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Abstract

The diagnosis of personality disorders in adolescents is a controversial idea. Personality disorders can bring about a stigma and may create effects on quality of life. Developmental implications should be considered when diagnosing adolescents with personality disorders, or any other mental illness, due to the incomplete formation of identity during adolescent years. There is also evidence that attachment patterns may influence personality disorder symptoms and should also be considered as a way to conceptualize personality in general. The current diagnostic systems may not provide a complete framework from which to conceptualize adolescents and ideas for restructuring the diagnostic system is discussed. This paper will explore adolescent personality disorders from the perspectives of development, attachment, and trauma and will explain perceived flaws with the current diagnostic system.

CONSIDERATIONS FOR THE DIAGNOSIS OF PERSONALITY

DISORDERS IN ADOLESCENTS

A Research Paper

Presented to

The Department of Educational Leadership, Counseling

and Postsecondary Education

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree Master of Arts

by

Katherine J. Young-Kent

May 2007

This Research Paper by: Katherine J. Young-Kent
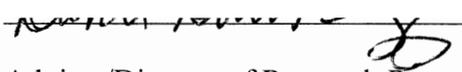
Entitled: CONSIDERATIONS FOR THE DIAGNOSIS OF PERSONALITY

DISORDERS IN ADOLESCENTS

has been approved as meeting the research paper requirements for the Degree of

Master of Arts.

3-8·07

Date Approved

Darcie Davis

Adviser/Director of Research Paper

3/20/07

Date Received

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Abstract

The diagnosis of personality disorders in adolescents is a controversial idea. Personality disorders can bring about a stigma and may create effects on quality of life. Developmental implications should be considered when diagnosing adolescents with personality disorders, or any other mental illness, due to the incomplete formation of identity during adolescent years. There is also evidence that attachment patterns may influence personality disorder symptoms and should also be considered as a way to conceptualize personality in general. The current diagnostic systems may not provide a complete framework from which to conceptualize adolescents and ideas for restructuring the diagnostic system is discussed. This paper will explore adolescent personality disorders from the perspectives of development, attachment, and trauma and will explain perceived flaws with the current diagnostic system.

THE DIAGNOSIS OF PERSONALITY DISORDERS IN ADOLESCENTS

Personality disorders are diagnosed to explain maladaptive patterns in functioning. There are three different clusters of personality disorders, grouped together based on levels of functioning and impairment. The Diagnostic and Statistical Manual of Mental Disorders, also known as the DSM-IV-TR, created by the American Psychiatric Association (2000), provides guidelines for the diagnosis of personality disorders and other mental illnesses. The DSM-IV-TR cautions about the diagnosis of personality disorders in individuals younger than eighteen due to the belief that personality may not be completely formed until adulthood. Despite that caution, personality disorders are diagnosed in adolescents and even children.

Several issues need to be considered when diagnosing adolescents with personality disorders. Since personalities may not be completely formed or stable during the adolescent years, it is important to consider whether or not the symptoms observed are pathology or part of the process of human maturation. A discussion will follow about the considerations regarding developmental theories and attachment patterns.

There is also concern regarding the current diagnostic system described in the DSM-IV-TR. Similarities exist between the symptoms of personality disorders and other Axis 1 disorders in the DSM-IV-TR which can create error or confusion

in the diagnostic process. Concerns related to the DSM-IV-TR classification system are discussed below and suggestions for a restructured classification system are explained. This paper will conclude with recommendations for counselors when considering personality disorders in adolescents.

<center>Personality Disorders</center>

The criterion for personality disorders are outlined in the American Psychiatric Association's fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (2000). In this manual (DSM-IV-TR), personality disorders are described as stable and inflexible abnormal perceptions and patterns of personal experiences that are considerably different from those found in most social or cultural groups. These differences are usually observed during adolescence or young adulthood. These distorted perceptions and responses lead to distress and impairment for the individual (American Psychiatric Association, 2000).

Types of Personality Disorders

The ten different personality disorders are organized into three clusters: A, B, and C. Each cluster represents a group of personality disorders with similar features. Cluster A personality disorders are characterized as odd or eccentric and include Paranoid, Schizoid, and Schizotypal. Dramatic, erratic and emotional personality disorders, such as Antisocial, Borderline, Histrionic and Narcissistic, are in Cluster B. Cluster C personality disorders have anxious and fearful

components and include Avoidant, Dependent and Obsessive-Compulsive (American Psychiatric Association, 2000).

