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Assessment of criterion validity of personality disorder diagnosis in adolescents and relations between attachment style and personality disorder diagnosis

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Summary

Aim. Assessment of criterion validity and temporal stability of personality disorder diagnosis in adolescents and relationships between attachment styles and personality disorder diagnosis.

Material and methods. 50 adolescents (46 girls and 4 boys, aged 15–17) hospitalized at the department of child and adolescent psychiatry were assessed with *the Structured Clinical Interview for DSM-IV Axis II Personality Disorders* (SCID-II) and *the Inventory of Parent and Peer Attachment* (IPPA). After one year, adolescents meeting the criteria for a personality disorder (PD) diagnosis were reassessed with the SCID-II.

Results. In the first stage of assessment, diagnostic criteria for different types of personality disorders were met by 41 adolescents (82%) (mean number of criteria = 5.9). Criteria were met most often for borderline personality disorder (BPD) (n = 26; mean number of criteria = 7.9). In the second stage of assessment, the interview was re-administered to 21 adolescents (51%); the mean number of criteria was = 6.6. A statistically significant relationship between the number of PD diagnostic criteria in assessment one and the number of criteria in assessment two was obtained ($r = 0.58$; $p < 0.01$). 82% of the participants with PD were insecurely attached to their mothers. In the borderline group, 83% of the participants reported anxious-avoidant attachment style.

Conclusions. PD traits in adolescence, specifically BPD, are stable across one year.

Key words: personality disorders, attachment styles, adolescents

Introduction

Until the late 1990s it had been widely accepted that personality disorders were only present in the adult population. Traits of personality disorders are stable among adolescents and may concern 6 to 17% of teenagers [1, 2]. In clinical populations, the prevalence of personality disorders is much higher and reaches as much as 40 to 60% with an overrepresentation of borderline personality disorder [3]. A growing body of research endorses the diagnosis of personality disorders in adolescence [4–9] due to satisfactory temporal validity and evident clinical features.

Until now, separate criteria for personality disorders in children and adolescents have not been formulated. Research on this subject usually employs DSM-IV criteria for adult personality disorders [10]. According to many scholars, this approach is correct [2, 11, 12] although not optimal as ignoring the characteristic behaviors and viewpoints of adolescents may result in incorrect diagnosis. Moreover, it is doubtful that dichotomic criteria are reflective of adolescent behavioral instability or that they are able to catch subclinical types [9, 13]. In addition, at this stage of development symptoms from axis 1 and 2 often co-occur – a phenomenon which complicates the differential diagnosis even further [12, 13].

It seems that PD diagnosis in adolescents may profit from *the Alternative Personality Disorders Model*, postulated in the DSM-5, which takes a continuous perspective [14] and enables a more precise evaluation of individual functioning. Another difficulty in the process of diagnosing personality disorders in children and adolescents results from a lack of adequate tools. *The Structured Clinical Interview for DSM-IV Axis II Personality Disorders* (SCID-II) is used the most often [15, 16].

There is substantial evidence to suggest that insecure attachment is an important risk factor in adult PD [17, 18]. Research on adolescents showed negative correlation between secure attachment and a diagnosis of PD and positive correlation between disorganized attachment and borderline personality disorder (BPD) [18]. Anxious-avoidant attachment style was shown to be related to cluster A PD, whereas anxious-ambivalent attachment is related to dependent, histrionic and borderline personalities [18, 19]. Dismissive-avoidant attachment is a risk factor for narcissistic and antisocial personalities [20] and, finally, preoccupied attachment was associated with histrionic, borderline, schizotypical [21], and obsessive-compulsive [22] personalities.

These results inspired us to continue research on child and adolescent PD and their pathogenesis.

Objectives

1. Assessment of criterion validity and temporal stability of PD in the youth
2. Assessment of relationships between attachment styles and PD.

