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# Personality Disorders in Adolescents and Different Therapeutic Approaches

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## Abstract

A personality disorder can be diagnosed at any age if the diagnostic criteria are met, which means also in adolescence. Diagnosing personality disorders is important since only with clear diagnosis specialized treatment can be applied. Several specialized (psycho)therapies have been developed for treating adolescent personality disorder with evidence-based efficiency, especially in borderline personality disorder—adolescent identity treatment (AIT), mentalization-based therapy (MBT), and dialectical behavior therapy (DBT). All are evidence-based therapies. Pharmacotherapy is not the therapy of choice and only a few studies have clearly demonstrated its efficiency; however, it is still largely utilized in clinical practice.

**Keywords:** personality disorders, adolescent, borderline personality disorder, adolescent identity treatment, mentalization-based therapy, dialectical behavior therapy

## 1. Introduction

Each person has a set of personality traits that are unique and make up one's personality. *Personality* can be defined as recognizable and permanent characteristics and attitudes that are reflected in thinking, feeling, and behaving (impulse control, the way of establishing and managing interpersonal relationships) [1]. Personality develops and evolves since childhood and shapes throughout life. *Temperament* is a biologically determined trait manifested from birth [2]. Rothbart et al. introduced three factors of temperament for the early and middle childhood that, later on in the development, shape personality dimensions, such as negative affectivity, extraversion, and effortful control [2].

Temperamental characteristics show high stability and are developmentally associated with personality traits during adulthood including extraversion or high energetic level, agreeableness, conscientiousness, neuroticism (emotional stability), and openness [2]. An important personality trait is *character*, which mainly refers to the substantive aspects of experiencing and related behavior. At the heart of the psychological understanding of character are traits that are important in terms of the individual's will, morality, and ethical and value orientation [3]. Naturally, our achievements in solving mental and life's problems depend on our abilities. The great scope of competence can be combined with various talents and the scope of skills as well [3].

Personality disorder (PD) is defined as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, and leads to distress or impairment [4]. People with PD have disrupted behavior, cognition, and emotions when in contact with other people and society, while the individuals and the people around them suffer [1]. The ICD-10 classifies the following PD: paranoid, schizoid, dissocial, emotionally unstable (impulsive and borderline type), histrionic, anankastic, anxious (avoidant), dependent, and other (e.g., narcissistic) [5]. The DSM-5 divides PD into three clusters. Cluster A personality disorders are characterized by unusual and odd-eccentric behavior and introverted individuals including paranoid, schizoid, and schizotypal PD. Cluster B personality disorders are associated with dramatic, emotional, and erratic behavior: antisocial, borderline, histrionic, and narcissistic PD. Cluster C includes avoidant, dependent, and obsessive-compulsive PD associated with anxious and fearful disorders. The division into three groups is useful for educational and research purposes; however, it also has its limitations. Clinically, there is a lot of overlapping between various PDs. The frequency of individual PD varies from study to study, and even greater differences are present when looking at the frequency of individual PD in a given population. Borderline PD is present in 0.9–3% of the general adolescent population, in 11% of outpatient adolescents, and 49% of admitted adolescents [4].

People diagnosed with PD from one group may also meet the diagnostic criteria of PD from the other, which occurs in about 9% [4]. Individuals from group C and A most commonly have an associated PD (6.0 and 5.7%, respectively), while this occurs only in 1.5% of individuals in the group B [4]. Due to PD overlapping and for other reasons as well, the PD criteria in ICD-11, which will come into effect in January 2022, have been modified [6]. ICD-11 follows a dimensional understanding of PD and largely abandons the categorical view. The new division of PD follows the psychodynamic tradition, the scientific model of the core PD characteristics, and thus provides guidance for clinical treatment [7]. It provides an assessment of the severity of the disorder, and enables to diagnose three levels of PD and code subthreshold personality difficulty. ICD-11 specifies five domain qualifiers of personality, which include negative affectivity, detachment, dissociality, disinhibition, and anankastia. In addition to these five markers, a borderline pattern qualifier can also be specified. The latter may be applied if at least five out of nine borderline PD criteria according to DSM-5 are present. An example of a diagnosis of borderline PD following the new features in ICD-11 is for example a moderate PD with borderline pattern, negative affectivity, disinhibition, and dissociality [7].

