Personality disorders and insecure attachment among adolescents

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Chapter 7: **Summary and general discussion**

Introduction

This final chapter presents a summary of the findings from this thesis. Thereafter, the results are connected and interpreted. Lastly, the broader implications of our study are discussed. What have we learned of personality disorders, insecure attachment and non-suicidal self-injury (NSSI) in adolescents? How can mental health care for adolescents with these problems be improved? What further research is recommended?

The aim of this thesis is to investigate personality disorders, insecure attachment and NSSI in adolescence, and to examine therapeutic factors related to dropout and outcome after intensive psychotherapy for these conditions.

Summary of findings

In Chapter 2, changes in personality disorders and symptomatology were explored after intensive MBT in adolescents, and the relation between personality disorder variables and outcomes. To this end, a sample of 62 (out of 115) adolescents was examined for personality disorders at pre- and post-treatment by using the Structured Clinical Interview for DSM personality disorders (SCID-II) and the Symptom Check List 90 (SCL-90). Dropout was due to respondents failing to complete the set of web-based questionnaires during post-treatment or not showing up for the final SCID-II interview appointment. These respondents did not differ from the final sample in number and type of personality disorders. At pre-treatment, co-occurrence between the personality disorders was high. At post-treatment, about three quarters of the participants showed a lower number of personality disorders, while two thirds no longer met the SCID-II criteria for a personality disorder. However, symptom reduction could not be predicted by pre-treatment personality disorder variables. Thus, personality pathology can diminish after intensive MBT, although it is not clear if this outcome is a result of the treatment given, as no control group was included.

In Chapter 3, therapeutic factors known to promote recovery (Yalom & Leszcz, 1985) were examined in farewell letters (N = 70) written without instruction at the end of treatment and whether these factors were related to therapy outcome. Content analysis was performed on these letters by two independent raters using Yalom's 12 therapeutic factors combined with potential additional therapeutic factors as coding categories. These factors were related to outcome, operationalised as a decrease in psychological symptoms measured with the SCL-90. All therapeutic factors of Yalom and

four new factors were identified, although in different rates compared to studies using self-report questionnaires. The therapeutic factors 'cohesion', 'interpersonal learning output', 'guidance' and 'identification' were mentioned by nearly all participants and are therefore considered important for recovery in adolescents with personality pathology. These therapeutic factors seem to be a precondition for the factors that were correlated with therapeutic success, namely the factors 'interpersonal learning input', 'self-esteem' and 'turning point', though it is not clear whether these factors led to this change. For that reason, it is suggested with great caution that clinicians in an intensive group psychotherapy practice among adolescents with personality disorders should focus on—next to the common therapeutic factors—a) how the group members come across to one another, b) the sense of value for the group, and c) trying out new behaviour and setting boundaries for behaviour that undermines change. However, it would be premature to connect firm clinical implications to these findings. Further prospective research is necessary to determine the generalisability of these results to other intensive MBT services for adolescents with personality pathology. Furthermore, the question arises whether the interplay between all therapeutic factors and the value placed on them in general differs not only according to the content and purpose of a group (Yalom & Leszcz, 2005) yet also in individual group members. In that case, treatment could focus not only on diminishing symptoms but also on optimising important therapeutic factors for that individual. Further research seems important for treatment in general and for personalisation of treatment.

In Chapter 4, the association between the therapeutic relationship and dropout in an intensive MBT treatment for adolescents with personality disorders was evaluated. Patients (N=105) included were both dropouts and completers of intensive MBT treatment. The therapeutic relationship was measured with the Child version of the Session Rating Scale (C-SRS) that was completed after each group therapy session by the patient. For each patient, the treatment termination status (dropout or completer) was indicated by the treatment staff. It was found that both groups began with similar scores on the C-SRS; although on average as treatment progressed, the scores of completers increased from the start to the end of therapy, while the scores of dropouts decreased during therapy. At the end of the treatment period the scores differed significantly between dropouts and completers. A significant decrease in C-SRS scores between consecutive sessions was common for all patients, though a significant decrease in C-SRS scores during the last two sessions occurred more often for dropouts. The conclusion was drawn that a substantial reduction of the rated quality of the therapeutic relationship during the course of therapy increases the risk of premature termination. As a consequence, the patient's judgement of the quality of the therapeutic relationship should be monitored and discussed with the patient and the group. Doing so could improve the therapeutic relationship and decrease the risk of dropout.

