition* and the Dimensional Inventory of Personality Symptom Item Pool, these measures have yet to be tested for use in adolescents. It is important to mention these measures for future study in adolescents, as the field will not

move forward if the clinical utility of these measures are not also demonstrated in young people.

Until screening research has been conducted, there is sufficient evidence available about the prevalence and stability of adolescent BPD as well as the reliability of screening tools to justify convening an expert group to generate consensus about specific recommendations about the assessment and treatment of adolescents who self-harm who may also have BPD. The use of transparent methods (e.g., A Delphi Process; Jorm, 2015) throughout this process is indicated.

Limitations and Future Research

Because research about the validity of BPD in adolescence and its treatment has burgeoned in recent years, this could be a reason why some of the selected CPGs in our research did not address BPD in adolescents who self-harm in greater detail. Updating of CPGs is therefore needed. Given the high comorbidity between BPD and other psychiatric disorders such as MDD and substance abuse disorders (Sharp & Fonagy, 2015), it is important to also explore the assessment, diagnosis, and treatment of BPD in the context of CPGs for these conditions in adolescents.

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