Different models are used to determine the difference between normal and pathological functioning within personalities. In Norman's (1963) five-factor personality model clients are rated along five dimensions: neuroticism, introversion versus extroversion, closedness versus openness to experience, antagonism versus agreeableness, and conscientiousness. Responses of clients determine personality characteristics and can aid the client with identifying why he or she may have problems in certain areas or why some situations may cause anxiety (a person with high levels of introversion may experience anxiety if he or she is asked to share about his or her life in front of several people). The DSM-IV-TR Personality Disorder clusters can also be viewed as existing on a continuum with Axis 1 mental disorders (American Psychiatric Association, 2000).

Diagnosis of Personality Disorders in Adolescents

A debate exists about whether or not to diagnose personality disorders in adolescents. Although the DSM-IV-TR describes personality disorders first being observed in adolescence or young adulthood, one criterion for the diagnosis of several personality disorders is that the client be 18 years of age or older (American Psychiatric Association, 2000). This contradiction points to the ongoing debate over whether or not personality disorders should be diagnosed in

adolescents. On one hand, the characteristics of the disorders can be present in adolescence, but on the other hand, the personality is not fully formed and some behavioral or cognitive distortions may be influenced by adolescent development and the formation of identity. In fact, the DSM-IV-TR itself states "it should be recognized that the traits of a Personality Disorder that appear in childhood will often not persist unchanged into adult life" (American Psychiatric Association, 2000, p. 687). This area of research is in its infancy and there are several questions left to be answered in order to better understand personality and personality development, both normal and abnormal.

One study conducted by Westen, Shedler, Durrett, Glass, and Martens (2003) found the manifestations of personality disorders have more similarities than differences among the adolescent and young adult populations. During the course of this study, 296 adolescents, aged 14 to 18, currently seeking counseling were reviewed by their individual clinicians using several measures (Shedler-Westen Assessment Procedure – 200 for Adolescents (SWAP-200-A), demographic questionnaires, diagnostic checklists, etc.). The results of this study showed that based on the responses of the clinician-raters, personality disorder diagnoses are applicable to adolescent clients. In fact, it appeared that roughly 15% of adolescents meet criteria for adult personality disorders.

However there are some considerations when diagnosing adolescents with personality disorders. One consideration is that there is significant comorbidity

(ability to diagnose more than one disorder at a time) between personality disorders, and some mood disorders, in adolescents. Several of the adolescents in the above-mentioned study met criteria for between three and six of the ten different personality disorder diagnoses (Westen, Shedler, Durrett, Glass, & Martens, 2003). Finally, there appeared to be an over-diagnosis of avoidant and anti-social personality disorders among adolescents. This may be due to clinicians' overemphasis on acting out behaviors or difficulties forming peer support groups that seem to be common among the adolescent population (Westen, Shedler, Durrett, Glass, & Martens, 2003). Although there appears to be evidence that personality disorders do exist in adolescents, it is not surprising that different considerations need to be made when diagnosing personality disorders in adolescents and adults.

Adolescent Personality Disorders' Affect on Quality of Life.

It is necessary to investigate the prevalence of personality disorders among adolescents because these diagnoses may cause increased impairment in adulthood. Identifying these personality characteristics in adolescents may help to prevent later increased maladaptive behaviors and responses to stress or help to gain an understanding of mental health development between the adolescent and adult stages of life. It appears adolescents diagnosed with personality disorders are at greater risk for receiving diagnoses of both personality disorders and Axis 1 disorders in young adulthood (Nakash-Eisikovits, Dutra, & Westen, 2002). Other

studies provide evidence that the diagnosis of mental illness (including personality disorders) can affect much more than mental health.

A longitudinal study was conducted by Chen, Cohen, Kasen and Johnson in 2006 to assess adolescent and young adults' perspectives on how physical illness, mental illness, and personality disorders affect quality of life. Participants (ages 9 to 18) were assessed in 1983 and again between 1991 and 1994 to see if early diagnoses affected future quality of life. Among its findings, this study uncovered that those with one or more personality disorder in adolescence showed higher levels of stress, problems with relationships, and had a lower rating of quality of life among several dimensions when they were assessed years later. It is also important to note that this study found those participants with both personality disorder and Axis 1 diagnoses in adolescence has significantly impaired physical health, role stress, and lower levels of social support and resources at the follow up assessment (Chen, Cohen, Kasen & Johnson, 2006).

