ESSPD NEWSLETTER

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Message from the President

Welcome to summer 2014 edition of the ESSPD newsletter. I will take the opportunity in this message to make a few comments about the issue and to urge you to join us at our forthcoming conference in Rome October 16-18th 2014. I hope to meet many of you there. Please recommend the conference to interested friends and colleagues.

This issue of the ESSPD newsletter focuses on adolescence and personality disorder and I thank all the authors for taking the time to write challenging and thought-provoking papers. Times have changed. It is no longer assumed that personality disorder is an inappropriate or unacceptable diagnosis during adolescence and there is increasing interest in the formation of personality and its disorders early and late in adolescent development. Acceptance of personality disorder as a problem for adolescents suggests that the problem needs to be identified earlier rather than later. It seems that there is concern about conflating self-harm and depression with personality disorder and both these points are discussed in the articles. This change of attitude towards personality disorder has arisen in the context of some increasingly persuasive developmental and treatment research although the authors writing in this issue are clear that more research is urgently needed. In addition it is unclear how the research has influenced clinical services – probably very little. Translating research into clinical practice remains one of the unanswered problems of mental health services. The papers give a number of references to help the reader extend his or her interest.

Presentation of recent research into personality disorder and adolescence will occur at out next congress in Rome, October 16-18th. Here there are a number of sessions focused on work with adolescent with experts presenting their latest research. If you have not already registered there is still time. I do hope that you will join us for a stimulating, high quality programme in a city of distinction and history. In the meanwhile enjoy this newsletter.

Anthony W. Bateman
President, ESSPD

Scientific News

Diagnosing PD in adolescence—current dilemmas and challenges

Michael Kaess

Diagnosing PD in adolescence—current dilemmas and challenges by Michael Kaess

Although no changes were ultimately made in the overall categorial classification of personality disorders (PDs) in the DSM-5, the new manual did include minor modifications related to an increasing paradigm shift over the past few years: the DSM-5 confirmed PD diagnosis in adolescents (American Psychiatric Association, 2013).

For decades, this topic was controversially discussed among researchers and clinicians alike. The long-standing agreement that PDs have their roots in childhood and adolescence was directly at odds with various (false) beliefs about adolescent PD: firstly, that the diagnosis of adolescent PD is not valid because adolescence is a period of tremendous developmental changes and, thus, personality is not sufficiently mature at this age; secondly, that stability of pathological personality traits is reduced because personality development is still in flux and this precludes diagnosis; and thirdly, that PD was considered untreatable and therefore diagnosing the condition was associated with high levels of stigma.

Some authors have been arguing in favor of diagnosing PD for many years already (Chanen & McCutcheon, 2008) and with regards to borderline personality disorder (BPD), there is increasing evidence for both its validity (Chanen & McCutcheon, 2013; Miller, Muehlenkamp, & Jacobson, 2008) and stability (Chanen et al., 2004) among youths. Even more importantly, there is now sufficient evidence that PD can be treated and that early intervention may be effective in adolescents (Chanen & McCutcheon, 2013). Since adolescent PD is likely to be highly associated with a continuous risk of self-harm and suicide, severe and multiple comorbid mental and physical disorders and long-lasting functional impairment, early intervention in PD will be an important goal for future health care systems (Kaess, Brunner, & Chanen, in press).

Early intervention in PD requires early detection! Thus, the issue of diagnosing PD in adolescence is and will remain critical, and it is still associated with several challenges:

1. From research in adolescent BPD, we know that disease patterns differ from those among adults (Kaess et al., 2013). More acute and reactive symptoms (e.g., self-harm and risk-taking behavior) dominate the clinical picture of this disorder during adolescence. Disturbances in interpersonal relationships and identity, which are considered core problems among adults, are reported less frequently among youths; however, it remains unclear whether these problems appear less often at early ages or whether adolescents have more trouble reflecting on those problems. The latter would not be surprising given that adolescents can usually not reflect on a dozen difficult relationships or a decade of planning their own future. A deeper **understanding of the impact of age on the criteria of PD** and possibly even establishing developmental criteria should be a goal of future research.

