

RESEARCH NEWS



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ATP TREATMENT WORKS

BY CARLA SHARP, PHD, AND CAROLYN HA, BS

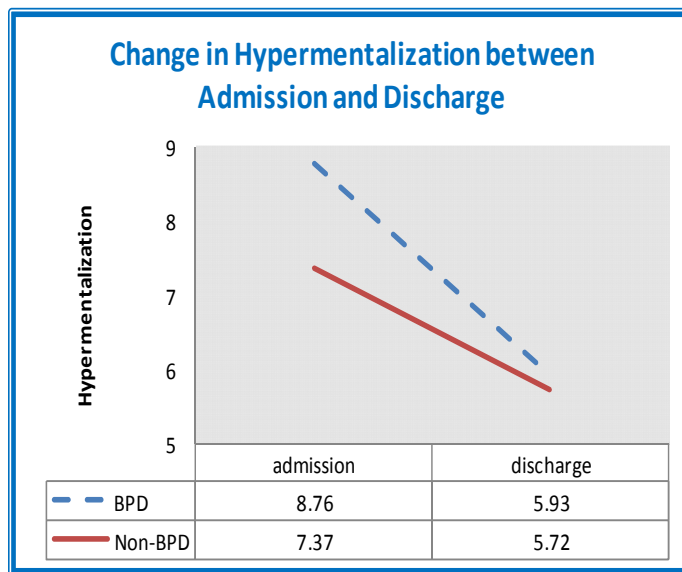
In a previous issue, we shared our findings that were published in 2011 in the *Journal of the American Academy of Child and Adolescent Psychiatry*. These findings suggested that teenagers with traits of borderline personality disorder tend to overinterpret the mental states of others. We call this hypermentalizing and we showed that when adolescents hypermentalize, their feelings get overwhelmed and they feel emotionally dysregulated. Furthermore, these findings suggested that a very worthwhile target

for treatment of adolescent patients is the reduction of hypermentalizing.

In a follow-up study that has been submitted for publication, we show that our treatment at ATP actually reduces hypermentalizing in all adolescent patients on the unit, but particularly so for those with borderline traits. We are excited by this finding because it means that the treatment on the unit works to address a key risk factor for the development of borderline personality disorder in teens. In this study, 257 consecutively

admitted adolescents completed a social-cognitive (mentalizing) assessment at admission and discharge. We showed statistically significant reduction in hypermentalizing. Additionally, we showed that the reduction in hypermentalizing was more pronounced for teens with BPD traits (see Figure). The reduction in mentalizing was correlated with a reduction in borderline symptoms.

Outcomes research is a long and time consuming process. However, findings such as these show the value of longitudinal research in empirically validating the excellent clinical work on the Adolescent Treatment Program of The Menninger Clinic.



SYMPTOM CHANGE IN TEENS WITH BORDERLINE PERSONALITY DISORDER

BY CAROLYN HA, BS

Similar to evidence from adult research on Borderline Personality Disorder (BPD), adolescents diagnosed with BPD are at increased risk for hospitalization due to thinking about or trying to end their life, or having more severe Axis I symptoms (i.e. anxiety and depression). Understandably, these teens also report having difficulty in school. Despite this, there are currently few studies examining the effect of treatment on Axis I symptoms, like depression or anxiety, in adolescents who also have BPD.

Research in adults has demonstrated that the presence of BPD makes it more difficult to treat anxiety or depression. However, whether this is the case for adolescents with BPD remains unknown. Therefore, the goal of this research study was to examine axis I symptom change in adolescent inpatients with and without BPD across admit and discharge time points.

Adolescent patients on the unit were asked to complete a self-report questionnaire upon admission and then again at (continued on page 3).....

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PARENT-CHILD ATTACHMENT AND ADOLESCENT SUICIDE

BY AMANDA VENTA, BS



One of the interviews teens complete during their stay at the Adolescent Treatment Program is the Child Attachment Interview, which measures the dominant style in which adolescents talk about their most important caregiver relationships and most difficult circumstances. Previous research has shown that individuals generally fall into three general attachment styles: those who acknowledge the value of relationships and impact of loss, those who show significant and generalized anger and disappointment with close others, and those who are dismissive of the importance of close relationships or the impact of loss. Furthermore, many previous studies have shown that the attachment style children have

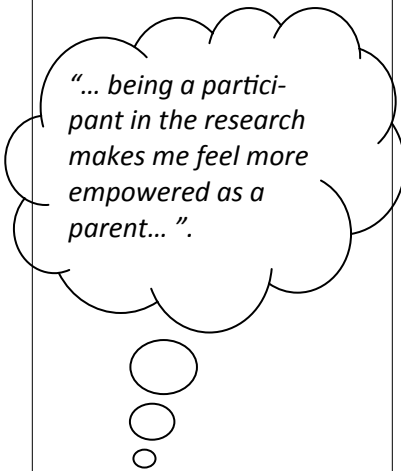
with their caretakers has a great effect on their well-being and future relationships.