Developmental Framework of Personality Disorders

Changes in personality are part of normal development. The importance of considering development while diagnosing adolescents with personality disorders, or any other mental illnesses, has already been noted. Adolescence is a time of transition – from being a child to becoming an adult. Motor development has slowed during this stage and cognitive, emotional and relational developments are in high-gear. One theory of development was proposed by Erik Erikson in 1950.

In his theory, Erikson describes development over the lifespan based on eight psychosocial crisis stages. In each stage, an individual faces a developmental crisis. Successfully resolving these crises allows an individual to move forward with healthy development, while unsuccessfully resolving crises can leave an individual stuck in one stage of development. The fifth of Erikson's stages seems to be of particular interest when discussing personality development and adolescents. In this stage of Erikson's psychosocial developmental theory (1950), each individual is faced with the crisis of identity consolidation versus identity confusion (or diffusion).

Erikson's Model and Personality Disorders

Successful resolution of Erikson's fifth crisis in psychosocial development is critical for future relationships and self-esteem. The successful resolution of this crisis allows adolescents to form a clearer sense of self, personal beliefs and morals and to identify their place in the social structure. In contrast, unsuccessful resolution of this crisis can lead to a disorganized sense of self, an ambiguous social identity, and difficulty with integrating states and feelings appropriately into behavior. It appears those who resolve this crisis through identity confusion often have trouble setting occupational goals and later may adopt deviant social roles (Crawford, Cohen, Sneed, & Brook, 2004).

The formation of identity lays the groundwork for future beliefs about competence and self-esteem. Personality development in particular is significantly

influenced by identity formation. Erikson (1968) described the development of a

healthy personality as a never-ending progression towards self-acceptance and

wellbeing. Relationships are also impacted by the resolution of the fifth

psychosocial crisis, as the sixth crisis includes the ability to create and maintain

intimate relationships. If the identity crisis is negatively resolved, individuals may

experience a difficult time existing in healthy intimate relationships (Crawford,

Cohen, Johnson, Sneed, & Brook, 2004).

Interestingly enough, the signs of identity confusion are similar to the

symptoms of personality disorders. Cluster B personality disorders (anti-social,

narcissistic, histrionic and borderline) are consistent with signs of identity

confusion due to the dramatic, disruptive and even psychotic tendencies present

within their criteria (Crawford, Cohen, Johnson, Sneed, & Brook, 2004). Cluster

B personality disorders simultaneously involve unstable and sometimes

melodramatic relationships, which is consistent with the Eriksonian view that

unsuccessful resolution of the identity crisis would negatively influence

relationships in the sixth crisis stage. An encouraging aspect of this

developmental framework is that even if a psychosocial crisis is negatively

resolved, that does not mean that individual is destined to have negative identity

formations and relationships for the rest of his or her life. It may mean the

individual will remain confused about his or her identity longer than peers the

same age, but he or she can eventually move on and positively resolve this crisis.

In a longitudinal study on personality development, it was found that younger cohorts of participants (ages 11 to 15) were more likely to display Cluster B personality traits than older cohorts (ages 16 to 22) or the same cohorts in the future. This supports Erikson's psychosocial developmental model in that the participants in the younger cohort were at the age in which the identity crisis would begin to emerge. Symptoms associated with cluster B personality disorders (borderline, histrionic and narcissistic) relate to Erikson's description of identity diffusion, where as older cohorts were assessed at a time in which they were experiencing life changes that created more identity consolidation (finishing high school, starting college or entering the workforce, etc.). Additionally, only older subjects noted difficulties in maintaining relationships, which is consistent with Erikson's model as well, as these older subjects would be moving on to the intimacy crisis (Crawford, Cohen, Johnson, Sneed, & Brook, 2004).

Personality development in adolescence significantly influences future personality characteristics and even possible disorders. Erikson's model of psychosocial development is one theory that describes personality formation during this stage of life. Many factors can contribute to successfully or unsuccessfully resolving psychosocial crises – family, environmental stressors, abuse history, and so on – the responsibility is not with the individual alone. Studies support the existence of identity and intimacy crises in adolescents and provide a framework from which to describe possible reasons for the formation of

personality disorders (unresolved psychosocial crises). As stated above, changes in personality are a normal part of development and it is important for clinicians to consider development when diagnosing or treating personality disorders in adolescents.