## **2. Borderline personality disorder**

Borderline PD is one of the most common PDs and these individuals are also more likely to seek medical help and suffer from significantly more associated mental disorders (depression, anxiety disorders, psychoactive substances abuse, and hyperkinetic disorder) compared to the general population [8]. Vulnerability for borderline PD can be clearly recognized during the development period. The concept of borderline personality has evolved throughout history. Morel and Kraepelin used this term to describe the states between neurotic and psychotic conditions primarily based on phenomenological clinical descriptions and by ignoring the developmental and dynamic aspects of pathology [9].

Kernberg linked the classical psychoanalysis, the object relations theories, the psychology of self (immature integrative self-functions) with the psychobiological and neurobiological theories, and defined the concept of borderline personality

disorder as a pathological personality organization that is intermediate between psychotic disorders and neuroses—symptomatically, structurally, and genetically-dynamically [10, 11]. This concept was further enhanced by the Linehan's biosocial model [12].

According to DSM-5, at least five of the following nine criteria must be present to code borderline personality disorder [4].

1. Frantic efforts to avoid real or imagined abandonment
2. Unstable and intense relationships
3. Identity disturbance, seen in an unstable self-image or sense of self
4. Impulsivity
5. Suicidal behavior
6. Affective instability (episodic dysphoria, irritability, anxiety: lasting a few hours to days)
7. Chronic feelings of emptiness
8. Displays of inappropriate anger (verbal/physical fights)
9. Micropsychotic episodes, transient stress-related paranoid ideation/dissociative symptoms

In addition, these patterns are enduring, inflexible, and clinically relevant to diminish social, educational, or professional functioning. The onset of this pattern is traced back at least to adolescence or early adulthood and it is not a manifestation of another mental disorder and is not due to the consumption of psychoactive substances [4].

Quite a few features of borderline PD (impulsivity, emotional instability, dysfunctional interpersonal relationships, impaired self-image, and identity diffusion) may also—to some extent—be characteristics of adolescent period. In order to diagnose a borderline PD in an individual during adolescence, the features must have been present for at least 1 year and cause severe dysfunction [4]. If the adolescent reacts highly destructive, has transient psychotic reactions and behavioral problems, uses psychoactive substances, has emotional disorders associated with the loss of a relationship with the important other or negative emotions, one can suspect a borderline PD [13].

In the clinical picture of borderline PD in adolescents, one often sees anger towards parents, depression without any existential despair, tension, loss of empathy, impulsive behavior, and brief psychotic episodes including a paranoid thoughts and depersonalization without thought disorder [14].

### **3. Personality disorders during adolescence**

It is a legitimate question whether to diagnose or not to diagnose PD before the age of 18. That is during adolescence – the time of major developmental changes, when the personality is not yet fully formed. However, relevant classifications and guidelines, based on a number of studies, allow us to diagnose a PD before 18 years

of age. According to ICD-10, a PD can be diagnosed regardless the age of person if the diagnostic criteria are met; however, this is exceptionally rare before the age 16 or 17 years [5]. This is even more clearly defined in ICD-11, where the diagnosis of PD is made whenever the diagnostic criteria are met [6].

The DSM-5 allows for a diagnosis of PD in children and adolescents, when personality traits are particularly maladapted, permanent, and not related to a specific developmental period, mental disorder, or cultural background with the exception of antisocial PD, which cannot be diagnosed before the age of 18. For a diagnosis to be made, the characteristics of PD should have been present persistently for at least 1 year [4]. One should keep in mind that the characteristics of PD identified in childhood will change and that some types of PD will become less obvious or even disappear in later developmental periods (borderline, antisocial PD). The NICE recommendations do not define a chronological age at which a PD can be diagnosed. Instead, they focus on the individual level of developmental maturity and an understandable therapeutic plan to be provided to the person diagnosed with PD [15]. However, PD should not be diagnosed in individuals under the age of 13 and is not applicable until an individual finishes puberty. Because PDs have long been considered as therapy resistant, this diagnosis is misused even today as an excuse to refuse a patient. When diagnosing a person with PD, especially if it is an adolescent, an appropriate treatment must be provided along with the diagnosis. Prevention, early detection, and timely treatment are essential [15].