The primary objective of Chapter 5 was to examine adolescent attachment insecurity in adolescents with personality pathology. The first aim of this study was to examine deviations in

insecure attachment distribution of the normative pattern in the whole sample as well as in subgroups of patients with borderline personality disorder (BPD) and other personality disorders. Sixty adolescents were investigated pre-treatment using both categorical and continuous measures of the Adult Attachment Interview (AAI). The second aim of this study was to explore whether attachment representations alter during the course of intensive MBT and whether these alterations are related to changes in psychological distress. Therefore, pre- and post-AAI (N = 33) differences were related to psychological distress measured by the SCL-90. Adolescents without a post-AAI did not differ significantly from the others in age, gender, severity of symptoms or personality disorders. The duration of treatment for these patients, however, deviated significantly. It was found that the most disturbed category of insecure attachment, the 'cannot classify' category, was overrepresented at pre-treatment. No differences in attachment insecurity were observed by type of personality disorder, although adolescents who spoke in a devaluing way about their father were more likely (*OR* 1.6) to be diagnosed with BPD. At post-treatment, half of the participants showed a positive change in the attachment representation, which was related to a significant lowering in level of psychological distress. Furthermore, the whole sample demonstrated change towards increased secure attachment. Taken together, no relation was found between the type of personality disorder and the (forced) attachment classification. Attachment insecurity diminished over the course of intensive MBT. However, as stated before, it cannot be concluded that changes are due to the treatment itself.

Chapter 6 studied different aspects of NSSI in clinical practice in association with personality disorders, symptoms, and coping skills (N = 140), to enhance the understanding of NSSI and improve treatment interventions. Assessment was done pre- and post-treatment using a questionnaire on NSSI developed for clinical practice as well as the SCID-II, the SCL-90 and the Cognitive Emotion Regulation Questionnaire. As expected, NSSI was found to be common, yet more surprising was that NSSI was related to the number of personality disorders and not exclusively to BPD or any other specific personality disorder. Furthermore, the frequency of NSSI was found not to significantly differ between patients with BPD, patients with other personality disorders and patients without personality disorders. Patients with NSSI disclosed significantly more psychological symptoms of distress at the start of treatment. They also reported using the negative coping skill self-blame more often and positive skills refocusing and positive reappraisal less than the no NSSI group and NSSI starters group. Concerning contagiousness of NSSI, this study found that, with great caution, NSSI can be considered contagious in clinical practice, as approximately one fifth of the inpatients without NSSI behaviour started NSSI during treatment. However, other reasons for starting NSSI besides contagiousness could be applicable, such as increasing stress due to the inpatient treatment, therapeutic interventions, or non-reporting of NSSI at the start of the treatment despite psychoeducation and thorough questioning. To summarise, NSSI is common in clinical practice for clinical adolescents and not exclusive to BPD. The presence of NSSI in others may influence those

who had not previously engaged in the behaviour to begin doing so in clinical practice. Reducing self-blame and enhancing positive refocusing and positive reappraisal could be important treatment targets.

General Discussion

In this thesis, three important results emerged. First, observational practice-based research among clinical adolescents is complicated due to specific circumstances that must be considered, especially concerning treatment outcome. Wherefore the course of action for current research in adolescent personality pathology is questionable. Second, a high rate of co-occurrence exists between personality disorders, insecure attachment representations and NSSI among clinical adolescents. Third, over the course of intensive MBT substantial positive changes occur in clinical adolescents: not only in personality disorders and symptomology, but also in attachment insecurity. In this discussion, these outcomes are further explored.

Observational practice-based research among clinical adolescents

The high-risk adolescents this thesis focusses on have hardly been studied before. In randomised clinical trials (RCTs), considered the highest standard of evidence, these patients are mostly excluded, because they are characterised by comorbidity and all too often lack motivation. This is surprising, since the (financial) burden of this group of patients on society is substantial due to, among others, the direct medical costs of self-inflicted injury including NSSI and suicide attempts. This observational practice-based study differed from the research conducted in controlled specialty settings by studying a real-world practice with clinical adolescents. By doing so, this study provides rare insights into clinical adolescents with personality pathology, insecure attachment and NSSI.