<div align="center">Attachment Framework of Personality Disorders</div>

Attachment research supports Erikson's developmental model (Lyddon & Sherry, 2001; Nakash-Eisikovits, Dutra, & Westen, 2002). It has been accepted that one of the most important developmental challenges is the formation of one's individual identity and connecting that with relationships with others (Lyddon & Sherry, 2001). Attachment goes further by claiming the way individuals attach to caregivers in the first few years of life affects their ability to feel secure within themselves and in relationships with others. Those individuals who experience disruptions in attachment at an early age may be at an increased risk to display symptoms associated with personality disorders in adolescence and early adulthood.

Early Work on Attachment

Attachment theories have received a lot of attention in recent years. Theories of attachment claim relationships with caregivers early in life form the foundation for a child's sense of self and also lays the groundwork for how one will confront future developmental challenges (Lyddon & Sherry, 2001). Healthy relationships with caregivers in early life influence later relationships, self-

esteem, and coping mechanisms in a positive way, while the opposite is true for those who have negative relationships with caregivers during early development.

The first well-known study designed to better understand childhood attachment and its lasting affects was conducted by Mary Ainsworth in 1978. This study involved observation of an infant's responses once a caregiver left the child with strangers and again once the child and caregiver were reunited. From these observations, three attachment styles were identified: secure, insecure-avoidant, and insecure-ambivalent. Securely attached children displayed a balance of involvement with the mother and with the environment. They were upset when their mother left, but were comforted later and responded to her return with happiness. These children used their mother as a checkpoint for security by returning to her often before returning to play in the new environment. Insecure-avoidant children became overly involved with the environment and did not react significantly to the mother's leaving or returning. Observers believe this style may reflect inconsistent nurturing or lack of nurturing during the first year of life. Lastly, insecure-ambivalent children were inconsolable when their mother left, but then reacted harshly upon her return. These infants were observed attempting to push their mother away if she attempted to console them. Observers hypothesized this may be due to a fear of abandonment (Ainsworth, 1978). Ainsworth's study was the first to empirically classify attachment (Nakash-Eisikovits, Dutra, & Westen, 2002).

Several studies have built off of Ainsworth's early work. Bartholomew

(1991) observed attachment styles can develop from positive or negative

perceptions of the self and others. Bartholomew identified four attachment styles

(secure, preoccupied, fearful and dismissive) to describe how this self-and-other

model may affect relationships with the self and relationships with others. Secure

individuals have a positive perception of themselves and of others. They expect

others to be accepting and responsive. Preoccupied individuals have a negative

perception of themselves but a positive perception of others. Their ability to be

self-accepting depends on if they feel accepted by others. If they feel rejected,

they are more likely to be disapproving of themselves. Fearful individuals have a

negative perception of themselves and others. They believe others are

untrustworthy and typically avoid close relationships with others to protect

against future rejection. Finally, dismissive individuals have a positive perception

of themselves and a negative perception of others. Dismissive individuals

maintain high levels of independence and invulnerability by avoiding close

relationships with others to protect against disappointment (Bartholomew &

Horowitz, 1991).

This self-and-other model of attachment proposed by Bartholomew and

others has been validated through empirical research. Griffin and Bartholomew

(1994) gave three different assessment measures (self-reports, friend-reports, and

romantic partner reports) to college students and a person with whom the student

had a close relationship - either a friend or a romantic partner. Participants were

also interviewed about peer and family attachments by trained raters and were

judged on levels of attachment and attachment patterns based on their

explanations and descriptions of their memories of relationships and attachments

in the past (experiences of acceptance or rejection, separation and loss, gaining

and giving support, future expectations, etc.). The results of this research provided

validity for the self-and-other model. Participants' judged attachment styles were

strongly correlated with predicted relationship patterns and perceptions of

themselves. Their self models correlated with measures of self-concept and their

other models correlated with measures of relationship patterns (Griffin &

Bartholomew, 1994). The work done by Bartholomew and her colleagues has

been referenced for much of the information on the link between attachment and

personality disorders.

The Connection between Personality and Attachment

Many questions have been raised about the relationship between early

attachment patterns and personality development. If one's personality is a

persistent pattern of cognition, drive, affect, emotional and impulse regulation,

and the ability to bond with others, it is related to attachment, as attachment is

related to most of these areas (Nakash-Eisikovits, Dutra, & Westen, 2002).