Material

The study participants were teenagers hospitalized at the Department of Child and Adolescent Psychiatry of the Medical University of Warsaw and their parents. In addition to the lack of consent of the teenager or his or her parent to participate in the study, we adopted the following exclusion criteria: (1) foster care (Orphanage, Youth Sociotherapy Center, Youth Educational Center, and other institutions), (2) diagnosis of: pervasive developmental disorders, psychotic disorder, bipolar disorder, and/or intellectual disability.

The research group included 50 people (46 girls and 4 boys) aged 15 to 17 years (M = 15.7; SD = 0.85). Psychiatric diagnoses at discharge included: neurotic, stress-related and somatic disorders – 42% (n = 21), eating disorders – 30% (n = 15), mood disorders – 14% (n = 7), behavioral and emotional disorders – 10% (n = 5), personality disorders – 4% (n = 2) (patients who turned 18 prior to discharge). 64% (n = 32) of patients had concurrent problems, mainly self-harm (60%; n = 30) or attempted suicide (46%; n = 23).

Research tools

Structured Clinical Interview for DSM-IV Axis II Personality Disorders

The SCID-2 [15], Polish version [16], was used in the study. It includes all 10 types of PD according to DSM-IV [10] and personality disorders enumerated in appendix B. The procedure provides for the possibility of using the entire interview or a part of it and the interview may be preceded by a screening test, which is *the SCID-II Personality Questionnaire*. The questionnaire consists of 119 questions and is filled in by the participant. The proper interview is preceded by a short conversation whose goal is to determine the participant's typical behavior and his/her relations with other people and his or her reflective functions. The following stages focus on the verification of diagnostic criteria. Each of the criteria is scored: 1 – "absent", 2 – "below threshold" and 3 – "present". When in doubt no score is given. A score of 3 ("present") implies the necessity to evaluate: (1) whether the described behavior is abnormal in relation to cultural expectancies; or (2) whether it is inflexible and manifests in many personal and social contexts; or (3) whether this pattern leads to significant pain or debilitation

of social, professional or other areas; (4) whether the pattern is stable over the long term or (5) if it could be better explained as a symptom or consequence of another psychiatric disorder or as an immediate effect of psychoactive substances abuse or general health. Diagnosis of antisocial personality disorder requires at least 3 criteria; avoidant, obsessive-compulsive, passive-aggressive, paranoid and schizoid personality disorders require at least 4 criteria; and the remaining diagnoses require at least 5 criteria.

Inventory of Parent and Peer Attachment – IPPA

IPPA (*Inventory of Parent and Peer Attachment*) [23] is based on a multidimensional model of attachment theory, encompassing both its cognitive and affective aspects. It is composed of 3 parts covering the relationships (1) with mother (or the person in her role) (2) with father (or the person in his role) and finally (3) with close friends. Each part contains 25 questions and the participant answers them on a 5-point Likert scale: 1 – "almost never or never true", 2 – "not very often true", 3 – "sometimes true", 4 – "often true", 5 –"almost always or always true". The inventory covers 3 areas of attachment: (1) *Trust*, understood as trust toward parents and friends and as respect and understanding from their part; (2) *Communication*, understood as the ability to talk to close ones about self or own problems and needs; (3) *Alienation*, understood as the level of isolation and feeling of being misunderstood by close people and related emotions. The Polish version of the questionnaire has satisfactory reliability and criterion validity [24]. Scores between 1 and 4 sten are considered low; between 5 and 6 are considered medium and between 7 and 10 are considered high [24].

Method

There were 2 stages of assessment. The goal of the first stage was to gather a group of adolescents meeting the PD criteria (SCID-II) and to assess them using the IPPA. In the second stage, the participants were reevaluated after one year. This was done to establish the temporal stability of PD diagnosis in participants from the first stage (another assessment using the SCID-II).

