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Personality disorders in adolescence

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Summary

Adult personality disorders are well recognized and described in the literature. The discussion about the possibility of the presence of personality disorders in adolescents started about 20 years ago. Some authors claim the before the age of 18 it is only possible to identify precursors of future personality disorders and such a standpoint is reflected in diagnostic criteria. This is based on the assumption that personality in adolescence is still not well established. Consequently, the criterion on the persistence of symptoms for the period of time cannot be met (the persistence of symptoms of personality disorders for the period of at least two years). Other approach postulates that problems presented in adolescence should not be exclusively limited to Axis I according to DSM. The proponents of this approach claim that current diagnostic tools are not adjusted to adolescents, thus it is very difficult to measure stability and persistence of symptoms in this age group. This paper presents literature review on personality disorders in adolescence.

Key words: personality disorders, diagnosis, adolescence

Introduction

Both clinical observations and results of many studies show that Axis I disorders diagnosed in childhood and adolescence are quite often accompanied by symptoms which exceed main diagnosis such as self mutilation, risk behaviours or low motivation to treatment [1]. The common observation is that patients with the same diagnosis e.g. depressive disorder or conduct disorder, differ with respect to rejection sensitivity, tendency to view others as having bad intentions, aggression or inability to maintain stable emotional relationships domains [2–5], which could justify taking into consideration a diagnosis of personality disorders. By the end of the 20th century the dominant view was that personality disorders could not be diagnosed before the age of 18. The as-

The study was not sponsored.

sumption was that personality in adolescence continually changes towards stability at the age of 30 [6, 7]. The standpoint was reflected in ICD-10 [8] and DSM IV-TR [9] diagnostic recommendations and was more the result of the scarcity of research on personality disorders in childhood and adolescence rather than conclusions derived from empirical evidence [2]. Although the results of studies conducted in 1990s suggested the presence of traits of personality disorders in children, the main emphasis was on the lack of persistence (or changeability) [2, 10] of behaviours, attitudes or habits for the period of at least two years [6, 7, 11, 12]. It was also emphasized that the diagnosis of personality disorders in adolescence can be stigmatizing and disadvantageous. It was noticed though, that children with identical DSM Axis I diagnosis differ with respect to functioning as well as prognosis and the course of the healing process, which enforced different treatment strategies [3, 13–15]. The results of current studies show that personality disorders can be observed in children and adolescents [1, 10, 14, 16, 17]. What is more, it is claimed that antisocial personality disorders begin with conduct disorders in childhood and/or adolescence [15, 18] whereupon time stable pattern of inappropriate behaviours in children and adolescents should be treated within the framework of personality disorder [16]. In the last decade, the dominant view was that the onset of adult personality disorders should be sought in childhood [1, 11, 14, 16–19]. It is of the utmost importance that the knowledge in this field be expanded as abnormal development of personality in adolescence can be crucial for the presence and persistence of various problems e.g. with close relationships or social functioning later in life [1, 11, 14].

Aim

The goal of the article is to review current literature on personality disorders in adolescence.

Epidemiology

The prevalence of personality disorders in children and adolescents is hard to assess due to an insufficient number of studies. According to Johnson et al. [14] and Western et al. [3] the prevalence of personality disorders in adolescence ranges between 6%–17%. Studies on adult populations show that the prevalence of personality disorders ranges between 10%–15% [1, 3]. Furthermore, Grilo et al. [20] point that DSM Cluster A (paranoid, schizoid or schizotypical) and B (antisocial, borderline, histrionic and narcissistic) personality disorders are diagnosed equally often both in adult and adolescent populations. The diagnosis of Cluster C personality disorders (obsessive compulsive, avoidant or dependent) decreased with age in patients between the ages of 9 and 27 [14]