There is evidence that personality pathology in adolescents is related to

attachment. The Relationship Questionnaire, developed by Bartholomew and

Horowitz in 1991, was given to clinicians to assess their adolescent clients during a study conducted by Westen et al. in 2003. This questionnaire consists of four short paragraphs that describe the four attachment patterns. Clinicians were asked to rate, on a seven-point scale, to what degree their client resembled each of the four attachment styles. The results displayed a relationship between attachment patterns and personality disorder diagnoses among the adolescents. Those clients perceived as having disorganized attachment styles were particularly likely to have a personality disorder. Furthermore, those conceptualized with having an insecure attachment, as identified from Ainsworth's theory, were at risk of developing substance abuse problems, involvement with criminal activity, and having unresolved trauma histories (Nakash-Eisikovits, Dutra, & Westen, 2002).

Attachment patterns do not just affect the way one views relationships with present and future caregivers. Attachment patterns influence the way one relates to the world as a whole and makes meaning out of his or her experiences (Lyddon & Sherry, 2001). These can become salient beliefs and interactions which integrate into the personality, possibly resulting in a personality disorder.

Four Categories of Attachment and Personality Disorders

Attachments made with caregivers during infancy or early childhood shape the way one views the self and others. Insecure attachments can lead to personality pathology apparent in adolescence and young adulthood. As a self-fulfilling prophesy, people often evoke reactions from others and interpret

feedback in a way that reinforces their working beliefs about themselves and others (Bartholomew & Horowitz, 1991). In this way, the personality becomes strengthened over time, possibly resulting in a distorted view of the self and others.

Attachment styles have been connected to particular personality disorders. When attachment, like development, is taken into consideration, behaviors and reactions seem to make more sense. Many symptoms of personality disorders are what would be expected from someone with a particular attachment pattern. Using Bartholomew's categories of attachment, the parallels between attachment and personality characteristics are described.

Preoccupied attachment is connected with dependent, obsessive-compulsive, and histrionic personality styles. This attachment category includes a positive evaluation of others and a negative evaluation of one's self. Those with dependent, obsessive-compulsive and histrionic personality styles seek acceptance from others through accomplishments and attention. Their caregivers are often overprotective, demanding of excellence, or are enmeshed in their relationships with the child. These children receive messages that they cannot accomplish anything on their own, are not good enough, are to blame for problems, or need to earn attention. Those with preoccupied attachment styles interact with others in a manner that reinforces their beliefs that they need others' attention or respect to be valued by avoiding interactions or being overly needy of attention. Often times

these individuals magnify mistakes or accidents to reinforce to themselves that

they are out of control. They then seek the acceptance of others to establish self-

worth (Lyddon & Sherry, 2001).

Avoidant personality styles are observed when both preoccupied and

fearful attachment patterns are present. Both these attachment patterns have a

negative view of self, but the view of others fluctuates between positive and

negative. Individuals who are avoidant typically desire to be accepted by others

but fear rejection so much they are unlikely to have many friends. In the

friendships they do have, this personality style is likely to be overly dependent,

which pushes others away and reinforces the fear of rejection. The caregivers of

children with avoidant personality styles typically are engulfing or avoidant

themselves. This causes their children to feel fearful of engulfing relationships in

the future (Lyddon & Sherry, 2001).

Fearful attachment patterns can lead to paranoid personality styles. This

attachment category has a negative perception of both self and others. Paranoid

personality styles are guarded and defensive. People with this personality style are

distrustful of others and tend to blame other for mistakes or unfortunate

circumstances. The caregivers of these individuals were probably rejecting and

degrading, which led to hostility towards others and a negative view of the self.

Those with paranoid personality styles isolate themselves from others, reinforcing

loneliness and suspicion (Lyddon & Sherry, 2001).