Statistical methods

Nominal variables were presented as percentages. Means and standard deviations were used to present continuous variables. For qualitative analysis, χ^2 tests and Crammer's V coefficients were calculated. Quantitative analysis was performed with the

use of Pearson's *r* coefficients. Results were considered statistically significant when *p*-value was lower than 0.05. The analysis was performed using Statistica 13.1.

The research protocol was approved by the Committee of Bioethics of the Medical University of Warsaw (KB/289/2013).

Results

SCID-II: Personality disorders at stage one

In the first stage, 50 adolescents were assessed. 82% (n = 41) of them met the qualitative and quantitative diagnostic criteria for individual types of personality disorders. Mean number of met criteria was 5.9 (SD = 3.14). For BPD (n = 26) the mean number was 7.9 (SD = 1.34), for obsessive-compulsive personality (n = 5) it was 5.4 (SD = 1.14), for narcissistic personality (n = 2) it was 8.0 (SD = 0.00), for depressive and avoidant (n = 3 in each case) personalities is it was 6.0 (SD = 1.00). For the remaining 2 types of personality disorders only single cases were found (with 6 criteria met for the paranoid personality and 4 for the passive-aggressive personality). Symptoms reported with highest frequencies are presented in Table 1.

Table 1. **Diagnostic criteria for individual types of personality disorders with highest frequencies at stage 1**

	CRITERION	
BPD (n = 26)	suicide attempt	96%
	self-harm	89%
	emotional instability	89%
	rage attacks	73%
	feeling of inner emptiness	69%
	instable self-image in contact with others	62%
	anger management difficulties	58%
	impulsiveness	58%
	instable interpersonal relations	56%
OCP (n = 5)	rigidness and stubbornness seen by others	100%
	perfectionism	80%
	trouble getting rid of unnecessary things	80%
	paying special attention to details, rules, order, and organization	60%
	unwillingness to share work with other people	60%
	rigidness and stubbornness seen by self	60%

table continued on the next page

DPD (n = 3)	negative self-image	100%
	self-criticism	100%
	rumination	100%
	low mood	67%
	negativism and criticism toward others	67%
	pessimistic attitude	67%
	guilt and remorse	67%
APD (n = 3)	all criteria	60%
NPD (n = 2)	exaggerated sense of self-worth	100%
	fantasizing about own strength	100%
	demands excessive admiration	100%
	envy	100%
PPD (n = 1)	suspiciousness	
	doubts about loyalty of friends	
	unwillingness to confide in others	
	worry that information will be used against him/her	
	alertness to covert humiliation	
	unfounded suspicion of infidelity	
PAPD (n = 1)	passive resistance	
	complaints about not being understood	
	contentiousness and mocking authorities	
	rebelliousness and regret	

BPD – borderline personality disorder; OCPD – obsessive-compulsive personality disorders; DPD– depressive personality disorders; APD – avoidant personality disorders; NPD – narcissistic personality disorders; PPD – paranoid personality disorders; PAPD – passive-aggressive personality disorders

SCID-II: Personality disorders at stage two

21 participants were included in reevaluation, which translates to 51% of the original sample of patients with clinical PD at stage 1 (the majority of those who refused to participate in stage 2 explained that they were not willing to revisit the clinic). Vast majority of the children who agreed to retake the assessment met the criteria for BPD in the first stage (14 participants), avoidant and narcissistic PD were each represented by 2 participants, single cases were observed for obsessive-compulsive, depressive and paranoid PD.

Mean number of diagnostic criteria in stage 2 was 6.6 (*SD* = 3.17). For BPD (*n* = 11) it was 8.64 (*SD* = 0.81), for avoidant PD (*n* = 4) it was 5.3 (*SD* = 0.96), for narcissistic PD (*n* = 2) it was 8.5 (*SD* = 0.71). In the case of obsessive-compulsive PD, one person met 6 diagnostic criteria. Symptom frequency in stage 2 is presented in Table 2 .