Only a subgroup of patients who were included in this study could be followed from the start until the end of treatment, despite many attempts to reach and motivate them. Several circumstances seem to complicate research on adolescents. First, adolescents are difficult to motivate to participate in research projects without reward, especially in studies with questionnaires in a pre-post design. Participating in research is undoubtedly even more difficult for clinical adolescents due to their psychopathology. Second, adolescents generally think short term and are guided by the here and now, which influences outcomes per measurement moment. Similarly, adolescence is a period of emotional maturation, characterised by big leaps forward and backwards in developmental tasks, such as separation-individuation and identity formation (Kaltiala-Heino & Eronen, 2015). Young people grow and show change until at least 23 years of age. As a result, it is unclear if, for instance, the outcomes of intensive treatment in adolescence are the effect of treatment given, natural developmental change or a combination of both. At the same time, adolescence is a developmental phase in which

opportunities for change in personality pathology are greater, under the right conditions, than in adulthood. Third, the role of parents and peers could be an important factor of influence on the motivation and outcome of intensive treatment and needs further study. To conduct research on adolescents, the aforementioned circumstances must be considered and likely affect the degree to which this group is examined.

There is dispute concerning classifying personality disorders in adolescence, although momentarily classifications are a starting point in research and in some countries for insured health care. On the one hand, classifying personality disorders in adolescence encourages an early intervention and thus prevention of crystallisation of behaviours that can have severe consequences on functioning. In addition, it may stimulate research and thus the development of effective treatments for specific groups. On the other hand, if a clear distinction cannot be made between normal adolescent problems, adolescent psychiatric problems that know a natural recovery and the adolescent problems that are the start of severe personality pathology, the risk of classifying normal behaviour as pathologic is considerable. Research shows a subgroup of severely affected adolescents for whom BPD remains relatively stable over time, while a less severe subgroup moves in and out of the classification of BPD (Miller, Muehlenkamp, & Jacobson, 2008). Another concern is that adolescents in the phase of identity disturbance and formation may be at risk of identifying with a classification of a personality disorder. Therefore, classifying personality disorders in adolescence may stigmatise adolescents. A dimensional or network approach instead of a categorical approach to personality disorders may better account for the developmental variability and heterogeneity found among adolescents.

Specific concerns exist on how to accurately measure insecure attachment in adolescence. In general, one may wonder how secure attachment appears in the developmental stage of adolescence. First, attempts to gain autonomy in adolescence may temporarily lead to higher rates of dismissing attachment during this developmental period (Warmuth & Cummings, 2015) than at later age. A feature of a separation-individuation process is that adolescents tend to rebel against parents, which in case of negative experiences possibly occurs even more. Second, adolescents generally think short term, which may affect the ability to reflect on parent-child early life experiences. In this adolescent AAI study, the overrepresentation of the cannot classify and forced preoccupied attachment representation is possibly indicative of psychopathology severity in combination with temporary vulnerability associated with adolescence. The change towards increased secure attachment at the end of treatment may be related to the lower scores on psychological distress due to which the adolescents were better able to respond AAI questions. Unfortunately, there are as of yet no validated ‘quick and easy’ measures for identifying attachment insecurity, though accurate detailed analysis of attachment seems important among high-risk adolescents. Measurement of attachment in adolescent psychiatry is in its infancy (van Hoof, 2017), although the probability that this will change is likely hampered

because of the complexity of the concept attachment. In this study the AAI is used, which is a labour-intensive tool for clinical practice. Scoring of the AAI is a complex process and requires completion of a two-week intensive training course in scoring and coding procedures (Main, Goldwyn, & Hesse, 1998).

As argued above, research on clinical high risk adolescents is complicated. More research is needed to advance prevention and treatment programs and to reduce the burden of this group on patients, their families and society. Simultaneously, it is questionable whether using mainly quantitative research methods for this target group is the correct course of action for current research in psychopathology. The validity of a questionnaire in high-risk adolescents with varying mental states seems doubtful for this group. Indeed, in this study written reflections on the treatment process appear to be more indicative of therapeutic recovery than a questionnaire. Perhaps qualitative instead of quantitative research methods, or a combination of both, offers more clarity on how to optimise prevention and treatment programs for clinical adolescents and how to reduce dropout.

