

# The Brown University Child and Adolescent Behavior Letter



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# CABL

### *Borderline personality disorder*

## Spotlight on borderline personality disorder: History, genetics, and neurobiology

By Priya Gearin, M.D.

One of my friends is a neuroscientist, and not long ago I met some of her other neuroscientist friends. Interesting conversations begin when a psychiatrist and neuroscientist connect, and among those conversations was one about the history, genetics, and neurobiology of borderline personality disorder (BPD).

Borderline personality disorder is currently defined by DSM-5 as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts.” It requires five of nine criteria, such as fear of abandonment, recurrent

suicidality or self-harm, and affective instability, and can be diagnosed in individuals under the age of 18. The term “borderline” was first used in psychoanalytic circles in the 1930s to describe the behavior patients who seemed to regress in unstructured environments. Over time clinical symptoms of BPD were recognized, such as fear of abandonment, idealization and devaluation of close relationships, and suicidality, and the diagnosis was first incorporated into the DSM-III in 1980. While researchers at the time, such as Dr. John Gunderson, were picking up on observable features of BPD, the biological basis of the disorder [See \*Borderline personality disorder\*, page 3...](#)

### *Hoarding*

## Treating pediatric hoarding behaviors with an exposure response prevention model: A case study

By Kristen Gardiner, B.S., Jennifer Herren, PhD., Jennifer Freeman, PhD., & Erin O'Connor PhD.

With TV shows such as *Hoarding buried alive*, mainstream media depictions of hoarding disorder are presented mostly in the context of adults. Interestingly, however, studies have found that the onset of hoarding disorder often occurs in childhood between the ages of 8 and 10 (Morris et al., 2016). Since hoarding can onset at a young age, early intervention could help decrease the long-term impairment of the disorder. According to the *Diagnostic and statistical manual of mental disorders* hoarding disorder is characterized as tending to collect items, difficulty in throwing items away despite the items' value or significance, and possessing an excessive number of items, leading to clutter (5th ed.; DSM-5; American Psychiatric Association,

2013). Despite a typical onset in childhood, most hoarding treatment and research has focused on adults because hoarding behaviors in youth can be challenging to identify due to family accommodation (Morris et al., 2016). In this article, we will review the prevalence of pediatric hoarding and provide a case example to describe clinical considerations for treating pediatric hoarding with exposure with response prevention (ERP).

Research on pediatric hoarding is limited; however, a recent study in Turkey found that the prevalence of hoarding disorder is estimated to be 0.98% amongst children and adolescents (Akıncı et al., 2021). The researchers stated that these [See \*Hoarding\*, page 4...](#)

an integrated cognitive function or set of functions. Networks that have been shown to have variations in individuals with BPD include the default mode network, salience network, and medial temporal lobe network (Pier et al., 2016).

While there is much to learn about BPD, let us not forget that the research and advocacy efforts of families of children with BPD led to the recognition of the disorder on a national level. BPD often

starts in adolescence and brings many challenges to parents and families who are uncertain what to make of their teenager's concerning behaviors. As research continues to investigate the biology behind BPD, I believe clinicians will improve our ability to educate families and apply effective treatments, to empower those living with this condition to, in the words of Dr. Marsha Linehan, build a life worth living.

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## Hoarding

From page 1

prevalence findings for pediatric hoarding are likely underestimated compared to studies with adults because parents' behaviors influence children's capacity or access to hoard items. A child might not meet the criteria for hoarding because of caregiver involvement in limiting the child's hoarding abilities (Akıncı et al., 2021). Given the family involvement, pediatric hoarding can be difficult to distinguish, notably because hoarding behaviors can be adjacent to OCD symptoms. In a study investigating symptom presentation and treatment in youth with OCD, researchers found that 43% of their participants experienced hoarding behaviors (Rozenman et al., 2019). Although the DSM no longer identifies hoarding disorder as a subcategory to OCD, hoarding behaviors are prevalent in children presenting with and without OCD symptoms. Researchers have also found that children who presented with hoarding symptoms had similar responses to CBT as children who had OCD symptoms without hoarding behaviors (Rozenman et al., 2019). Since children with OCD and hoarding behaviors responded to CBT treatment, the CBT model for OCD treatment provides a framework for treating pediatric hoarding.

### Current treatment

The current treatment model for pediatric hoarding is adapted from an ERP model, the gold standard treatment for OCD, and adult hoarding treatment, which both include exposure to throwing items away (Morris et al., 2016). ERP is a cognitive behavioral therapy that aims to gradually introduce feared stimuli to limit a patient's avoidance, which would ultimately lower their overall anxiety around

the stimuli. In the context of hoarding disorder, the exposure model is around gradually throwing items away. For example, an exposure target for a child with hoarding behaviors could be gradually throwing away broken crayons and starting with the child's least favorite crayon or color. Additionally, researchers have adapted the ERP model to address the needs of pediatric hoarding by including more parent training to reduce accommodation and positive reinforcements to motivate children (Morris et al., 2016).

### Sally had developed deep connections with almost everything in her room, from candy wrappers to pharmacy receipts to used juice boxes.

To illustrate the use of ERP with pediatric hoarding behaviors, we will present a case example of an 8-year-old female, Sally, presented with primary hoarding in outpatient treatment at an anxiety specialty center. Case details are modified to ensure confidentiality. Sally received weekly home-based services with an exposure coach (e.g., a bachelor's level provider supervised by a psychologist) and monthly office visits with a psychologist. Sally's primary concerns were difficulty around discarding items she had collected in her room. Sally had developed deep connections with almost everything in her room, from candy wrappers to pharmacy receipts to used juice boxes. Sally's hoarding behavior caused her to experience high anxiety when parting from items. To manage the number of items accumulating in Sally's room, Sally's mom would accommodate

Sally's hoarding by throwing items away without Sally knowing.