Table 2. **Diagnostic criteria for individual types of personality disorders with highest frequencies at stage 2**

	CRITERION	
BPD (n = 11)	attempted suicide	100 %
	impulsiveness	100%
	emotional instability	100%
	self-harm	91%
	rage attacks	73%
	attempts to avoid real or feared rejection	73%
	feeling of inner emptiness	64%
	instable self image in contact with others	64%
	pattern of instable interpersonal relationships	64%
	transient paranoid or dissociative symptoms	64%
	anger management difficulties	55%
APD (n = 4)	avoiding activities	100%
	reluctant to form relationships	100%
	concentration on thoughts of rejection and criticism	75%
	withdrawal from new social situations	75%
NPD (n = 2)	exaggerated sense of self-worth	100%
	envy	100%
	entitlement to special privileges	100%
	exploitation of others	100%
	lack of empathy	100%
OCPD (n =1)	rigidness and stubbornness seen by others	100%
	rigidness and stubbornness seen by self	100%
	perfectionism	100%
	trouble getting rid of unnecessary things	100%
	conscientiousness	100%
	avarice	100%

BPD – borderline personality disorder; APD – avoidant personality disorders; NPD – narcissistic personality disorders; OCPD – obsessive-compulsive personality disorders

In 16 cases (76%), personality disorder type at stage 2 remained unchanged. In 5 participants, at stage 2 there was a change in personality type (2 paranoid PD and 1 BPD changed to avoidant PD). 2 participants who met BPD criteria as well as 1 person who met depressive disorder criteria at stage 1 could no longer be diagnosed with any PD at stage 2

Testing of the hypothesis concerning the fulfillment of the diagnostic criteria for personality disorders by children and adolescents was carried out in relation to people assessed at stage 2 ($n = 21$) (figure). In the quantitative analysis, correlation coefficient was $r = 0.58$ ($p < 0.01$) indicating a significant relationship between the 2 stages of assessment conducted within one year (stage 1 and stage 2). Qualitative analysis (χ^2 test) proved that the relationship between stages one and two was significant (Crammer's $V = 0.863$; $p < 0.001$).

The Inventory of Parent and Peer Attachment (IPPA) – mother

The research group counted 38 people (93%)out of 41 meeting the diagnostic criteria for PD (the remaining 3 individuals had had no contact with their mothers

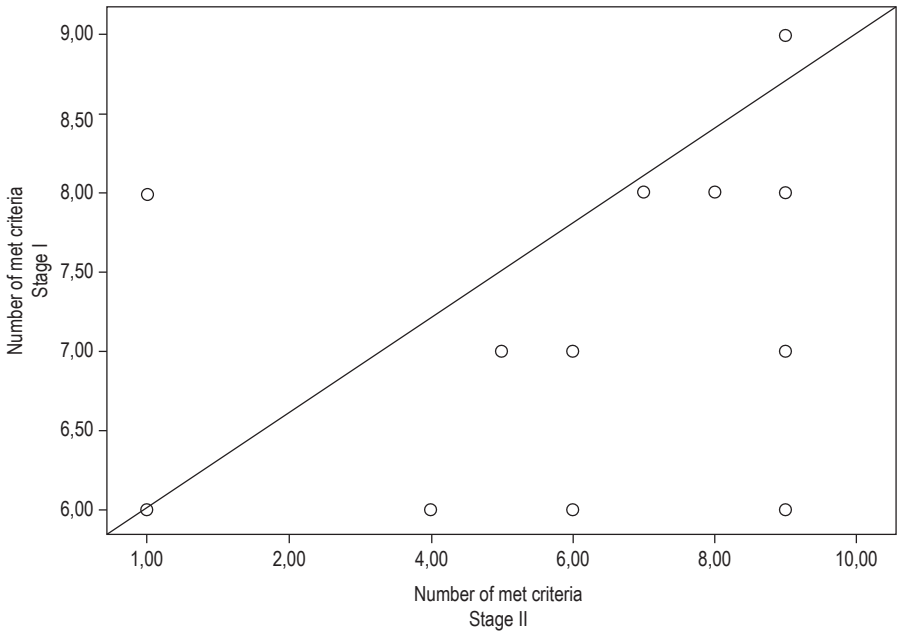

Figure 1. **Scatterplot of the number of met diagnostic criteria for personality disorders at stage 1 and stage 2 (n = 21)**