A negative view of others and a fluctuating view of the self characterize a mixture between the fearful and dismissive attachment styles. Individuals diagnosed with antisocial, narcissistic, and schizotypal personality traits (or disorders) are likely to have this attachment pattern. People with these personality styles are angry, bizarre, impatient, and antagonistic towards others. They view emotional reactions as forms of weakness and lack empathy towards others. The caregivers of individuals with fearful/dismissive attachment styles were possibly abusive, over evaluating, cold and cruel. This role-modeling by the caregivers causes the child to become self-reliant, hostile and malicious. The fluctuating self-view is a defense against others and can be perceived as a sense of entitlement to mask felt insecurity. People with fearful/dismissive attachment styles reinforce their beliefs that the world is hostile and cruel by turning others against them, isolating themselves, or taking on an indifferent stance towards others (Lyddon & Sherry, 2001).

Schizoid personality styles are connected with dismissive attachment. This attachment category involves a positive view of the self and a negative perception of others. People with schizoid traits are uninterested and indifferent towards others. Their caregivers were probably unresponsive to the child's emotional needs and did not allow the child to become well socialized. These individuals do not appear affected by their deficit in relationships and have a positive view of themselves regardless (Lyddon & Sherry, 2001).

Borderline personality styles do not seem to fit into any category specifically and also seem to fit into them all in some way. There is an argument that people with borderline traits may fit into their own disorganized attachment category. These individuals fluctuate between their beliefs about others and about themselves without much consistency. They are impulsive, emotional, vacant and extremely reactive. Individuals in this category move hastily between extreme closeness and extreme avoidance in relationships, which causes an array of fickle relationships in their lives. Their development was probably chaotic with caregivers who alternated between being over-involved, critical or incongruent. There was probably little structure or stability within the home environment, which led to a lack of emotional regulation. Physical and sexual abuse likely occurred during childhood and adolescence (Lyddon & Sherry, 2001). The ups-and-downs of this personality, and corresponding attachment style, leave questions about the existence of a fifth attachment category in Bartholomew's model.

Attachment Application to Counseling

The ties between attachment and personality development are hard to ignore. Like development, attachment models need to be considered when diagnosing adolescents with personality, or any other, disorder. If clinicians attempt to assess the attachment history of individual clients, as well as the meaning the clients give to their history, the treatment focus of counseling could

become clearer. Additionally, Clinicians need to identify how environmental feedback may reinforce the clients' perceptions about themselves and others and attempt to reorganize it. The counseling relationship itself can serve as a means for clinicians to observe and experience patterns of attachment and refute maladaptive attachment patterns (Lyddon & Sherry, 2001). To benefit adolescent clients in treatment, it is necessary to consider all aspects of personality development and attempt to identify the context out of which these traits developed to best treat the client.

<center>Integration of Axis II and Axis I disorders</center>

Now that contextual considerations of personality disorders have been discussed, attention will be given to alternative diagnoses of personality disorders. There is a stigma associated with the diagnosis of personality disorders. Recently, questions have been raised about the stigma of personality disorder diagnoses, particularly on adolescents and young adults. In addition, some Axis 1 diagnoses and personality disorders share symptoms, which have raised questions about integration to decrease stigma and combine treatment methods (Hodges, 2003). Particularly, the similarities between the diagnoses of Posttraumatic Stress Disorder and Borderline Personality Disorder have received attention. A discussion follows on implications for these similarities as well as possible revisions to the current diagnostic system.

Similarities between Diagnoses

To start, some criteria for the diagnosis of Posttraumatic Stress Disorder (PTSD) and Borderline Personality Disorder (BPD) are similar. Among others, some symptoms that characterize PTSD include detachment or estrangement from others, decreased interest and pleasure in previously enjoyed activities, irritability and anger outbursts, and dissociative symptoms (American Psychiatric Association, 2000). Similarly, BPD's symptoms include unstable relationships, feelings of emptiness, difficulty controlling anger, instability of affect, and paranoia or dissociative symptoms (American Psychiatric Association, 2000). Many of the similar symptoms have to do with reactivity, affect on relationships, and experiences of trauma.

These two disorders are commonly diagnosed together. One study, examining the symptoms of people diagnosed with borderline personality disorder, found that 56% also met criteria for PTSD (Zanari, Frankenburg, Dubo, Sickel, Trikha, Levin, & Reynolds, 1998). Both have become what have been referred to as "garbage can" diagnoses due to their broad range of symptoms, relational affects, and stress-related issues (Hodges, 2003). The two diagnoses may actually be the same disorder, with one being more salient over time. BPD may be somewhat of a "chronic PTSD." Personality disorders, especially BPD, may develop out of long-term experiences with trauma during the early years of

life, which may leave individuals more prone to PTSD symptoms when he or she

encounters extreme stress in the future (Hodges, 2003).