Diagnostic criteria

Despite difficulties expressed by many authors, no diagnostic criteria have been formulated for personality disorders in adolescence to this day [2–4, 12, 14, 21]. It seems that the main argument against the diagnosis of personality disorders in adolescents, about lack of stability and persistence of symptoms in time, is not very well supported by the results of empirical studies [1–4, 6, 14, 16, 17, 21]. Moreover, the results of current studies show that personality traits continue to change throughout adulthood, but only modestly after the age of 50 and not 30, as it was thought before. The greatest changeability of personality is observed in adulthood, not in adolescence [6]. The research on stability of symptoms of personality disorders in adolescence have revealed correlations between 0.4 and 0.6 with similar results observed in studies on adults [1, 14, 16]: Cluster A r = 0.5 for ages 13–16, r = 0.49 for ages 16–22 and r = 0.56 for ages 22–33; Cluster B r = 0.65 for ages 14–16, r = 0.50 for ages 16–22 r, after exclusion of antisocial personality disorder r = 0.55 for ages 22–23.; Cluster C r = 0.48 for ages 13–16. and r = 0.42 for ages 16–22.

The diagnostic criteria currently used in studies on abnormal development of personality in adolescence are based on DSM criteria for adults [3, 4]. According to many authors it is not an optimal solution. Firstly, false negative or positive diagnosis are possible if behaviours, attitudes and traits characteristic of adolescence are not taken into consideration [2, 3, 5, 17]. Secondly, dichotomous character of DSM criteria makes it impossible to reflect time changeability of problems specific for developmental age. Additionally, the overlap of Axis I and II symptoms in children and adolescents makes differential diagnosis more challenging (e.g. depressive episode in the course of personality disorders) [2, 11, 20].

Alternative Model of Personality Disorders introduced in DSM-5 [15, 22] is attempted to define structured multidimensional definition of personality disorders which incorporates Five Factorial Model of Personality (FFM) [23] (extroversion vs. introversion, emotional stability vs. neuroticism, openness to experience, agreeableness vs. antagonism and conscientiousness vs. disorientation) as well as functioning of an individual in domains of identity, empathy, intimacy and autonomy [15, 22, 23, 24]. Multidimensional understanding of personality structure makes diagnostic process more flexible and sensitive as it enables to identify personality patterns which intensity impedes functioning of an individual but still below diagnostic threshold for personality disorders. (e.g. rejection sensitivity or deeply rooted avoidance strategies)

Both DSM-5 [22] and DSM-IV [9] define personality disorders as an enduring and inflexible pattern of long duration that lead to significant distress or impairment that are not due to use of substances or another medical condition. DSM-IV [9] criteria focused mainly on the assessment of an individual in cognitive and interpersonal domains whereas DSM-5 [22] addresses also psychodynamic (related to identity, autonomy and self-determination) and biological domains. It can be concluded that the newest version of American Psychiatric Association classification is a step

towards multi context understanding of dysfunction of an individual regardless of age. The results of studies on temperament and personality traits in children and adolescents [25, 26] validate Five Factorial Model thus making DSM-5 [22] criteria applicable in the diagnosis of personality disorders in adolescents. Although DSM-5 Alternative Model of Personality Disorders is based on theoretical model which makes it useful in adolescents [27], it has not taken into account age-specific patterns of functioning. In conclusion, diagnostic criteria for personality disorders in adolescents still await better structuring as well as development of age specific diagnostic tools [2, 3, 21].

Clinical picture of personality disorders in adolescence

The number of data on clinical picture of personality disorders in childhood and adolescence is limited. The available results suggest that the character of personality disorders in childhood and adolescence is almost analogous to adult population [3]. The results of studies on borderline personality in adolescence confirm this assumption [4, 28]. Activation of hostile emotions in stressful situations, emotional liability, frequent experience of internal emptiness and loneliness, tendency for engagement in intensive and unstable interpersonal relationships, external attribution accompanied by attribution of hostile and harming intentions to others, auto-destructive behaviours (e.g. self-injury) are observed both in adolescents and adults with borderline personality [3, 12, 29]. The clinical picture of personality disorders in adolescence from 14 years of age is convergent with adults whereas in childhood the clinical picture of still-forming borderline personality may suggest the presence of a psychotic disorder [2, 29]. Some authors emphasize that the emergence of traits of borderline personality disorders in adolescence increases the risk of future adaptation problems, aggressive and suicidal behaviours, conflict with the law as well as promiscuity [1, 14].