since they were very young or the contact was very limited). Most participants scored low in terms of communication (63%, n = 24) and trust (74%, n = 28), and high in terms of alienation (68%, n = 26). The general score for the 3 dimensions for most participants was low (63%, n = 24) (Table 3). After controlling for intensity of each of the dimensions [23, 25], 3 attachment styles were detected: 29 participants (76%) had anxious-avoidant attachment style with respect to mother, 7 (18%) had secure attachment and 2 people (0.5%) had anxious-resistant attachment.

Table 3. **Evaluation of attachment – 3 IPPA dimensions: Trust, Communication and Alienation**

	Communication	Trust	Alienation	General score
Attachment to mother				
low score	24	28	5	24
medium score	7	4	7	6
high score	7	6	26	8
Attachment to father				
low score	20	24	3	18
medium score	7	3	5	10
high score	6	6	25	5
Attachment to peers				
low score	14	24	5	20
medium score	16	12	8	13
high score	7	1	24	4

In the most prevalent, BPD group, anxious-avoidant attachment was dominant (83%). Attachment styles in the mother–participant relationship, split into PD groups are presented in Table 4.

Table 4. **Attachment styles split into PD groups**

	APD	OCPD	PAPD	DPD	PPD	NPD	BPD
Attachment to mother							
secure	0	2	0	1	0	0	4
anxious-avoidant	1	3	1	2	1	1	20
anxious-resistant	1	0	0	0	0	1	0

table continued on the next page

Attachment to father							
secure	0	1	0	1	0	1	2
anxious-avoidant	1	4	1	2	1	0	15
anxious-resistant	1	0	0	0	0	0	3
Attachment to peers							
secure	0	0	0	1	0	1	4
anxious-avoidant	2	3	0	2	1	0	13
anxious-resistant	0	2	1	0	0	1	6

BPD – borderline personality disorder; OCPD – obsessive-compulsive personality disorders; DPD – depressive personality disorders; APD – avoidant personality disorders; NPD – narcissistic personality disorders; PPD – paranoid personality disorders; PAPD – passive-aggressive personality disorders

The Inventory of Parent and Peer Attachment (IPPA) – father

The research group counted 33 people (80%) out of 41 meeting the criteria for PD. The remaining 6 individuals were brought up by single mothers or in reconstructed families and had had no contact with their fathers. 2 participants did not respond to all questions. Vast majority of participants reported low level of communication (61%, $n = 20$) and trust (73%, $n = 24$) and high level of alienation (76%, $n = 25$) with respect to father. The general score in case of most participants was low (55%, $n = 18$) (Table 3). After controlling for intensity of 3 specific dimensions, 3 attachment styles were detected: 24 participants (73%) had an anxious-avoidant attachment to father, 5 people (15%) had a secure attachment to father and 4 people (12%) reported anxious-resistant attachment. The anxiety-avoidant style dominated in the study group, including the most numerous group of people meeting the diagnostic criteria for BPD. Attachment styles in the father–participant relationship, by types of personality disorders, are presented in Table 4.

The Inventory of Parent and Peer Attachment (IPPA) – friends

Research group counted 37 people (90%) out of 41meeting the criteria for PD. 4 participants refused to fill in the questionnaire because, as they claimed, they had no close friends. Scores were usually medium (43%, $n = 16$) in terms of communication, low in terms of trust (65%, $n = 24$) and high in terms of alienation (65%, $n = 24$). The general score was low (54%, $n = 20$) (Table 3). In terms of attachment styles, 21 persons (57%) had an anxious-avoidant attachment, 6 people (16%) had a secure at-

tachment with their peers and 10 people (27%) had an anxious-resistant attachment. The research group was dominated by anxious-avoidant attachment. Attachment styles in the peer–participant relationship, by types of personality disorders, are presented in Table 4.