Co-occurrence in the sample

As expected, in this study substantial co-occurrence between the personality disorders, insecure attachment representations and NSSI was found. The co-occurrence between the personality disorders parallels findings in other studies (Chiesa, Cirasola, Williams, Nassisi, & Fonagy, 2017; Tyrer, Crawford, & Mulder, 2011). Furthermore, no differences in attachment classifications and NSSI were found between personality disorder groups. Due to this substantial symptom overlap in combination with the overlap with symptoms of puberty, classifying personality pathology in adolescence correctly is difficult, perhaps even impossible, particularly in severely dysfunctional adolescents. As a result, the DSM categorisation by type of personality disorder seems arbitrary in adolescents with multi-morbidity. The general model of personality pathology currently in use seems especially limited for adolescents because it disregards overall adolescent developmental problems and family dynamics. The criteria for a personality disorder in the DSM-5 concern the individual and are not based on the context of the patient, even though the context is especially important in adolescents (Chen, Brody, & Miller, 2017; van Harmelen et al., 2016). A dimensional model that describes not only the core pathology but also the influence of adolescence, attachment insecurity and family interactions, may be more meaningful for high-risk adolescents than the current classification system.

The substantial co-occurrence between attachment insecurity and personality pathology could confirm that attachment insecurity is indeed an underlying factor or a risk factor for developing a personality disorder in adolescence (Levy, Johnson, Clouthier, Scala, & Temes, 2015; Venta, Shmueli-Goetz, & Sharp, 2013), assuming that the insecure attachment occurred earlier than the personality disorder. This assumption would fit into the diathesis-stress model, which suggests that parent-child attachment along with current and past stressors, temperament and genes contribute to the emergence of psychopathology (Steele, Bate, Nikitiades, & Buhl-Nielsen, 2015). On the other hand, it may also

be that the two problems have no relationship other than that they often occur simultaneously in adolescents with severe psychiatric problems. Another possibility to be considered is that severe psychopathology and puberty negatively affect attachment security and that recovery of severe psychopathology results in more secure attachment. Nevertheless, this study stresses the importance of secure attachment for adolescent mental health. Especially the influence of paternal attachment during adolescence requires further attention, because this study found with great caution that BPD is likely to develop in adolescence in the absence of paternal positive attachment behaviour in combination with the devaluation state of mind towards the father.

Changes over time

A substantial number of the severely disturbed adolescents in our sample changed positively over the course of intensive MBT. Although MBT was likely of influence, it cannot be concluded that changes are due to the treatment itself. In addition to a decrease in personality pathology and symptomology, attachment insecurity developed for the better as well. The question remains whether intensive MBT contributed to the achieved result; and if that is the case, which element of this treatment had impact? The first hypothesis is that in different ways, the partial hospitalisation was especially relevant for this group of adolescents with overall adolescent developmental problems and their families. Probably, the intensity of being in therapy 24 hours a day, 5 days a week, made the breakthrough of solid, unhealthy patterns possible. Moreover, being away from home increased the likelihood of altering fixed interaction patterns in the family situation and the severely disturbed separation-individuation process. Furthermore, the continuous availability of MBT-trained nursing staff during the partial hospitalisation presumably could have been of influence (Reiner, Bakermans-Kranenburg, Van IJzendoorn, Fremmer-Bombik, & Beutel, 2016). Hypothetically, for some participants an emotional corrective experience occurred in the relationship with the group and treatment staff during the partial hospitalisation, which resulted in a less insecure attachment representation. Second, psychotherapy in a group with a group psychodynamic approach could have contributed to change (Yalom & Leszcz, 2005). The therapeutic factors 'cohesion', 'interpersonal learning output', 'guidance' and 'identification' seem to be pre-conditional factors for the predictors found in this study for therapeutic success, namely 'interpersonal learning input', 'self-esteem' and 'turning point'. Third, focussing on mentalization in the different therapies in the program may have stimulated a positive outcome by learning clinical adolescents' effective emotion regulation and interpersonal interaction. Also, the influence of social support from family and friends (van Harmelen et al., 2016) or age-related development may have caused the change.

