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BRIEF REPORT

Associations Between Borderline Personality Disorder Symptoms and Personality Functioning in Adolescents: A Brief Report

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Borderline personality disorder (BPD) is a serious mental disorder, which has been linked to a number of negative outcomes in adolescents and adults. BPD is generally linked to more severe impairments in personality functioning. The (differential) association of specific BPD symptoms with severity level, however, has not been explored yet. The present study explores the relationship between all nine BPD symptoms and impairments in personality functioning in adolescents using a cross-sectional design. A total of 116 treatment-seeking adolescents were administered semistructured interviews for *DSM-IV* Axis I and Axis II disorders and the semistructured interview for personality functioning *DSM-5* (STiP-5.1). Furthermore, the potential association of symptom disorders, and more specifically mood disorders, with level of personality functioning was assessed. Together, the nine BPD criteria were significantly related to STiP-5.1 total score, even when controlling for the presence of a mood disorder. However, when taking the effect of number of symptom disorders and the other BPD symptoms into account, only the presence of recurrent self-harm and/or suicidal behavior and intense anger, were associated with a higher level of impairment in personality functioning. These findings emphasize the diagnostic importance of repeated self-harm and suicidality and provide additional evidence for the value of using BPD criteria to easily identify teenagers at risk.

Keywords: borderline personality disorder, level of personality functioning, Section-II personality disorder, repeated self-harm and suicidality, adolescents

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Borderline personality disorder (BPD) is a serious mental disorder with long-lasting consequences for professional, social, mental, and physical functioning (Videler et al., 2019).

Typical BPD symptoms, such as self-harm and suicidality, often first appear in adolescence (Brager-Larsen et al., 2022) and pose risks for social and academic functioning (Hastrup et al., 2022). This warrants early detection and intervention in youth who are at high risk of developing BPD (Hutsebaut et al., 2023). However, single symptoms of BPD, like self-harm, are also prevalent (Gillies et al., 2018) and changeable (d'Huart et al., 2022), questioning their utility to identify young persons with severe personality pathology at risk for long-term disability.

The Alternative Model for Personality Disorders (AMPD; American Psychiatric Association [APA], 2013) and more specifically, the Level of Personality Functioning Scale (LPFS) were introduced to capture better the core of personality pathology. The AMPD shifts focus from behavioral and experiential manifestations of psychopathology (Criterion A in Section II) to latent personality impairments (Criterion A in Section III) and traits (Criterion B in Section III) (Hutsebaut & Bender, in press). Interestingly, a recent study showed superiority of the AMPD, and more specifically of the LPFS, in predicting future disability outcomes in a (homogeneous) clinical sample of adults with PDs as compared to Section-II PDs (Weekers et al., 2024). Although the AMPD aims to replace the former classification model, both approaches may therefore be complementary when assessing personality pathology. The AMPD may better capture core impairments predictive of future disability, while the Section-II model may be better at capturing concrete symptoms, that is, self-harm.

To the best of our knowledge, there are no studies explicitly exploring the relationship between severity of impairments (Section III) and occurrence of specific personality disorder (PD) symptoms (Section II) in young persons. Early detection could benefit from identifying

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specific concrete PD symptoms closely associated with (severe) impairments in personality functioning. The concrete nature of Section-II PD symptoms makes them accessible for early detection, but identifying associated lower levels of personality functioning may be significant for predicting future psychosocial disability (Weekers et al., 2024). Although the Section-II model is polythetic in nature, some Section-II BPD features may indicate more severe levels of functioning compared to other features. For example, a previous study showed that a loss of control over emotions was less related to personality pathology in puberty than in adulthood, while symptoms of relational impairments on the other hand required more severe personality impairments to become manifest in adolescents (Debast et al., 2017). Such findings suggest that different BPD symptoms may require more or less latent impairments to manifest themselves in adolescents. However, the study lacks formal PD criteria and does not use the AMPD's concept of personality functioning, raising questions about the identified symptoms reflecting true PD symptoms and limiting its overall usefulness.