Relationship between attachment style and personality disorders diagnostic criteria

Statistical analyses were performed separately for different attachment figures (mother, father and peers); different attachment styles (secure, insecure, including anxious-avoidant and anxious-resistant style); and for the group of participants meeting and not meeting the diagnostic criteria for PD. We obtained a trend-significant relationship between attachment to mother and meeting the diagnostic criteria for PD (Cramer's $V = 0.737$; $p < 0.06$). We did not obtain significant relationships between attachment to father or peers and meeting the diagnostic criteria for PD (Cramer's $V = 0.588$; $p > 0.50$ for attachment to father and Cramer's $V = 0.574$; $p > 0.50$ for attachment to peers).

Discussion

Diagnostic criteria for personality disorders

We obtained an overrepresentation of participants meeting the qualitative and quantitative criteria for PD. This percentage is higher than values usually reported in the literature for both the general population and the clinical population. This may be related to our recruitment procedure. The research was carried out among hospitalized patients. Very often the reason for hospitalization was suicidal ideation or attempted suicide, which could influence the frequency of cluster B PD. According to the American Psychiatric Association, patients with BPD make up 30–60% of the clinical population. In adolescents the percentage is between 41 and 64% [10, 26].

The use of the SCID-II interview was dictated by lack of Polish diagnostic tools for the diagnosis of personality disorders in children and adolescents. On the other hand, there are examples in the literature justifying the use of diagnostic criteria for PD in adults while diagnosing adolescents [2, 11, 12]. Increase in the mean number of met criteria observed over the year suggests a strong positive correlation between the first and second stages of assessment. Our correlation coefficient is congruent with other temporal stability coefficients for personality disorders in adults and adolescents, i.e., $r = 0.69$ for teenagers aged 14–16 years, $r = 0.40$ –0.82 for people below 20 years of age and $r = 0.58$ for people between 16 and 22 years of age [1, 4, 27]. Taking into

account the structure of our research group and the domination of patients with BPD we should conclude that these values are specific for BPD. This disorder, like others from cluster B, are considered to be the most temporally stable in both adults and adolescents (r = 0.60–0.62) [1, 4, 6, 9]. This justifies the assumption that what we measured is a fairly stable pattern of behavior rather than a momentary manifestation of traits resulting from axis 1 disorders or a typical adolescent behavior. Moreover, this is an argument for acknowledging BPD as a diagnostically sound construct for the developmental age.

Relationship between attachment style and meeting the diagnostic criteria for PD

We obtained trend-significant results concerning the relationship between attachment to mother and meeting diagnostic criteria for PD. Lack of other statistically significant relationships was probably due to a low number of participants in the study group and individual subgroups, including various types of personality disorders. Results for the borderline group demonstrate a dominance of anxious-avoidant attachment style. This goes against most of the literature where a relationship between the anxious-resistant or disorganized attachment style and BPD is reported [18, 28, 29]. However, there is some data to suggest the relationship between anxious-avoidant attachment and BPD [17].

Anxious-avoidant attachment does not exclude disorganized attachment [20]. We suppose that this may be the case in our sample as approximately 30% of participants showed anxious-resistant attachment to peers. It is possible that cultural norms encourage an expression of disorganized attachment to mother through behaviors typical for anxious-avoidant attachment, while in relations with other people – typical behavioral representation [30]. Cultural patterns and differences may also play a role. Cultural norms specifically suppress the expression of anger in girls who are expected to show obedience. This strengthens avoidance strategies instead of confrontation and thinking instead of experiencing. Expression of intense emotions may take up inadequate forms (redirecting anger against the self, self-harm, suicide attempts, communication through symptoms). It is specifically important in the context of our research group who, in vast majority, meet the BPD diagnostic criteria. The sample is composed exclusively of girls, 85% of whom reported self-harm and 65% attempted suicide.