#### **4. Personality disorders treatment in a development period**

The purpose of diagnosing PD is to provide the adolescent with the appropriate treatment. It is the adolescent period that has a corrective potential and by introducing a therapy in time, we can significantly influence the course of PD. Adolescents with PD should be treated by a team of highly qualified professionals with a clearly structured intervention model and therapeutic plan [8, 13, 15]. Primarily, the patient must be provided with continuity and consistency. Adolescents with PD, especially borderline patients, have a tendency to form intense relationships; therefore, it is necessary to set clear time and space framework for treatments with different therapists. It is essential to organize treatments adequately—not too much and too little. Team members often have different views on the adolescent's problems and symptoms, which often lead to conflicts within the team; therefore, supervision is necessary. Often, many services (social services, school, general physician, previous therapist) are involved in the treatment; therefore, roles and tasks need to be clearly identified and coordinated. One of the main treatment goals of all team members is to support the adolescent in his separation and individualization and to actively involve him in the decision-making process. Many adolescents with borderline PD have experienced traumatic events; however, trauma processing is often not the primary intervention. Primarily, it is necessary to reduce suicidality and increase emotional stability [15, 16].

There are many different psychotherapeutic approaches to treat PD. Mentalization-based therapy (MBT), dialectical-behavioral therapy (DBT), and adolescent identity treatment (AIT) are among the most common. It is not so important which specific psychotherapeutic approach is used in the therapy but that certain changes outside the therapeutic relationship are triggered [13, 16]. According to Lambert, these changes are to be accountable for 40% of success in psychotherapy [17]. It is important to include the rest of the family in the therapy, to generate changes in the school, and that all significant others receive appropriate psychoeducation. Psychotherapeutic factors such as therapeutic posture, curiosity,



optimism, consistency, empathy, and warmth contribute 30% to the success of a therapy. The adolescent's expectations of how successful the therapy will be contributing a further 15%. In addition, 15% is contributed by the specific psychotherapeutic techniques [17].

To achieve an optimal therapeutic process, regardless of the type of therapy, the therapist needs to be open, accepting, and optimistic and maintain a positive mental representation of the adolescent as well as curiosity and interest in getting to know the adolescent as a holistic personality, not only in the context of his or her disorder [16]. Since AIT is a younger and not so known therapy as MBT and DBT, it will be explained in more detail than the last two therapies below.

## 5. Adolescent identity treatment

Adolescent identity treatment (AIT) is an integrative therapeutic approach based on the principles of Paulina Kernberg, which includes modified elements of transference- focused psychotherapy, psychoeducation, behavior-oriented home plans, therapeutic contract, and intensive family work with adolescents and parents (adapted from [16]). Identity diffusion and interpersonal malfunctioning are regarded as the core of the borderline PD in adolescents and, as such, forming a base for the essential principles of AIT. The AIT focuses on identity stabilizing and integration of the concepts of the self and significant others, which gradually affects interpersonal relationships and leads to resolving interpersonal conflicts. The AIT applies verbal and nonverbal communication as well as countertransference. The basic principle of the AIT is to work on the dominant affect. The therapist focuses on the dominant affect the adolescent is affected by—here and now. Clarification, confrontation, and interpretation are applied as therapeutic techniques.

*Clarification* is the most common AIT therapeutic technique. It is used to explore and understand what the patient is saying. The adolescent's subjective feelings and perceptions are explored in detail until the therapist is able to understand exactly what the patient has in mind. Clarification is the therapist's invitation to the adolescent to explain information that is vague, not clear, confusing, chaotic, and contradictory. It allows the adolescent to fully access the internalized, unconscious meaning of his/her actions and encourages self-reflection. This method is of essential importance for borderline PD, as identity diffusion is strongly pronounced in borderline patients. Examples of clarification:

- I did not understand...
- Did I get this right? You said...
- What did you mean by saying...?
- Please, could you explain that to me in detail?
- Is it because you do not have words to describe it, or because you have not thought about it?

*Confrontation* is not a common therapeutic technique, especially not at the beginning of a therapy, as adolescents may feel attacked when it is used too soon. Confrontation is supposed to be an invitation to the adolescent to look at the inconsistencies and contradictions and to bring to attention information (verbal or nonverbal) he or she is not aware of or regards as completely normal. It is important

to use it as an encouragement to talk about auto- and hetero-aggressive thoughts and behaviors that interfere with therapy. Examples of confrontation are:

- You are telling me about a rather excruciating pain, but you are laughing at the same time. This does not fit. Do you have any idea what could this mean?
- You are saying that you are fine, but I see fresh cuts. How do these things fit?
- You are telling me you are not disappointed, yet you are struggling with tears. Can you explain this?