The current study is a cross-sectional study aimed to explore the relationship between all nine symptoms of BPD and impairments in personality functioning in adolescents recruited in a clinical setting. We chose BPD given the evidence that BPD features reflect severe, general personality pathology (Sharp et al., 2015) and given the evidence that BPD features may emerge early in puberty, making them suitable for early detection (Hutsebaut et al., 2023). In addition, we controlled for symptom disorders, to assess whether BPD symptoms would still be associated with severe impairments after controlling for other frequently occurring symptoms of mental disorder. Mood disorders were specifically selected, as mood disorder symptoms and BPD symptoms have considerable overlap (e.g., emptiness, suicidality, and self-harm). We had no specific hypotheses beforehand given the lack of previous studies.

Method

Participants

The data for this study were derived from three different studies, more details can be found in Hutsebaut et al. (2017) and Weekers et al. (2021, 2022). For the present study, we included all adolescents aged 12–19 from these previous studies, resulting in a total of 116 treatment-seeking adolescents. The study was conducted in a specialized mental health care center, de Viersprong, which focuses on addressing personality-, conduct-, and family-related issues among adolescents and adults. The age of the participants ranged from 12 to 19 years ($M_{age} = 16.16$, $SD = 1.76$), 89.7% of them were female.

Procedure

The standard admission procedure consisted of semistructured interviews to assess the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*) Axis I and Axis II disorders. In addition, all adolescents underwent the semistructured interview for personality functioning *DSM-5* (STiP-5.1) to assess the level of personality functioning. The administration of the STiP-5.1 took place after an initial consultation with a clinician which involved both adolescents and their parents. The psychologist who was administrating the STiP-5.1 was only informed about the name and age of the participant. Prior to the interview, informed consent to participate in the study was obtained from the adolescent, and if they were under 16 years of age, parents also provided consent.

Prior to data analysis a power analysis was conducted. With a power of .80, $\alpha = .05$, and nine predictor variables in the linear regression model at least 114 participants were needed to detect a medium effect size ($f^2 = 0.15$) (G*Power; Faul et al., 2007). The Ethics Committee of the University of Amsterdam granted approval for this study.

Measures

Semistructured Interview for DSM-5 Personality Functioning (STiP-5.1)

The STiP-5.1 is a clinical interview based on the LPFS of the AMPD included in Section III of *DSM-5* (APA, 2013; Hutsebaut et al., 2017). The interview structure revolves around the 12 facets outlined in the LPFS. Each of the facets has five levels of severity, that should be scored during the interview on a scale ranging from 0 (*minimal or no impairment*) to 4 (*extreme impairment*). Subsequently, the scores for both the self-functioning scale and interpersonal functioning scale are obtained based upon clinical interpretation (Hutsebaut et al., 2017). Acceptable to good interrater reliability was found in a clinical (adolescent) sample, with intraclass correlation coefficients (ICCs) ranging from .57 to .96 for the domain of self-functioning and ICCs for the domain of interpersonal functioning ranging from .73 to .97 (Weekers et al., 2022). The STiP-5.1 demonstrated good internal consistency in the present sample with Cronbach's alpha of .82 for the self-functioning domain, .86 for the interpersonal functioning domain, and a Cronbach's alpha of .90 for the total score.

Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)

The SCID-I (First, Gibbon, et al., 1997; First, Spitzer, et al., 1997; translated in Dutch by van Groenestijn et al., 1999) is a semistructured interview used to diagnose *DSM-IV* Axis I disorders. Good interrater reliability was demonstrated across various samples, particularly when interviewers have undergone formal training (which was the case in the current study), with an overall kappa of .85 (Ventura et al., 1998).

Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II)

The SCID-II (First, Gibbon, et al., 1997; First, Spitzer, et al., 1997; translated by Weertman et al., 1996), essentially identical to the current SCID-5-PD (*DSM-5*), was used to assess personality disorders. Criteria were scored as "present" if they demonstrated pathological, pervasive, and persistent characteristics. PD not otherwise specified was diagnosed when at least five PD criteria were present (Verheul et al., 2007). Good interrater and test–retest reliability within PD samples was demonstrated with ICCs of .90 for avoidant and .95 for borderline PD (Lobbestael et al., 2011).

