Clinicians seem reluctant to diagnose personality disorders (PDs) in adolescents (Allertz & van Voorst, 2007; Chanen & McCutcheon, 2008). Different arguments are usually 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,
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, Laurensen, 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 (Laurensen 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.

Joost Hutsebaut, Clinical psychologist and principal investigator, De Viersprong, National Institute for Personality Disorders, P.O Box 7, 4660 AA Halsteren, The Netherlands, E: Joost.Hutsebaut@deviersprong.nl

Dineke Feenstra, health care psychologist and principal investigator, De Viersprong, National Institute for Personality Disorders, P.O. Box 7, 4660 AA Halsteren, The Netherlands, T: +31 88 76 56 200, E: dineke.feenstra@deviersprong.nl
References