Clinicians used an ERP model to help Sally build skills to discard items. Before initiating exposure, Sally's clinicians provided psychoeducation around the exposure model by explaining anxiety cycles and how avoidance maintains distress over time. Exposures for Sally began with creating a hierarchy around items in her room, where she rated items on a scale from 0 (not a problem) to 10 (very distressing) based on how hard they would be for her to throw away. The hierarchy provided a framework on where to start with exposures and allowed Sally autonomy over what items she kept or discarded. Given Sally's high level of distress when asked to discard items, treatment emphasized caregiver involvement, collaborative exposure selection and modification, and the use of rewards to enhance motivation.

### Dealing with parental accommodation

Considering Sally's level of distress and parental accommodation at the start of treatment, parent involvement was critical for Sally's treatment. Sally's parents attempted to reason with Sally by discussing why certain items were worth keeping while others were not; however, for Sally, every item she hoarded was valuable to her. Psychoeducation was provided to Sally's caregivers to support shifting their focus from trying to understand Sally's attachment to an item to supporting Sally in throwing things away. To encourage consistency in throwing items away, Sally's exposure coach suggested that Sally throw away her empty snack bags each day after coming home from school. Initially, Sally struggled to throw her snack bags away, but after consistently doing it, she eventually had little to no distress. For treatment to be most effective for Sally, her mom needed to support her in throwing items

away herself rather than mom accommodating and throwing things away for Sally. Sally's mom could best support her daughter by saying, "I know this is important to you, and I know it is hard to have to part with this item, but we are going to have to say goodbye now." This acknowledges the distress Sally is experiencing and validates her connection while maintaining the expectation that Sally cannot hold onto every item in her room.

In addition to Sally's parents supporting her in throwing items away, it is also important that her parents use a gradual approach to encourage Sally to complete exposure. Since Sally is young and may not have fully conceptualized the importance of exposure work, her parents and therapist needed to start small with exposure work and adjust the difficulty level of each exposure. Sally's exposure coach modeled for Sally's mom how to modify the difficulty level of exposures, while still setting the expectation that Sally would throw away at least one item in each session. For example, it was too difficult for Sally to throw away her McDonald's Happy Meal box, so her coach altered the exposure and asked her to throw away only the fries container. By adjusting the exposure to be easier, Sally was able to throw away the fries' container and feel accomplished. Sally was successful with this approach, and each session would throw away another section of the paper until it became easier to throw it away entirely. By starting small, Sally slowly habituated to throwing items away and gradually increased the size or number of items each time.

## Rewards

As treatment progressed and Sally made progress discarding items, choosing an item to part with was more difficult than throwing away an item. To support Sally and maintain the expectation that something would be thrown away, Sally benefited from modifying the exposure to make it more approachable. Her coach chose three items and asked her to throw away at least one of the three items, which gave Sally autonomy over what she was throwing away while decreasing the overwhelming feeling of choosing something by herself. By adjusting the exposure depending on the difficulty level or significance of each item, therapists and caregivers can help support a child's success with exposure.

Another important clinical consideration in treating pediatric hoarding is establishing a clear and concise reward system to help motivate children to complete exposures. In the context of hoarding behaviors, a reward system can be difficult to maintain and implement, especially if desirable rewards are tangible items the treatment aims at reducing. Sally would agree to throw away an item if her mom would agree to replace the item with a newer version of it. To address this dilemma, the family and treatment team developed a rewards system that included prizes that were not toys or items for the patient to later hoard but were experiential rewards like going to her favorite restaurant. The balance is in finding rewards that the patient is excited to work toward and that do not add to the patient's collection

of items. Sally's parents created clear boundaries around what was considered a successful exposure and what rewards could be earned for completing exposures. With a clear expectation for exposure and rewards, Sally understood that the more items she threw away, the sooner she could have ice cream or visit a park.

Overall, ERP with an emphasis on parent involvement, allowed Sally to gradually feel more comfortable discarding hoarded items. This case illustrates the importance of caregiver involvement, having consistent and manageable expectations, limiting accommodation around throwing items away for the child, and using a rewards system when treating pediatric hoarding. Pediatric hoarding is challenging to diagnose and treat primarily due to family accommodation, which is why an ERP model with a focus on family involvement can provide an effective framework for treating children with hoarding behaviors.

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## Antipsychotics

### Main barrier to monitoring metabolism for patients: lack of resources

By Alison Knopf

Metabolic monitoring for second-generation antipsychotics (SGAs) is essential for the health of the patient, but providers don't always have the resources to do it, and parents sometimes oppose the blood tests.

A recent study interviewed psychiatrists in Australia to find out how the problem might be fixed.

Prescription of SGAs are increasing across the world. In the United States, the

Food and Drug Administration (FDA) has approved risperidone and aripiprazole to treat irritability associated with autism, and older SGAs such as olanzapine, clozapine, and quetiapine are also commonly used off-label in children.

The link between SGAs and metabolic adverse effects has been known for more than a decade, and many studies have reported that children given these medications are two or three times more likely to develop diabetes. Using these medications off-label in this population can be even more risky, according to studies.

The best practice is early monitoring for SGA-induced metabolic effects, because

this can lead to prevention of long-term adverse outcomes. But despite the recommendations that monitoring be conducted, it isn't always, and the results are unnecessary disease. As it is, there is minimal uptake of clinical guidelines in youth prescribed antipsychotics, researchers have found.

### Why nonadherence?

In interviews with the psychiatrists, the researchers learned that lack of resources as well as parental opposition to monitoring were the main barriers, and that the gap between best practice standards

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