

## Commentary

# Personality disorder in adolescence: The diagnosis that dare not speak its name

KENNETH R. SILK, Department of Psychiatry, University of Michigan Health System, USA

The major problem in diagnosing personality disorder in adolescence is not whether the diagnosis is valid, but rather that the diagnosis might not 'stick' over time. More troublesome would be that the diagnosis would 'stick' for a period of time much longer than what the patient's current symptoms might suggest that they should stick. We now know, primarily from the work of Zanarini, Frankenburg, Hennen, Reich and Silk (2005) as well as from the Collaborative Longitudinal Personality Disorders Study, (Skodol et al., 2005) that many people who, in adulthood meet the criteria for borderline personality disorder (BPD), do not maintain that diagnosis over the subsequent years of follow-up. This does not mean that these people do not have residual symptomatology, and perhaps symptomatology that can significantly impact their everyday functioning; it simply means that the person no longer meets the full criteria set for that particular diagnosis.

Nonetheless, it is important that patients repeatedly are evaluated and reevaluated with respect to whether they do or do not continue to meet criteria for the diagnosis. This failure to reevaluate will cause the diagnosis to stay with the patient long after the patient no longer meets the diagnosis. And this is where, in my opinion, the stigma may reside in that the patient can no longer escape the once made diagnosis. The patient may then encounter situations where his or her complaints and concerns (medical as well as psy-

chiatric or psychological) are dismissed because he or she is simply viewed as a 'character disorder'. This, to me, is the most profound impact of stigma in people who once have met a diagnosis but who may or may no longer retain it (Silk, 2002).

Certainly in this instance, this young woman would appear to meet the criteria for personality disorder, and this would help in the planning of a treatment protocol for her (American Psychiatric Association, 2001). It would allow the treaters to appreciate that a simple biological approach will probably only be, at best, moderately effective in her treatment (Tasman, Riba, & Silk, 2000), and a personality disorder diagnosis would hint at which issues might be very salient and how to address those issues in a psychotherapeutic endeavor. Also, it might mitigate against a therapy where transference is intensely encouraged (Gunderson, 2001; Paris, 2004).

With respect to diagnosing a personality disorder in adolescence (Cohen, Crawford, Johnson, & Kasen, 2005; Westen, Shedler, Durrett, Glass, & Martens, 2003), I refer back to my initial paragraph. If the goal of diagnosis is to convey the maximum amount of clinical information that one can pack into a 'label', then the diagnosis of personality disorder, if the patient appears to meet the diagnosis, should be made even if the patient may move beyond the diagnosis at some future time. Thus, I might modify the Diagnostic and Statistical Manual of Mental Disorders to read 'It should be

recognized that the traits of a Personality Disorder that appear particularly in childhood and often in adolescence may not regularly persist into adult life, and thus reevaluation of the personality disorder diagnosis must be considered at regular intervals. This is true for adults as well.'

I would not, at this juncture, want to say that the diagnosis of conduct disorder be abandoned and changed into antisocial personality disorder. Antisocial appears to be the most damning and stigmatizing of all the personality disorders, and I would do my best to refrain from that label unless I was absolutely convinced that such label did apply.

I believe that we might be able to resolve some of the differences between those who think of bipolar spectrum disorder (BPSD) and those who think of BPD (or those who think of conduct disorder and those who think of antisocial personality disorder) by considering that these are probably similar in that they are probably caused by a similar constitutional predisposition. In the case of BPSD vs. BPD, I would agree that both of the disorders are probably driven by problems with emotional regulation. However, how the difficulty in controlling emotions is presented clinically, and particularly how the predisposition expresses itself in interpersonal situations, that is, how the patient interacts with others as well as how the patient relates to us, is crucial here. These interpersonal interactions or style may not only be the most telling feature in distinguishing the two disorders clinically, it may also be the distinguishing feature in how the individual is able to navigate the world (Bolton & Gunderson, 1996; Paris, Gunderson, & Weinberg, 2007).

The uniqueness of psychiatry has long resided in our appreciation of the nature of the interpersonal relatedness between the patient and the therapist (Westen, 1997). It is precisely this interpersonal relatedness that would allow such distinctions between diagnoses that may have similar neurobiological drivers but different expressions of those predispositions. After all, in practice we deal with phenotypes and not genotypes even though

we would all wish that we would be closer to and have a better appreciation of the underlying psychobiological issues.

One word of caution about the diagnostic process. This young woman appears to have used drugs heavily since the age of 12, and the impact of this persistent drug use is difficult to assess. There is a belief that in the face of chronic drug usage and thus a chronic altered mental state, many young adolescents fail to negotiate certain developmental stages, and this failure to master these developmental milestones may be mistaken for, and may also be a primary cause of, what we diagnose as personality disorder not only in adolescence but in adulthood as well.

## References

- American Psychiatric Association. (2001). American Psychiatric Association Practice Guidelines. Practice guideline for the treatment of patients with borderline personality disorder. *American Journal of Psychiatry*, 158 (Suppl 10), 1–52.
- Bolton, S., & Gunderson, J. G. (1996). Distinguishing borderline personality disorder from bipolar disorder: Differential diagnosis and implications. *American Journal of Psychiatry*, 153, 9, 1202–1207.
- Cohen, P., Crawford, T. N., Johnson, J. G., & Kasen, S. (2005). The children in the community study of developmental course of personality disorder. *Journal of Personality Disorders*, 19, 466–486.
- Gunderson, J. G. (2001). *Borderline personality disorder: A clinical guide*. Washington, DC: American Psychiatric Press.
- Paris, J. (2004). Personality disorders over time; implications for psychotherapy. *American Journal of Psychotherapy*, 58, 420–429.
- Paris, J., Gunderson, J., & Weinberg, I. (2007). The interface between borderline personality disorder and bipolar spectrum disorders. *Comprehensive Psychiatry*, 48, 2, 145–154.
- Silk, K. R. (2002). Borderline personality disorder: The lability of psychiatric diagnosis. *Current Psychiatry*, 1, 11, 25–33.
- Skodol, A. E., Gunderson, J. G., Shea, M. T., McGlashan, T. H., Morey, L. C., Sanislow, C. A., Bender, D. S., Grilo, C. M., Zanarini, M. C., Yen, S., Pagano, M. E., & Stout, R. L. (2005). The Collaborative Longitudinal Personality Disorders Study (CLPS): Overview and implications. *Journal of Personality Disorders*, 19, 5, 487–504.

- Tasman, A., Riba, M. B., & Silk, K. R. (2000). *The doctor-patient relationship in pharmacotherapy: Improving treatment effectiveness*. New York: Guilford Press.
- Westen, D. (1997). Divergences between clinical and research methods for assessing personality disorders: Implications for research and the evolution of Axis II. *American Journal of Psychiatry*, *154*, 7, 895–903.
- Westen, D., Shedler, J., Durrett, C., Glass, S., & Martens, A. (2003). Personality diagnoses in adolescence: DSM-IV Axis II diagnoses and an empirically derived alternative. *American Journal of Psychiatry*, *160*, 5, 952–966.
- Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2005). The McLean Study of Adult Development (MSAD): Overview and implications of the first six years of prospective follow-up. *Journal of Personality Disorders*, *19*, 5, 505–523.

Address correspondence to: Kenneth R. Silk, Department of Psychiatry, University of Michigan Health System, 4250 Plymouth Road, Rachel Upjohn Building Box 5769, Ann Arbor, MI 48109-5769, USA. Email: ksilk@med.umich.edu