A Call for Integration

One argument for the consideration of integrating these two diagnoses in

the next revision of the DSM-IV-TR is the stark difference in the way these two

disorders are perceived by clinicians and society alike. PTSD is a diagnosis that is

non-blaming and has a focus on external causes. BPD, on the other had, is viewed

as a personality flaw of the client and its causes are seldom considered. There

seems to have been development of a mental health "caste system" for those with

BPD, as they are viewed by many as untreatable and not worth the effort. Clients

diagnosed with PTSD are eligible for disability assistance without having a

disorder per se, while BPD clients have lost court cases due to their incredibility

as witnesses (Hodges, 2003). These different responses are given to basically the

same symptoms.

Another possibility is the development of a continuum for stress responses

rather than two similar diagnoses that are treated so differently. This would allow

clinicians to identify not only the severity of stress the client experienced but also

the intensity of the response to that stress (Hodges, 2003). Developmental and

attachment models could be beneficial in this case as well, as using these lenses

would encourage clinicians, courts, and society to consider the causes of the

responses to stress rather than just the responses alone. It has also been suggested

that the broad diagnoses of PTSD and BPD be narrowed according to the

responses to particular stressors (i.e. sexual abuse, war, abandonment, etc.) rather

than attempting to explain all types of trauma responses in a uniform manner

(Hodges, 2003).

It is difficult to determine where BPD ends and PTSD begins or vice

versa. Despite the similarities, these two diagnoses are treated very differently.

Possible solutions to narrow these broad diagnoses, integrate the two, or identify a

spectrum of responses have all been recommended. Kroll (2003) argued that, "in a

nutshell, the present concepts of PTSD and borderline are each so vague and

encompass so many heterogeneous conditions that it is impossible to know what

each one is, let alone whether they are the same thing" (p. 70). Viktor Frankl

(1959) also raised a valid point when he suggested human suffering, from

whatever source, is a normal factor of life rather than an issue that needs to be

resolved or medicated.

<div align="center">Alternatives to the DSM-IV-TR Classification System</div>

In addition to the suggestions to integrate current diagnoses, there are also

arguments for restructuring the current diagnostic system entirely. Shortcomings

of the DSM-IV-TR have been identified and clinicians and researchers together

are calling for a more comprehensive diagnostic strategy. This restructuring

would include adopting developmental and attachment approaches into the

classification system as well as highlighting client strengths. The claim is that

these strategies, although minimally tested, would improve the diagnostic process

for all ages and issues, including adolescent personality disorders (Lopez,

Edwards, Pedrotti, Prosser, LaRue, Spalitto & Ulven, 2006).

Downfalls of the DSM-IV-TR

One main complaint about the DSM-IV-TR criteria is the focus on

negative aspects of client functioning rather than addressing strengths. The

current diagnostic system asks clinicians to identify symptoms of the client that

make them "abnormal." This may cause clinicians to miss the entire context of

their clients' problems, as they are focused almost entirely on the identification of

negative characteristics to create a diagnosis. This narrow focus during the

diagnostic process does not allow practitioners to identify the clients' strengths,

resources, supports, and even cultural influences (Lopez et al., 2006). The process

of human change is also missing from the current system, so it does not take into

account maturation processes or adjustment (Barone, Maddux, & Snyder, 1997).

Another weakness of the DSM-IV-TR diagnostic system is that it

classifies individuals into discrete categories. Identifying where clients exist along

a continuum of functioning may be more beneficial when identifying contextual

aspects of the clients' complaints and addressing the severity of the symptoms.

Because of this discrete method, clients are diagnosed with a mental illness

simply because they report the presence of a symptom without regard to the

severity of the symptom or whether or not that symptom really is "abnormal" in

all contexts. An analysis from a sample of clients diagnosed with personality

disorders and those with "normal" functioning found the personalities in the two

groups had more similarities than differences (Maddux & Mundell, 1999).

Thirdly, the current system of diagnosis does not adequately address

treatment procedures. The DSM-IV-TR identifies the issues that need to be fixed

during the treatment process, but it does not give much information about how to

change it (Maddux, 2002). Integrating different models into the diagnostic system

could provide stronger links between diagnoses and treatment of those diagnoses

by offering a more contextual framework from which to operate.