Statistical Analysis

First, linear regression analyses were performed to assess (a) the relationship between total STiP-5.1 score and the nine BPD criteria, (b) the relationship between total STiP-5.1 and Number of Axis I disorders, and (c) the relationship between total STiP-5.1 and Mood disorders (present/absent) (d) the relationship between STiP-5.1 and Age. All predictor variables were mean-centered to

aid interpretability. Next, hierarchical linear regression was used to assess the association between total STiP-5.1 score and the nine BPD criteria when controlling for the number of Axis I disorders. As the linear regression analysis revealed no relationship between Mood disorders and STiP total score and Age and STiP total score, Mood disorder and Age were not added as predictors in the hierarchical regression model. In the first model number of Axis I disorders was added as predictor and STiP-5.1 total score as a dependent variable. In the second model, all nine BPD criteria were added to the first model. Assumptions for regression analyses were checked and met: for example, no multicollinearity between predictor variables (average variance inflation factor = 1.26), independent errors (Durbin–Watson = 1.80). Data were analyzed using SPSS Version 27. As we had more than one predictor, we also reported adjusted R^2. Pearson correlations between all predictors and outcome are presented in Table 2.

Transparency and Openness

We report how we determined our sample size, all data exclusions (if any), all manipulations, and all measures in the study. All data, analysis code, and research materials are available upon request. This study's design and its analysis were not preregistered.

Results

Clinical Characteristics of the Sample

The clinical characteristics of the study participants are summarized in Table 1 in the online supplemental materials. A significant number of participants (81.8%) fulfilled criteria for at least one Axis I diagnosis, with a mean number of Axis I diagnoses of 1.86 ($SD = 1.49$, range = 0–6). Among these, mood disorders (56.8%) and anxiety disorders (36.9%) were the most prevalent. More than half of the participants (68.7%) were identified as having a personality disorder, with the most common PD diagnoses BPD (29.6%), and PD not otherwise specified (30.4%). The prevalence rates of BPD criteria (APA, 2013) in the present sample are presented in Table 1. Criterion 5 (53%) and Criterion 6 (53%) were the most prevalent BPD symptoms. The total LPFS score measured by STiP-5.1 ranged from 1 to 4 ($M = 2.6$, $SD = 0.6$) in the present sample.

Table 1
Prevalence of the Nine Criteria of BPD (N = 116)

Criteria of BPD	*N*	%
1. Frantic efforts to avoid real or perceived abandonment	34	29
2. A recurring pattern of unstable and intense interpersonal relationships	26	22
3. Experiencing disturbances in identity	38	33
4. Demonstrating impulsiveness in at least two domains that have the potential for self-harm	28	24
5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior	61	53
6. Unstable mood characterized by marked reactivity of emotions	62	53
7. Chronic feelings of emptiness	36	31
8. Demonstrating inappropriate and intense anger or struggling to manage anger effectively	37	32
9. Experiencing temporary, stress-related paranoid thoughts or severe dissociative symptoms	29	25

Note. BPD = borderline personality disorder.

BPD Symptoms and LPF

Linear regression analysis revealed a significant association between BPD and STiP-5.1 total score ($F = 3.49$, $p < .001$, $R^2 = .24$, adjusted $R^2 = .17$). Except for Criterion 1, all criteria of BPD demonstrated significant correlations with impairments in personality functioning (see Table 2). However, when taking the effects of all BPD criteria into account, only Criterion 5 (*recurrent suicidal and/or self-harming behavior*) was significantly related to the STiP-5.1 total score. The presence of recurrent self-harm and/or suicidal behavior was associated with a higher level of impairment in personality functioning ($b = 0.16$, $p = .007$). Number of Axis I disorders was also significantly associated with STiP-5.1 total score ($F = 7.03$, $p < .009$, $R^2 = .06$), although with a small effect size. Mood disorders were not significantly associated with STiP-5.1 total score ($F = 0.20$, $p < .653$, $R^2 = .002$). Furthermore, there was no association between Age and STiP-5.1 total score ($F = 0.04$, $p = .841$, $R^2 = .00$).

