GUEST EDITORIAL

Personality Disorders Begin in Adolescence

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Mental health clinicians have long been reluctant to diagnose personality disorders in adolescence. These attitudes have also inhibited the diagnosis of other major mental disorders that begin at this developmental stage. Opposition is based on an incorrect idea: that psychopathology in adolescence is fluid, and that it tends to remit with time. However, recent clinical interest in early psychosis reflects a desire to identify and treat mental disorders at their earliest stages (McGorry, 2013). This principle may well be applicable to personality disorders.

We have known for almost 50 years that antisocial personality disorders begin in childhood (Robins, 1966). The earlier psychopathology presents, the more likely it is to continue. This principle may also apply to borderline personality disorder (BPD). Chanen and McCutcheon (2013) have convincingly shown that this condition is diagnosable in adolescence, and suggest that its prevalence at that stage may be particularly high. While not all cases come to clinical attention in early adolescence, most patients date the onset of their symptoms to the period after puberty (Zanarini, Frankenburg, Khera, & Bleichmar, 2001). While the pre-pubertal precursors of BPD remain to be defined, recent research suggests that high-risk samples can be identified (Stepp, Pilkonis, Hipwell, Loeber, & Stouthamer-Loeber, 2010).

The articles that follow expand on these themes. Kushner, Tackett, and De Clercq (this issue) show that personality structure in adolescence is similar to trait dimensions previously described in adult samples, and that it is structurally stable. Glenn and Klonsky (this issue) document that a large percentage of adolescents hospitalized in psychiatry meet criteria for BPD. Goodman, Mascitelli, and Triebwasser (this issue) show that neurobiological markers for adolescent BPD are similar to those reported in adult populations. Jovev, McKenzie, Whittle, Simmons, Allen and Chanen (this issue) describe longitudinal research showing that like adult BPD, adolescent cases emerge from an interaction between temperament and life adversity. Finally, Biskin (this issue) summarizes data showing that the treatment of BPD in adolescents follows the same principles as in adults.

Thus evidence is gathering that adolescents with classical symptoms of personality disorder, particularly BPD, can be identified in clinical settings and can, most likely, be treated with many of the same interventions. The main obstacle at this point is the preference of many clinicians for diagnoses of mood disorders. All too many adolescents with a classical picture of BPD are receiving aggressive pharmacotherapy based on faddishly unjustified diagnoses of bipolar disorder (Paris, 2012). If it were more widely known that personality disorders begin in adolescence, and are both common and treatable at that stage, this obstacle could be removed.

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