To diagnose or not to diagnose: That is the question

Diagnosing PD in adolescence:
Current status and future directions

Outline

What is personality?

Current diagnostic systems

Usage of current systems

To diagnose or not to diagnose: Reliability, stability & validity of PD diagnosis and personality traits in adolescence

Future directions
- DSM 5
- ICD-11

What is personality?

Patterns of (intra-personal) behaviour
- Overt
- Covert – thoughts, emotions, sensations

Repertoires / strategies of interpersonal behaviour

Habitual

Across contexts – certainly in adults

Across time

Resistant (in part to transient environmental events)

Personality Development

Personality develops in the crucible of:
- Genetics
- Early temperament
- Attachment
- Life experiences / adversity
- Parenting styles

Early attachment / environmental experiences shape infant behaviour & neurobiology

Infants make an early contribution to environmental responses

Over time, transaction between child and the environment amplifies some traits and attenuates others

As children develop they begin to 'pull' certain environmental responses that continue to shape personality development

Personality Traits

Personality traits have their origin in temperament

Personality and temperament share similar traits and have a similar structure

Individual differences in childhood and adolescence personality traits share similar structure to those in adults
- Big 5 structure (Extraversion, Neuroticism, Conscientiousness, Agreeableness, Openess to experience) been found in number of studies

Stability of Personality Traits

Roberts & DelVecchio (2000): meta-analysis to evaluate stability of personality traits across the life cycle.
- Included studies from birth to old-age that reported trait measures made at least one year apart

Estimated population cross-time correlations as follows:

0-2.9 years	0.35	22-29 years	0.57
3-5.9 years	0.52	30-39 years	0.62
6-11.9 years	0.45	40-49 years	0.59
12-17.9 years	0.47	50-59 years	0.75
18-21.9 years	0.51	60-73 years	0.72

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Personality Disorder

Current diagnostic systems

DSM	ICD
A …… pattern of inner experience and behaviour that deviates markedly from the expectation of the individual's culture in two or more of the following areas: Cognition Affectivity Interpersonal functioning Impulse control	Markedly disharmonious attitudes and behaviour involving usually several areas of functioning e.g. Ways of perceiving and thinking Affectivity Style of relating to others Impulse control Arousal
Enduring pattern is inflexible and pervasive across a broad range of personal and social situations	Behaviour pattern is enduring… pervasive and clearly maladaptive to a broad range of personal and social situations
Pattern is stable and of long duration.	Behaviour pattern is of long standing
Not better accounted for as a manifestation or consequence of another mental disorder Not due to the direct physiological effects of a substance or a general medical condition	Not limited to episodes of mental illness Not secondary to another mental disorder or brain disease
Onset can be traced back to adolescence or early adulthood	Behaviour patterns always emerge in childhood and adolescence and continue into adulthood

DSM	ICD-10
PD diagnosis may be applied to adolescents in those *relatively unusual* instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent and unlikely to be limited to a particular developmental stage or episode of an Axis I disorder ASPD cannot be diagnosed in adolescence	Unlikely that the diagnosis of PD will be appropriate before the age of 16 or 17 years
	PD tends to appear in late childhood or adolescence and continues to be manifest into adulthood
Features must have been present for over a year	

Diagnosis – the paradox

Both diagnostic systems in use allow diagnosis

Both describe onset in adolescence

Both discourage diagnosis in adolescence

Clinicians do diagnose – reluctantly and probably rarely

Reasons not to diagnose

Adolescence is a time of developmental flux – symptom pattern may change

- i.e. is the diagnosis reliable?
- i.e. is the diagnosis stable?

Some features of PD resemble normal adolescent functioning

- i.e. is the diagnosis valid?

Diagnosis is stigmatising

- i.e. diagnosis potential for iatrogenic harm

Reliability

Using structured diagnostic interviews based on DSM criteria, research clinicians report adequate inter-rater reliabilities

- Becker at al, 1999; Blais et al, 1999; Garnet et al, 1994

Factor analytic studies demonstrate that structure of the diagnosis (BPD) can be replicated across samples and are similar to structures in adults

- Becker et al, 2006; Chabrol et al, 2004

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Stability

Research primarily in community samples indicates that persistence of the diagnosis is relatively unstable

Bernstein et al (1993): moderate PD diagnosis 29% stability, severe PD stability 24%. Diagnosis remained for clinically significant number and sub-clinical symptoms did remain in others

Research in inpatient samples:

Meijer et al(1998): 17/54 met criteria at index hospitalization. At 3 year follow-up only 2/14 still met criteria

Stability

Low temporal stability generally but subset of adolescents for whom stability of diagnosis remains.

Garnet et al 1994: 33% of adolescent inpatients (n=21) diagnosed with BPD met criteria 2 years later although specific symptom profiles had changed

Chanen 2004: sample of 101 out-patients. At baseline 11 met criteria for BPD. Persistence at 2 years 40%.