Second, a hierarchical regression was performed. In the first model, number of Axis I disorders was added as predictor of STiP-5.1 total score. In the second model, all nine BPD criteria were added as predictors. When taking the effects of number of Axis I (symptom) disorders into account, as well as all separate BPD criteria, only BPD Criterion 5 (*recurrent suicidal and/or self-harming behavior*) and Criterion 8 (*inappropriate, intense anger, or difficulty controlling anger*) were significantly related to the STiP-5.1 total score. Both the presence of recurrent self-harm and/or suicidal behavior ($b = 0.13$, $p = .024$; see Table 3) and inappropriate, intense anger or difficulty controlling anger ($b = 0.12$, $p = .049$; see Table 3) were associated with a higher level of impairment in personality functioning

Discussion

The primary aim of the present study was to explore the association between BPD symptoms and severity of personality functioning impairments in treatment-seeking adolescents. Eight out of nine symptoms of BPD were significantly associated with severity of impairments, but only the presence of recurrent self-harm and/or suicidal behavior and inappropriate, intense anger or difficulty controlling anger significantly predicted a lower level of personality functioning, when controlling for other BPD symptoms and for the number of Axis I disorders. We discuss some of the main findings.

First, Mood disorders were not related to severity of impairments in personality functioning. Furthermore, although the number of Axis I disorders was related to personality functioning, with a higher number of disorders related to more severe impairments, this association disappeared when BPD symptoms were taken into account. This suggests that repeated self-harm and intense anger, even in the presence of Axis I disorders, should be understood in relation to overall personality functioning.

Second, the diagnostic relevance of self-harm and suicidal behavior has implications for early detection. Repeated self-harm at an early age may signal severe impairments of personality functioning in handling developmental challenges, often intertwined with emotions related to interpersonal relationships (Hawton, Bergen, et al., 2012; Hawton, Saunders, et al., 2012). Close to 40% of adolescents reported that challenges in friendships were the primary triggers for their suicide attempts (Hawton, Bergen, et al., 2012; Hawton,

Table 2
Pearson Correlations Between Predictors and Outcome (N = 116)

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. STiP-5.1	—											
2. Mood disorder	.04	—										
3. BPD Criterion 1	.15	−.11	—									
4. BPD Criterion 2	.27*	−.2*	.18	—								
5. BPD Criterion 3	.19*	−.10	.10	.24*	—							
6. BPD Criterion 4	.30**	−.19*	.31**	.37**	.26*	—						
7. BPD Criterion 5	.33**	.18	.15	.17	.24*	.14	—					
8. BPD Criterion 6	.22*	−.11	.22*	.31**	.17	.22*	.18	—				
9. BPD Criterion 7	.20*	.06	.09	.16	.27*	.11	.24*	.20*	—			
10. BPD Criterion 8	.24*	−.19*	.18	.22*	.03	.28*	−.27	.33**	−.11	—		
11. BPD Criterion 9	.23*	.13	.22*	.25*	.17	.13	.22*	.14	.26*	.16	—	
12. Axis I disorders	.25**	.58**	.024	−.051	.018	.072	.24*	.10	.09	.07	.22	—

Note. STiP-5.1 = semistructured interview for *DSM-5* personality functioning; BPD = borderline personality disorder; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition.
* $p < .05$. ** $p < .001$.

Saunders, et al., 2012). The quality of interpersonal relationships is crucial for adolescents with borderline features (Moscoso et al., 2019), and self-harm and suicidality may express an inability to handle developmental challenges related to emotion regulation, friendships, and self-esteem. This may in addition explain why early age of onset for self-harm predicts a higher overall incidence of nonsuicidal self-harm over the life course (Brager-Larsen et al., 2022). Early onset also increases the risk for actual suicide attempts, and repeated self-harm may be one of the more reliable signs of severe impairments, resulting in lasting disability and symptom stress.