This interview was used to measure the attachment style of a group of 194 adolescents in hopes of better understanding how these styles were uniquely related to an adolescent's risk for suicide. Studying risk factors for suicide is an important part of our research program because death by suicide is a prevalent and serious concern among adolescents.

Based on the data collected, we determined that adolescents who had made multiple suicide attempts displayed a less angry style than adolescents who had only made one attempt, even after accounting for psychiatric diagnoses and sex. This finding was surprising because previous research has suggested that anger is a major source of motivation for any sort of self-harm and, therefore, we expected that adolescents who attempted suicide more often would display more anger. Nonetheless, this finding has contributed to a growing area of research that explores different expressions of anger. Specifically,

researchers have started drawing a distinction between anger that is outwardly visible and anger that is directed inwards. Because the Child Attachment Interview only picks up outwardly expressed anger, our findings can only demonstrate that adolescents who make multiple suicide attempts have less outward anger than those with single attempts. So it may be that adolescents with multiple previous attempts have replaced outwardly expressed anger with inward anger and that the latter is responsible for the increased number of suicide attempts.

While we cannot yet make conclusions about the role of inwardly directed anger in adolescent suicide, our study has helped identify an important area for future research and a feature of adolescence (i.e. anger) that may be an invaluable part of suicide risk assessments.



"... being a participant in the research makes me feel more empowered as a parent...".



PARENT PERSPECTIVES ON OUTCOMES RESEARCH

As we at The Menninger Clinic seek to learn more about the adolescents we treat, and how to provide the most effective treatment possible, getting parents' and adolescents' perspectives after they leave Menninger is critical. As ours is one of few research programs in the country collecting longitudinal data on adolescent inpatients, we feel a strong sense of urgency to collect this data and disseminate the knowledge gained to the scientific community and the public.

We recently asked several parents of adolescents who were treated on the ATP unit

why they choose to participate in our follow-up research program. Below is a comment from a parent:

"I participate in any follow-up research opportunity I can. I want to be of assistance because my daughter has been diagnosed with borderline personality disorder and PTSD, and I believe that the more information that can be gathered about these disorders the better - for her, her relationships and family, and the many families out there struggling like we are. Being involved with research makes me feel as though I am contributing in

some small way to the overall outcome. Parents of children with mental illnesses often feel so powerless and helpless - being a participant in the research makes me feel more empowered as a parent. I am willing to help in anyway I can because Menninger was such a source of support to me and my daughter."

- Anonymous Parent

Do you have a reason for participation that you'd like to share? Please e-mail aschramm@menninger.edu or call 713-275-5409 to share your experience with our research program, and what it means to you. We also welcome your feedback, comments, and questions.

SYMPTOM CHANGE

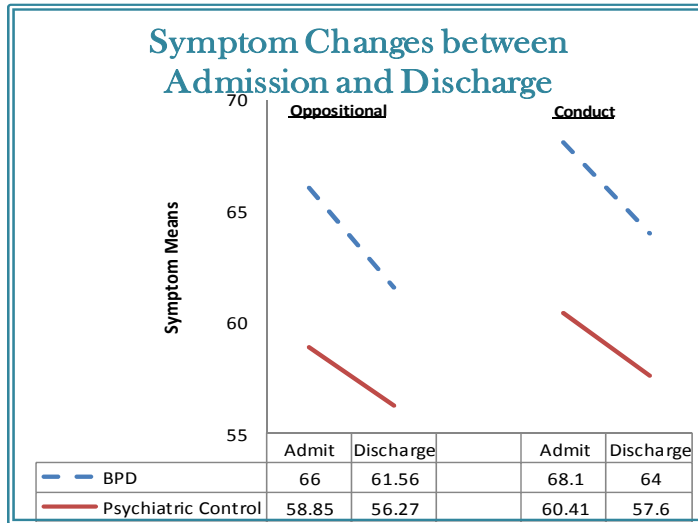
(continued from page 1) ... discharge. The average length of stay for patients ranged between 4-6 weeks. Twenty-nine percent of adolescents met criteria for BPD.

In comparison to patients without BPD, adolescents with the disorder had significantly steeper drops in symptoms from admit to discharge. In

fact, compared to adolescents without BPD, those with the disorder had a steeper drop in mood symptoms, anxiety, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD). The only symptom cluster that did not significantly improve for BPD patients was somatic

problems. However this could be because the level of somatic complaints were not above a clinically significant cut-off at admission for either groups. The figure provided demonstrate that upon admission, adolescents with BPD had clinically significant symptoms of conduct problems and oppositional defiant disorder, but at discharge, their symptoms dropped to below clinical cut-off.

Our findings show that adolescents with BPD do make significant gains after short-term treatment. Most importantly, this emphasizes the significance of early intervention for adolescents. Findings from this study are currently in preparation for publication in a peer reviewed journal and has recently been presented at the Association for Cognitive Behavioral Therapies in Toronto, Canada.