Diagnostic Alternatives

With all these theories about the current classification systems' downfalls,

there also need to be theories about solutions. One idea is to make adaptations to

the current DSM-IV-TR system. This could be accomplished by broadening Axis

IV categories to include psychosocial and environmental resources and strengths

along with problems the client experiences in the environment. Another

adaptation could be rescaling the current Axis V Global Assessment of

Functioning (GAF) scale. Currently, this scale goes from zero to one hundred

with zero being basically nonfunctional and one hundred meaning the client is

functioning at the optimal level. If the GAF was rescaled to include a mid point of

50, which would be the client's baseline, a better idea of functioning could result.

For example, a score of zero would correspond to mean the client is severely

impaired, 50 would mean the client is in good health, and a score of 100 would imply that the client is functioning at an optimal level (Lopez et al., 2006). The baselines would be gathered from the client's own reports and this way above-normal functioning, or progress, could be assessed. The third adaptation to the current DSM-IV-TR is the addition of a sixth axis to identify the client's strengths specifically. The creation of this axis would be beneficial in determining the course of treatment by building upon what the client already does well. These three revisions would be made to the current classification system instead of completely adopting a new method.

Another suggestion is using the New Personality Dimension created by Oldham and Morris (1995). This method conceptualizes personality disorders along a continuum of adaptation. In this way, the client's functioning could be placed along a continuum to identify the amount of stress the client is experiencing at any point in time, past or present, to better understand the responses. Particular personality characteristics such as narcissism or reactivity can be viewed as a strength on one end of the continuum, but can become maladaptive if they become too extreme. This method would also allow clinicians to communicate in a more positive manner with clients about their diagnoses by identifying strengths and weaknesses together (Oldham & Morris, 1995).

A third suggestion is the use of the Levels of Well Being assessment. This method identifies six areas of functioning: self-acceptance, environmental

mastery, positive relationships with others, identification of a life purpose, personal growth and development and autonomy. Clients would be rated on each of these categories rather than relying on a single-factor model such as the DSM-IV-TR (Ryff, 1989). Individuals with high levels of emotional, psychological and social well-being are described as "flourishing" while those with low levels of well being are referred to as "languishing" (Keyes & Lopez, 2003).

The fourth alternative was offered by Ivey and Ivey in 1998. This system, called Developmental Counseling and Therapy, or DCT, involves taking a developmental approach. In this model, the clinician attempts to understand the experiences of the client and the client's environment from a developmental standpoint to determine how the individual and environment may have contributed to dysfunction. Sometimes, what appears to be maladaptive behaviors or thoughts may actually be adaptations made by the client in response to some historical experience. The development of personality style may help the client respond to relationships, which can influence treatment. This system also capitalizes on the client's strengths rather than focusing on the weaknesses of the individual and encourages the clinician to try and understand the context of the client's symptoms.

Several suggestions for altering the current diagnostic system have been offered in response to identified deficits of the DSM-IV-TR system. Many of these alternative methods focus on using a continuum of behavior rather than

using discrete classification systems. Developmental approaches are also suggested, as is the use of a multi-factor system. There are also revisions to the current DSM-IV-TR that may help practitioners gain a more holistic perception of their clients to better help them reduce negative symptoms.

<div align="center">Conclusion</div>

The diagnosis of personality disorders in adolescents creates several concerns and considerations. Because identity and intimacy are formed during adolescence, a developmental framework for the diagnosis of personality disorders has been identified. In addition, due to the impact of attachment on the formation of relationships and emotional regulation, these issues also must be considered when attempting to diagnose personality disorders, especially in adolescence when attachment may still be forming. The diagnoses of personality disorders bring with them a stigma that is hard for individuals to avoid. There are similarities between personality and other mental health disorders, and erroneous diagnoses may create undue labeling or stigma. Focusing on vulnerabilities or unhealthy defenses may cause diagnoses to be chosen from an insensitive lens. Many suggestions exist for the introduction of a more comprehensive, contextual diagnostic system that can take into consideration all of these viewpoints and avoid the labeling and victim-blaming. If clinicians must diagnose clients, then they at least need to diagnose from a framework in which all contexts are considered. The research on personality development, the existence of personality

disorders in adolescence, and attachment patterns is still being conducted. In the

future, there will hopefully be more understanding about adolescent issues and

additional information about what is "normal" or "abnormal" during this time of

identity and relationship formation.

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