Diagnosing PD in adolescence—current dilemmas and challenges

2. Adolescent PD (particularly BPD) is associated with high rates of comorbidity (Chanen, Jovev, & Jackson, 2007; Kaess et al., 2013), rendering it difficult to make differential diagnoses in these individuals. Common comorbidities are affective disorders, substance use disorders, eating disorders, other PDs etc. It is important to increase our knowledge on **common mechanisms of comorbidity** and to develop guidelines for dealing with comorbidity in youths.
3. While risk-taking and self-harm behavior is strongly related to adolescent BPD, such behavior is very common among adolescents, shows a normative decline as adulthood approaches, and may indicate mental health problems (Kaess et al., 2014) that are rather transient. In the new DSM-5, diagnostic categories such as 'nonsuicidal self-injury disorder' and 'suicidal behavior disorder' have been proposed in section 3. Such categories may represent a threat to an early diagnostic (and perhaps dimensional) approach to BPD and neglect underlying features of the behavior that need to be targeted by treatment. More research on **PD as a potential underlying construct of pathological adolescent behavior** is needed.
4. Not diagnosing PDs increases the risk of perpetuating negative stereotypes, reducing the prospect of applying specific beneficial interventions and in creasing the likelihood of incorrect diagnoses, inappropriate interventions, and iatrogenic harm (Chanen & McCutcheon, 2013). However, PDs are still highly stigmatized among professionals and are also associated with patient 'self-stigma'. A **'public health offensive' is needed to decrease stigma** both in the normal population and among all health care professionals in the field of adolescent medicine (including child and adolescent psychiatrists and psychologists, pediatricians, pediatric surgeons, general practitioners, etc.
5. While adolescent PD can now be considered a reliable and valid diagnosis, we have opened a new borderline towards childhood. Some studies have indicated that PD features can be reliably identified among children and that PDs are lifespan developmental disorders (Tackett, Balsis, Oltmanns, & Krueger, 2009). Nonetheless, the issue of **age threshold and/or criteria for childhood PD** remains completely unresolved to date.

In summary, guidelines (e.g., NICE guidelines) and classifications (e.g., DSM-5) have made an important first step by approving the diagnosis of adolescent PD and consequently supporting early intervention in PD. However, this only lays the groundwork for future clinical and research approaches that are urgently needed in the field.

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Diagnosing PD in adolescence—current dilemmas and challenges by Michael Kaess (continued)

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Scientific News

The prevalence, structure and treatability of Personality Disorders in adolescents

The prevalence, structure and treatability of Personality Disorders in adolescents by Dineke Feenstra and Joost Hutsebaut

Clinicians seem reluctant to diagnose personality disorders (PDs) in adolescents (Allertz & van Voorst, 2007; Chanen & McCutcheon, 2008). Different arguments are usually being given, most of them referring to the intention to protect youngsters from stigmatizing and unhelpful labels (Freeman & Reinecke, 2007). However, DSM-IV-TR (American Psychiatric Association, 2000, p. 687) states that PDs may be classified in children and adolescents. Furthermore, recent studies support the validity and reliability of the diagnosis (see for example, Braun-Scharm, 1996; Grilo et al., 1998; Johnson et al., 2000; Johnson et al., 2005; Kasen et al., 2007; Westen, Shedler, Durett, Glass, & Martens, 2003). And, there is increasing evidence that early expressions of PD symptoms can be effectively treated (Chanen et al., 2008; Schuppert et al., 2009). This increasing body of evidence has influenced recent guidelines (National Institute for Health and Clinical Excellence, 2009). Surprisingly, it has had little impact on clinical practice (Laurenssen, Hutsebaut, Feenstra, Busschbach, & Luyten, 2013).