*Interpretation* helps the adolescent to self-reflect and explain the meaning of his/her thoughts and actions. The interpretation does not reflect the therapist's point of view, who knows everything, but as a hypothesis offered to the adolescents for their consideration. It is applied when clarification and confrontation have not had the desired effect and when the therapist thinks it is unrealistic to expect the adolescent will reach a certain insight on his or her own. Interpretation must follow the emotions (anger, hatred, anxiety, envy). Examples of interpretation are:

- This is how I see it, but correct me, if I am wrong.
- On the one hand, you are telling me that you are fine, but I see many fresh wounds on your arm.
- Then you tell me that no one would be sad if you killed yourself.
- Could it be that all these contradictory images are within you and that you do not know exactly whether you are feeling well or maybe you are still sad?

Regardless of the psychotherapeutic approach, sincerity, empathy, and warmth are the key characteristics of a therapist. AIT, however, added playful flexibility to the list, with the therapist explaining his/her thoughts, offering possible explanations as a hypothesis (interpretation) and adjusting to the adolescent. The therapist maintains a sound and meaningful stance, knows right from wrong, and maintains his or her position. Optimism is a necessary condition for the therapist to develop an idea of the adolescent as a healthy and stable person, including therapist's attitude that the adolescent is able to cooperate in sessions and that he or she can develop. The therapist maintains hope for change during therapy stagnation and when the risk of discontinuation of therapy occurs. The absolute presence of the therapist is crucial for the therapy. It can be manifested as curiosity and a genuine interest in the adolescent's experiences. The therapist is absolutely present when his or her nonverbal/body language and tone of speech reflect the adolescent's experience of the here and now. The therapist is a role model. For an adolescent, therapist may be the first person to ever really take a truly interest in him or her. By doing so, the therapist engages the adolescent to be curious, motivated, and interested in himself/herself.

Body language is an important factor in AIT. Therapists must be fully aware of their tone, facial expressions, thinking, and interest, paying attention to the adolescent in the treatment, and how all of this is being acknowledged by the adolescent. Nonverbal information is vital in therapy with PD adolescents, who are overly sensitive to possible rejection, split, and are not able to recognize contradictions in verbal and nonverbal communication or are prone to misjudging it. It does matter how the therapist dresses and whether he/she has a piercing or a tattoo. The latter, in particular, can be an important message of how a therapist treats his/her body or allows for various manipulations.

Intensive parental involvement in therapy is especially important in adolescents with PD and is therefore a crucial element of AIT. Working with parents can only be successful if there is no attribution of blame to the parents for the development of PD in their adolescent. If the parents are viewed as the “bad guys,” then the therapist may cause the adolescent to see him/her as a “better parent” and a “savior,” which brings many risks to the therapy. At the beginning of therapy, even very competent and functional parents can appear to be “pathological” due to psychological burden when living with an adolescent with PD.

It is important that the parents are not viewed as bad and invalidating by the therapist. If parents are not included in the therapy, the power of family dynamics and interactions significantly shaping the adolescent is being underestimated. It is essential to educate parents on the adolescent’s heightened sensitivity to emotional stressors, such as criticism, rejection, and separation, and how stressors can be avoided or reduced. Parents need an explanation that the therapy will not change the adolescent’s temperament; however, it will help him to control it more easily. Their job is to encourage the adolescent to go to therapy.

Therefore, *a contract with the parents* is delineated as well, which covers all issues described above. The goal of the contract is to optimize the family’s potential in therapy and to record the expectations and limitations of therapy. Possible factors that could lead to discontinuation of therapy are also included in the contract. The contract contains previously agreed and expected changes in the family (and not just in the adolescent) and clear rules regarding suicidal and self-harming behavior.

At the beginning of therapy, *a treatment contract with the adolescent* is drawn up with the adolescent and therapist responsibilities. The adolescent undertakes to attend therapy regularly, that is, 25 weekly sessions, to arrive “clean” and not to use any psychoactive substances before therapy, to talk about important issues (e.g., self-harming) at the very beginning of each therapy and not at the end of therapy. The contract also includes the duties of the therapist and exceptions to confidentiality (such as severe abuse of psychoactive substances, suicide, pregnancy), support for the patient not to discontinue therapy (external superego; e.g., the therapist calls the adolescent 2 hours prior to the therapy and reminds him or her of the appointment), and clear rules of a therapist conduct in case of suicidal and/or self-harming behavior (to call parents, hospitalization).