Summary Stability

Studies small

Confounding effects of treatment in most studies

Some commentators use data to argue for instability (Becker et al, 2002)

Some commentators use same data to argue for stability (Bradley et al, 2005)

Stability in adult samples similar to the rates in adolescence

Validity

Many of PD symptoms resemble 'normal' adolescent behaviours

No clear diagnostic descriptions to differentiate 'normal' from ' abnormal' development

Diagnosis relies on severity, persistence of behaviours and interference with normal functioning

Potentially clinicians make idiosyncratic decisions about what constitutes threshold

Validity

Adolescents with diagnosis of BPD more functionally impaired at time of diagnosis and at follow-up

Levy et al, 1999; Bernstein et al, 1993

Construct validity:

BPD associated in the literature with range of comorbidities; depression, substance abuse, PTSD and conduct disorder

Some studies support differentiation from Axis I disorders, e.g. Wixom et al 1993: Depressed adolescents with and without BPD differ on a number of variables such as history of abuse, family instability, dissociative symptoms

Stigmatising

No more so than in adults … but communicates a hopelessness about change early

Would changing the name help?

No evidence it would – stigma arises from:

Nature of the presenting behaviours

Clinicians' find presentation challenging

Historically negative prognosis … although this is changing

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Reasons to diagnose

Increase research attention to development of personality and personality difficulties in adolescence

Early / preventative interventions

Personality key inter-personal & intra-personal context for therapeutic interventions – yet frequently they are ignored

Development and application of appropriate treatments

Prevention of iatrogenic harm by application of inappropriate treatment

Future Directions

DSM 5

This information was obtained from DSM 5

(www.dsm5.org)

Reconceptualizing PD

- General PD diagnostic criteria
- Proposed set of PD traits
- PD types
- Levels of functioning

PD Diagnostic Criteria

- Impaired self / identity OR interpersonal dysfunction
- Extreme levels of one or more traits
- Stable across time/ situations; onset in adolescence/ early adulthood
- Not solely manifestation or consequence of another mental disorder, effects of substance, or general medical condition

Trait Domains Being Tested

Neg. Emotionality

Detachment

Antagonism

Disinhibition

Compulsivity

Schizotypy

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Facets of Negative Emotionality

Facets

- Emotional lability
- Anxiousness
- Suspiciousness
- Submissiveness
- Separation insecurity
- Pessimism
- Self-harm

PD Types

Five proposed

Schizotypal type

Borderline type

Avoidant type

Obsessive-Compulsive type

Anti-social / psychopathy type

Proposed Borderline Type

Negative Emotionality

Anxiousness, Emotional lability, Depressivity, Low self-esteem, Self-harm, Separation insecurity

Antagonism

Hostility, Aggression

Disinhibition

Impulsivity

Schizotypy

Dissociation proneness

Five Levels of Functioning

0 No impairment

1-2 Mild – Moderate impairment

3-4 Serious – Extreme Impairment (PD)

Specific PD Diagnoses

- Meets all criteria
- Severe or extreme impairment
- Strong, clear trait match to one type?
  - Yes → Diagnose type (e.g., **PD, Borderline type**)
  - No → Diagnose PD-TS (**PD-Trait Specified**)
    - List prominent trait domains, facets

ICD-11

Disclaimer

What is presented here is not necessarily the view of the PD Working Group or WHO

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Severity Classification

No personality disorder

Personality Difficulty

Personality Disorder

Severe Personality Disorder

Personality difficulty

An enduring pattern of perceiving, relating to and thinking about the environment and oneself that is inflexible, deviates from cultural expectations and is exhibited in social and personal contexts.

Do not pose a risk to self or others and social dysfunction is minimal or absent.

Personality Disorder

An enduring pattern of perceiving, relating to and thinking about the environment and oneself that is inflexible, deviates markedly from cultural expectations and is exhibited in a wide range of social and personal contexts.

Problems should be apparent in at least two of the domains of cognition, affectivity, control over impulses, gratification of needs, and handling interpersonal relationships, and

Be associated with either impaired social functioning and/or evidence of risk to self and/or others.

Severe Personality Disorder

An enduring pattern of perceiving, relating to and thinking about the environment and oneself that is inflexible, deviates markedly from cultural expectations and is exhibited in a wide range of social and personal contexts.

Personality-related problems should be complex, apparent across a wide range of domains including cognition, affectivity, control over impulses, gratification of needs, and handling interpersonal relationships, and

Be associated with either grossly impaired social functioning and/ or clear evidence of risk of severe harm to self and/or others.

Diagnosis in adolescence

Removal of age limits

Potential for specific adolescent descriptors of PD

What would you have in your description of PD in adolescence?

Future Directions

Developments in DSM and ICD may help with the diagnostic dilemma in adolescents:

- Traits
- Based on severity
- Identification of personality difficulty
- Personality types – more clearly linked to research
- Potentially less reified

Promote consideration of personality in adolescents by clinicians and researchers

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