Analyzing different attachment dimensions in the IPPA we should highlight that for all relations with significant others (mother, father, peers) the results were low in communication and trust and high on alienation. Communication is the

most important aspect of bond formation as it influences the quality of relationships [23, 30] and impacts negatively the formation of cognitive schemes and personality traits [31, 32]. Poor communication may be involved in low levels of trust presented towards attachment figures and high levels of alienation, which is, in our opinion, a coping strategy against rejection rather than a correct form of autonomy development.

Young et al. [32] claim that core cognitive believes in BPD include: (a) an inability to rely on others in terms of security, stability, care, and empathy; (b) an inability to meet own needs and over-sensitiveness to rejection; (c) sense of worthlessness and of not being important; (d) lack of competence in self-sustaining, combined with persistent fear of rejection. Coping with these core believes can take up different forms and manifest as: (1) punishing others for not meeting expectations (often expressed as rage), lack of self-control, low tolerance of frustration, (2) overinhibition of spontaneous acts, feelings and communication with others, which results in intense avoidance and withdrawal, (3) surrendering own preferences, decisions and wishes. The last two strategies result in not expressing emotions (especially rage), which accumulate and externalize as uncontrolled rage tantrums, psychosomatic symptoms, passive-aggressive behaviors, acting out, self-harm, attempted suicide or substance abuse. In this approach, people with BPD show similar functioning to ones with anxious-avoidant attachment style.

The importance of the anxiety-avoidant attachment style in the development of borderline personality disorder seems to be also explained by the concept that mentalization is the mediating variable between the attachment style, temperamental traits and personality disorders. It is understood not as a constitutional trait but, to a large extent, as dependent on quality of bond with the caregiver and specifically on correct mirroring of the child's subjective experience by the caregiver [33, 34]. The ability to mentalize has an impact on affect regulation and self-control. Poor execution of this function can result in so called automatic mentalization or an excessive concentration on affective aspects of events, susceptibility to experiencing other people's emotional states and emotional over-sensitiveness. Therefore, we presume that dismissive and unaccepting mothers, who induce anxious-avoidant and disorganized attachment, and over-absorbed and disorganized mothers, who induce anxious-resistant attachment, are not able to correctly mirror emotional states of the child and therefore worsen the development of mentalization and hamper control and emotional regulation of their children.

Assessment tools could also influence the results. Attachment in individuals with PD is usually assessed using semi-structured interviews. During such interviews attention is paid to the way in which the content is conveyed, coherence and reflectiveness

of the narrative and not to the content. Therefore, it is difficult to compare our results, obtained using the IPPA questionnaire, to research based on such interviews.

Limitations

This research has a number of limitations among which are: (1) low number of participants, especially in the second stage, (2) unique inclusion of psychiatric patients, (3) low number of adolescents with PD other than BPD, (4) overrepresentation of girls, (5) use of diagnostic criteria for adults, which do not take into consideration the specificity of adolescence, (6) lack of anonymity and unique use of self-report questionnaires, which could influence the truthfulness of the reports.

Overrepresentation of girls in the study group may be associated with the study being limited to the clinical group. The limited availability of psychiatric care for people of developmental age in Poland forces the admission to the 24-hour care system, mainly of people undertaking suicide attempts with a direct threat to their lives, which can potentially be a reason for a predominance of female sex among hospitalized patients of [35].

Conclusions

Criteria for PD in adolescents, specifically for BPD, are stable across one year time span and the number of symptoms increases which justifies the diagnosis of PD. Adolescent diagnosis of PD, especially BPD, may be associated with insecure attachment to mother.

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