Lastly, these findings further support the utility of BPD criteria, more specifically repeated self-harm/suicidality, and intense anger, for easily identifying teenagers at risk. While latent impairments in personality functioning may ultimately be more predictive for future disability, repeated self-harm and intense anger may be more easy to detect and still informative for possible impairments. As patients with low levels of personality functioning may be more challenging in treatment (Ehrenthal et al., 2019) and stable improvement may require improvement of personality functioning (Doering et al., 2014), young persons with repeated self-harm and suicidality and/or intense anger may be eligible for specialized treatment targeting their personality impairments.

Table 3
Impact of BPD Symptoms on the LPF (N = 116)

Model	*b*	*SE B*	95% CI *LL*	95% CI *UL*	*p*
Model 1 LPF ($R^2 = .05$, adjusted $R^2 = .04$)					
Intercept	2.586	0.054	2.478	2.694	<.001
Axis I	0.09	0.036	0.015	0.159	.019
Model 2 LPF ($R^2 = .264$, adjusted $R^2 = .189$)					
Intercept	2.582	0.050	2.482	2.681	<.001
Axis I	0.062	0.036	−0.009	0.134	.086
BPD Criterion 1	−0.006	0.059	−0.124	0.112	.921
BPD Criterion 2	0.074	0.068	−0.061	0.209	.280
BPD Criterion 3	0.024	0.068	−0.091	0.138	.684
BPD Criterion 4	0.090	0.067	−0.043	0.223	.181
BPD Criterion 5	0.133	0.058	0.018	0.249	.024*
BPD Criterion 6	0.004	0.059	−0.113	0.121	.945
BPD Criterion 7	0.065	0.059	−0.053	0.183	.276
BPD Criterion 8	0.122	0.061	0.001	0.243	.049*
BPD Criterion 9	0.024	0.064	−0.103	0.151	.710

Note. BPD = borderline personality disorder; LPF = level of personality functioning; CI = confidence interval; LL = lower limit; UL = upper limit.
* $p < .05$.

Strengths and Limitations

The present study has several strengths and limitations. Semistructured clinical interviews were used to assess BPD criteria as well as level of personality functioning. Furthermore, the sample was large enough to detect substantial associations. The present study is also one of the first studies showing specific associations between Section-II PDs and Section III level of personality functioning. Lastly, the ecological validity of the study is a notable strength, the study was implemented into the standard admission procedure of the mental health care facility, where clinical interviews were conducted by regular staff clinicians. On the other hand, several limitations should also be noted. First, we did not assess interrater reliability of the clinical interviews. Second, the mood disorder variable was a rather broad binary variable, limiting our interpretations. Third, the Axis I disorders' variable had a rather narrow range, a count of number of symptoms instead of a count of diagnoses would have been more informative. Fourth, this is a cross-sectional study, limiting the ability to make specific predictions. Future studies may use a longitudinal design in order to test the hypothesis that BPD symptoms predict impairments in personality functioning. Fifth, the sample consisted of a rather homogeneous group of youngsters with personality pathology, mostly female (almost 90%) and may not be a representative sample of adolescents seeking treatment. It would surely be valuable to investigate these associations within a broader sample, to see whether the distinctive value of BPD criteria in general and self-harm/suicidality and intense anger in particular, still holds. A related interesting research topic may be to study whether improvement in self-harm and anger management is related to improvement in personality functioning.

Conclusion

Our study demonstrated that BPD is associated with more severe impairments in personality functioning in a homogenous clinical sample of treatment-seeking adolescents. More specifically, when controlling for other BPD symptoms and number of Axis I disorders,

only recurrent suicidal and/or self-harming behavior and intense anger significantly predicted impairments in personality functioning. The presence of recurrent suicidal and self-harming behavior and intense anger may be markers for more severe impairments in personality functioning and may be especially informative for early detection, treatment assignment, and treatment planning in adolescents.

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