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, Openness to experience) been found in number of studies

Stability of Personality Traits
Included studies from birth to old-age that reported trait measures made at least one year apart
Estimated population cross-time correlations as follows:

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Correlation</th>
</tr>
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<tbody>
<tr>
<td>0-2.9 years</td>
<td>0.35</td>
</tr>
<tr>
<td>3-5.9 years</td>
<td>0.52</td>
</tr>
<tr>
<td>6-11.9 years</td>
<td>0.45</td>
</tr>
<tr>
<td>12-17.9 years</td>
<td>0.47</td>
</tr>
<tr>
<td>18-21.9 years</td>
<td>0.51</td>
</tr>
<tr>
<td>22-29 years</td>
<td>0.87</td>
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<tr>
<td>30-39 years</td>
<td>0.62</td>
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<tr>
<td>40-49 years</td>
<td>0.59</td>
</tr>
<tr>
<td>50-59 years</td>
<td>0.75</td>
</tr>
<tr>
<td>60-73 years</td>
<td>0.72</td>
</tr>
</tbody>
</table>
Personality Disorder
Current diagnostic systems

<table>
<thead>
<tr>
<th>DSM</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>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</td>
<td>PD traits must have been present for over a year</td>
</tr>
<tr>
<td>Usually, the diagnosis of PD will be inappropriate before the age of 16 or 17 years</td>
<td>PD traits to appear in late childhood or adolescence and continue to be manifest into adulthood</td>
</tr>
</tbody>
</table>

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 et 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
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

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
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

Reconceptualizing PD

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

DSM 5

This information was obtained from DSM 5
(www.dsm5.org)

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 \(\rightarrow\) Diagnose type (e.g., PD, Borderline type)
  - # No \(\rightarrow\) 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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