A home plan involves clearly agreed responsibilities of both the adolescent and parents. This includes clear measures for self-injurious behavior such as addressing the wound without any additional comments, threats, rewards, or conversation; the adolescent will discuss this with his/her therapist at the next regular session. If the wounds are deep, the adolescent should be taken to see a surgeon. Behaviors that violate the home plan resulting in the revocation of privileges are agreed upon and set out in the contract, including a reward system for behavior if the adolescent sticks to the home plan.

## 6. Mentalization-based therapy

Mentalization-based therapy is a psychosocial therapy to treat borderline PD (adapted from [18]). It derives from psychoanalysis, attachment theory, and developmental psychopathology and is based on mentalization. It was first intended for the treatment of adults with borderline PD, later on a version for adolescents (MBT-A) was developed. Mentalization is the ability to understand our own mental states and the mental states of other people and represents the capacity that makes us human. We mentalize when we are aware of the mental states of others and ourselves. MBT is based on the assumption that instability in mentalization is a



key problem of borderline PD. Similar to AIT, the therapist takes the position of a curious listener, who does not know what is going on and therefore encourages the adolescent to explain. The therapist observes the capacity for attachment and mentalization and applies various interventions to improve or at least maintain the adolescent's capacity to mentalize.

## **7. Dialectical behavioral therapy**

Dialectical behavioral therapy was developed by the psychologist Marsha M. Linehan and colleagues in the late 1980s to treat borderline PD [19]. Later on, Rathus and Miller developed a version of DBT for adolescents (DBT-A) [20].

The DBT is based on cognitive-behavioral therapy, dialectical philosophy, and on the findings of M. Linehan that people with borderline PD are prone to more intense and dramatic responses when facing specific emotional situations (e.g., romantic, friendly, and family relationships) compared to people without PD. People with borderline PD have quick and strong emotional reactions in the situations described above, remain emotionally aroused, and require more time to calm down than people without borderline PD [19]. As a result, DBT does not focus on the core unconscious conflict, such as in MBT. Instead, it focuses on how to change problematic responses with a range of different behavioral strategies [21].

DBT-A is a 16-week treatment that includes individual adolescent therapy once a week, family therapy as required, and a skills training group for families of adolescents with borderline PD [22]. It is aimed at reducing life-threatening and undesirable behaviors in therapy and behaviors that impair the quality of life. It empowers the adolescents to regulate their emotions, to appropriately deal with interpersonal relationships and cope with stress, and encourages mindfulness [20].

## **8. Pharmacotherapy**

The 2001 American Psychiatric Association recommendations [23], the 2009 NICE guidelines [15], which were reaffirmed in 2018 [24], and the Australian NHMRC guidelines for the treatment of borderline PD [25] do not recommend the use of pharmacotherapy as the first-line therapy. The World Federation of Societies of Biological Psychiatry recommendations mentions several studies reporting the efficacy of serotonin reuptake inhibitors (SSRIs), such as fluoxetine and fluvoxamine and second-generation antipsychotics in the treatment of PD [26].

The 2019 Timaus et al. study confirms clinical observations that most patients with PD are also treated pharmacotherapeutically [27]. Polypharmacy is high, which can also be attributed to the great comorbidity of PD with at least one additional mental disorder. For the most part, tricyclics, first-generation antipsychotics, and mood stabilizers are being omitted in the pharmacotherapy of PD. The mood stabilizer lamotrigine did not prove to be successful in the treatment of PD in a 2018 study [28]. The use of the atypical antipsychotic quetiapine and the opioid antagonist naltrexone has been increasing [27]. However, more studies are required to support the justification for using these medicines.

## **9. Conclusions**

Prevention and early detection of PD are essential in order to prevent long-lasting effect of PD on adolescent's overall functioning and interpersonal relationships.

When diagnosing a PD in adolescence, we are obliged to provide an appropriate and a PD specialized treatment (AIT, DBT-A, MBT-A). By introducing a therapy in time and by a licensed therapist PD treatment is very effective especially in the adolescent period which has a strong corrective potential.

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