The specificity of developmental age must always be taken into account in the analysis of symptoms classified to inappropriate development of personality. Some behaviours associated with normal separation and individuation process may be confused with inappropriate development of personality. The risk of false positive diagnosis increases if developmental patterns are not taken into account. In the study conducted by Westen et al. [3] the prevalence of antisocial and avoidant diagnoses in adolescents was higher than in adults. The authors explain that the results could reflect the characteristics of the sample but also be a reflection of symptoms and traits which are directly linked to maturation process.

Risk factors for personality disorders

The data on risk factors for personality disorders are available mainly from studies on adult populations. It can be assumed that most important risk factors in early childhood include: social isolation, poor health condition and behavioural problems

(e.g. strong negativism), in adolescence: low social competence, introversion, high emotionality. Risk factors independent of age include: sexual, emotional and physical abuse and maladaptive parenting which can provoke or sustain inappropriate behaviours [16]. The following risk factors are considered extremely important in the development of Cluster B personality disorders: rejection, emotional instability, incoherence and unpredictability of mother's behaviour and sexual abuse [1, 3, 4, 16]. Risk factors for the development of Cluster C (avoidant, dependent and obsessive compulsive) personality disorders include physical and emotional abuse [16].

The presence of Axis I disorders is also considered a risk factor for personality disorders. The majority of studies on comorbidity of Axis I and Axis II disorders has been performed on adult populations [3]. Girlo and Bernstein's [1] study on adolescents showed that the risk of Axis II diagnosis in adulthood is correlated with Axis I diagnosis in childhood. It seems that in adolescence the risk is correlated with the diagnosis of depressive, anxiety and conduct disorders with respect to all Clusters of personality disorders according to DSM [10, 16, 30] although some authors also point to the role of eating disorders and substance abuse [2]. Mood disorders, including depressive disorders correlated with six-fold increase in risk of Cluster B personality disorders in adolescence and eight-fold increase in Cluster C. Anxiety disorders were correlated with five-fold increase in risk for Cluster A and four-fold increase in risk for Cluster B. Adolescent conduct disorders were associated with four-fold increase in risk for all DSM clusters [10, 16, 31].

In adolescents with Cluster A personality disorders, 20% were also diagnosed with depressive disorders, 25% with anxiety disorders and 35% with destructive behaviours, while the latter were also associated with six-fold increase in risk of abnormal personality patterns in adulthood [10]. The presence of anxiety disorders in adolescence increased the risk of the diagnosis of paranoid personality disorders in early adulthood. Another observation was that sexual abuse was also a risk factor for Cluster A personality disorders. On the other hand, the presence of Cluster A personality disorders in adolescence increases the risk of mood and anxiety disorders and destructive behaviours in early adulthood [16]. In adolescents with Cluster B personality disorders, 28% were diagnosed with depressive disorders, 37% with anxiety disorders and 47% with conduct disorders [10]. Borderline personality disorder was more often diagnosed in patients with eating disorders and substance abuse [12]. A relationship has also been observed between the above mentioned disorders, bipolar depression, schizophrenia spectrum disorders and other Cluster B (antisocial, narcissistic, histrionic) personality disorders [4, 16]. Sexual abuse increased the risk of Cluster B personality disorders. On the other hand, sexual abuse in childhood and adolescence correlated with increased anxiety, depressive disorders and destructive behaviours in adolescence and early adulthood [16]. Physical neglect was also a risk factor for the development of borderline or narcissistic personality disorders [14]. Depressive disorders, destructive behaviours and anxiety disorders, (social phobia in particular) were observed in Cluster C personality disorder patients (23%, 34% and 51% respectively) [16].

Recapitulation

Studies on personality disorders in childhood and adolescence should resolve whether such diagnoses in children and adolescents are justified and aim to discover mechanisms leading to the development of normative and pathological personality [12, 16]. The number of studies is limited and the great majority of available research are retrospective studies on adults with the diagnosis of personality disorder [2–4, 10, 14, 16]. Therefore, the generalization of results on young population is limited. The increase of awareness among psychologists and psychiatrists followed by the change of type and range of interventions is of the utmost importance. The identification of risk factors should foster the development of prevention strategies. Axis I diagnosis expanded by Axis II may promote more complex interventions addressed to families and family members. Well tailored psychotherapeutic interventions may shorten hospitalization time and lower the costs of in-patient treatment. Adequate treatment in patients with inappropriately developing personality may decrease the prevalence of personality disorders in adulthood.

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