In 2008, De Viersprong started a research line on adolescent personality disorders. The aim of our research was to learn more about PDs in adolescents. To do this, we investigated the prevalence, structure and treatability of PDs in adolescents. Our research findings can be summarized as follows:

PDs are highly prevalent in adolescents, in a clinical sample of adolescents we found that approximately 40% of the adolescents were diagnosed with at least one PD (Feenstra, Busschbach, Verheul, & Hutsebaut, 2011). Our findings were comparable to previous studies in adolescent (e.g., Grilo et al., 1998; Westen et al., 2003), and adult samples (see Verheul & van den Brink, 1999). As has been concluded in other studies, there is no evidence that PDs are over diagnosed using standard 'adult' assessment instruments. Furthermore, we found that PDs in adolescents are associated with low quality of life and high medical costs (Feenstra et al., 2012). These findings were also comparable to studies in adults suffering from PDs (Soeteman, Verheul, & Busschbach, 2008; Soeteman et al., 2008). They highlight the fact that PDs affect life quality of adolescents more profoundly than common Axis 1 disorders, adding to the validity of the diagnosis. To investigate the structure of personality pathology in adolescents, we investigated the psychometric properties of the Severity Indices for Personality Problems (SIPP-118; Verheul et al., 2008). The SIPP-118 intends to capture the more generic aspects of personality dysfunction, comparable to the Level of Personality Functioning Scale (Bender, Morey, & Skodol, 2011) in DSM-5. We found that the psychometric properties of the SIPP-118 in adolescents were similar to those reported in adult samples (Feenstra, Hutsebaut, Verheul, & Busschbach, 2011). In a more recent study we demonstrated that the identity integration factor of the SIPP seems unaffected by age, but is able to differentiate between PD adolescents and adolescents suffering from Axis 1 disorders (Feenstra, Hutsebaut, Verheul, & van Limbeek, 2014). Again,

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Dineke Feenstra

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this adds to the validity of the dimensions of personality dysfunctioning, suggesting that disordered identity integration as supposed to underlay PDs cannot be reduced to the developmentally normative identity issues of adolescence. Finally, we investigated the outcome of Inpatient Psychotherapy for Adolescents (IPA). Adolescents with PDs improved in terms of symptom severity, personality functioning and quality of life. Adolescents with cluster C PDs benefitted most from an inpatient treatment program (Feenstra, Laurenssen, Hutsebaut, Verheul, & Busschbach, 2014; Feenstra et al., 2014). These findings support the treatability of PDs in adolescence, but also highlight the need to tailor treatment to the specific needs and vulnerabilities of different types and levels of severity of PDs. In a more recent study we demonstrated the feasibility of Mentalization-Based Treatment for adolescents (MBT-A) suffering from borderline personality pathology (Laurenssen et al., 2014).

Our findings add to the growing body of evidence that adolescent and adult personality pathology are more similar than different. We believe this is more than a purely conceptual issue. Diagnosing the disorder of PD will provide a conceptual framework, preventing clinicians to focus on only one aspect of the problem. A focus on personality issues, and thus a focus on self- and interpersonal functioning will also immediately provide targets for treatment (Luyten & Blatt, 2013). Acknowledging the inability of many of these adolescents to develop a constructive and trustful therapeutic alliance or their inability to be committed to treatment brings these issues at the core of therapeutic work. Furthermore, adolescence may be a key developmental phase to intervene. Changes might occur more quickly as is suggested by the effects of relatively short interventions (for example, Chanen et al., 2008). Further on, early detection and intervention of PDs might prevent long term 'side effects' that are associated with the chronic course of the disorder. It can prevent the 'snowballing effect' that can often be seen in adolescence, leading to major developmental delays that have their effects far beyond adolescence.

To conclude, we believe attention will shift from an ethical discussion to the acknowledgement of the need to detect and treat personality pathology as early as possible during its course. We also believe that in the coming years existing evidence based models will be further adapted to the specific needs of adolescents, delivering more developmentally specific treatment approaches for PDs in adolescents.

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Submissions

Theresa Wilberg

Newsletter Submissions

Submissions to the *ESSPD Newsletter* are accepted on an ongoing basis. Subject areas may include issues from clinical practice, views and comments on current development within PD, reports from affiliated societies, member information, national and international events and conferences, research updates on personality disorders and more.

We are interested in submissions from practitioners and researchers from both within and outside of Europe. The length of submissions should be from 300-800 words and formatted in Word. We suggest that the authors limit their use of references. Please enclose author photos with the all text.

Submissions should be emailed to Theresa Wilberg at uxthwi@ous-hf.no