EMOTION REGULATION DIFFICULTIES IN BPD

BY ANDREW SCHRAMM, BS

Learning that you or a loved one has been diagnosed with borderline personality disorder (BPD) can feel overwhelming. In these circumstances, some individuals report feeling exhausted, confused, or helpless – unable to control a problematic pattern of behavior that affects many aspects of one’s life. Difficulty regulating emotions, recurrent suicidal feelings or actions, and intense, chronic feelings of loneliness are a few of the challenges facing individuals with BPD and their families.

A recent study conducted on the ATP unit sought to better understand several aspects of the factors at play in the experience of someone with BPD. This study has recently been submitted for publication in a peer-reviewed, scientific journal. Findings were also recent-

ly presented at the 45th annual convention of the Association for Behavioral and Cognitive Therapies.

The findings of this investigation are three-fold: (1) Adolescents with BPD reported greater difficulty with emotion regulation than their peers without BPD. For example, individuals with BPD were much more likely to agree with the statement, “When I’m upset, I lose control over my behaviors.” (2) Adolescents with BPD also reported greater levels of experiential avoidance than their peers. Experiential avoidance (EA) is, psychologically, the opposite of mindfulness. Individuals with high levels of experiential avoidance report a pattern of avoiding uncomfortable private memories, emotional states, or thoughts. For exam-

ple, individuals with BPD were much more likely to agree with the statements, “I am afraid of my feelings,” and “I push away thoughts and feelings I don’t like.” The third (3), and most interesting, finding is that the relation between difficulties with emotion regulation and borderline personality features was partially mediated by experiential avoidance. In other words, the difficulties in emotion regulation associated with borderline features are explained, in part, by experiential avoidance.

These results highlight the role of experiential avoidance in the emotion regulation difficulties associated with BPD. They also provide a theoretical explanation for why mindfulness- and mentalization-based therapies are very effective modalities for treating BPD.

“... mindfulness and mentalization-based therapies are very effective modalities for treating BPD.”

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ATP CLINICIAN SPOTLIGHT



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PSYCHOLOGICAL TESTING: PURPOSE AND PLANNING

BY SANDY SOENNING, PHD, AND
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Parents and professionals frequently share misconceptions as to the purpose, need for, and risks involved in administering psychological testing. Contributing to the controversies that have surrounded psychological testing in recent years are a number of misconceptions fueled by popular culture, the media, and particularly misinformation now readily promoted on the internet. Oversimplifying, and even poking fun at, the role of psychological testing in the assessment process has denied it its rightful place of importance in the assessment process. In many psychiatric hospitals, psychological testing is no longer available.

Psychological testing remains an invaluable resource for clarifying diagnoses and defining an individual's unique strengths and limitations. Psychological testing can support clinicians as they make critical treatment decisions and this is not limited to diagnostic clarification. Testing has also been shown to assist in providing an evidence-based approach to discharge planning. In moving toward a more balanced understanding of psychological testing and resolving some of the controversy, there must be consistent and careful dissemination of *accurate* information. This article aims to expose and explore several of the most common misconceptions in support of this effort.



Misconception #1: Psychological tests provide a definitive diagnosis.

Psychological tests are not like blood tests that can identify the presence of a medical disorder, but they can assist in *clarifying* diagnoses. In formulating a diagnosis, our treatment team on the Adolescent Treatment Program (ATP) unit uses data from several sources in conjunction with psychological testing results. These sources include a thorough clinical history, review of records, behavioral observations, collateral information from parents and outpatient providers, and assessments provided by other members of the treatment team. Psychologists then search for convergence among clinical, normative and historical data to assist in diagnostic clarification.

Misconception #2: All teenagers who are admitted to the hospital require psychological testing.

All teenagers on the ATP unit are evaluated in a comprehensive, systematic way; however, the treatment team tries to individualize the assessment procedure based on each teenager's unique needs and situation. For instance, some teenagers have participated in recent psychological testing. In these circumstances, administration or re-administration of tests may produce invalid results. We collaborate with the adolescent, his/her parents, and the treatment team to identify specific questions to be answered through testing and then a determination is made as to what tests and measures to administer. Specialized testing, such as collaborative assessment and neuropsychological evaluation, might also be utilized depending on the needs of the child and the specific referral question.

Misconception #3: Once my child participates in psychological testing, the report automatically becomes a part of their school record.

Confidentiality is a concern for parents and adolescents alike. However, psychologists have both an ethical and a legal duty to protect the information that is obtained through psychological testing. Test reports are not released to anyone without a parent's or legal guardian's written permission, unless it is required by law. At all times, parents have the right to:

- designate to whom the disclosure is to be made
- specify the purpose or need
- expressly limit what information you authorize to be released
- revoke the authorization at any time
- indicate when the authorization expires

Psychological testing is a concept that is not well understood, and many parents may have their doubts as to whether such testing is needed. However, testing has clear benefits and understanding the benefits and facts can help to make the evaluation process a more comfortable experience for both the child and those involved in his/her care. In fact, because many adolescents report a feeling of relief at having a new understanding of why they think, feel and act in the ways that they do, assessment can be a great catalyst for change.