The results of this thesis provide hope for treatment and prospects for the future of adolescents with personality disorders, insecure attachment and NSSI. Though, it cannot be ignored that a small group did not show a change after intensive MBT, and an even smaller group deteriorated. This is no

surprise given the fact that deterioration rates as an outcome of psychotherapy range from 5% to 14% among adult patients and are thought to be even higher among children (Lambert, 2013).

Limitations

Several limitations exist in this study. This cohort study was not randomised. As a result, it is not possible to draw conclusions about the direct effect of the treatment itself. Furthermore, a large portion of the sample was not assessed at the end of the treatment. Co-morbid disorders next to the personality pathology were not studied. Moreover, the sample was a relatively small inpatient sample from one facility consisting of mainly girls with average cognitive capabilities. In consequence, generalisability to other adolescent personality disorder intensive psychotherapy services is to be determined. Despite these limitations, this study is quite unique because little research has been done into personality disorders and attachment insecurity among adolescents (Courtney-Seidler, Klein, & Miller, 2013; Hutsebaut, Feenstra, & Luyten, 2013; Sharp et al., 2016).

Clinical implications

What do these findings mean for clinical practice? As stated before, a high rate of co-occurrence between the personality disorders, insecure attachment representations and NSSI was found, let alone other co-morbid disorders that were not examined. The current classifications system for personality disorders seems to be a container of heterogeneity and therefore not appropriate for adolescents with personality pathology. In clinical practice, heterogeneity should be taken into consideration, and not masked by categorising. Consequently, two adjustments are proposed for classifying adolescent personality pathology. It is first suggested that a dimensional approach to personality disorders among adolescents may better account for the developmental variability and heterogeneity. Hopefully, a dimensional approach will reduce risk of stigmatisation or identification with a personality disorder diagnosis in adolescence. In contrast to the categorical diagnostic system, a dimensional system views various personality features along a continuum. The DSM-5 (APA, 2013) proposed dimensional model includes two dimensions: Criterion A: level of personality functioning and Criterion B: pathological personality traits. The second proposal is to use a system of classification that describes the core pathology dimensionally only once the influence of adolescence, attachment insecurity and family interactions has been assessed. In the diagnostic phase, adolescent personality pathology should be described in the context of this developmental phase of life and the patient's social system. This emphasises the importance of thorough descriptive diagnosis instead of merely a DSM-5 classification. A descriptive diagnosis for an adolescent should incorporate the interactions of the adolescent's pathology with 1) development and puberty 2) family dynamics and 3) relationships with peers. This descriptive diagnosis could be combined with the emerging concept of health and well-being called positive health (Heerkens et al., 2018). The positive health field works to

discover which specific health assets in the three domains of health—namely physical, social and mental health—produce longer, more meaningful and healthier life and which health assets lower disease risk and health care costs (Huber et al., 2011). The above requires development of new methods of researching clinical adolescents using qualitative rather than quantitative research methods, or a combination of both.

The identified co-occurrence has further consequences for treatment of adolescent personality pathology. According to the descriptive diagnosis, the treatment is needed to be part of a bigger personalised plan designed together with the adolescent and his/her social system. During treatment, adolescents could be asked regularly to reflect in writing on the treatment process and progress. With this information, treatment staff could adjust the personalised plan to optimise it for important therapeutic factors per treatment phase.

The co-occurrence that is found in other mental disorders (Caspi & Moffitt, 2018; Kessler, Chiu, Demler, & Walters, 2005) than personality disorders also has consequences for the content and organisation of health care in general, since the current health care system depends on the view that mental problems come as categorical disorders (van Os, Guloksuz, Vijn, Hafkenscheid, & Delespaul, 2019). These disorders should be treated according to evidence-based practice treatment guidelines on the basis of meta-analytic evidence of measurable symptom reduction at the group level. However, evidence-based guidelines at the group level may not be generalisable to the individual level, especially for severely disturbed adolescents with combined conditions. Several novel developments (van Os et al., 2019), however, suggest focussing on enhancing resilience, instead of on symptom reduction, and connectedness with others. Our study on attachment and therapeutic factors seems to show the importance of connection with others to grow emotionally in adolescence. For that reason, clinicians have to emphasise throughout all phases of treatment the importance of attachment relationships and learning from one generation to another and from social systems. In clinical adolescent MBT practice, clinicians enhance resilience to deal with vulnerabilities in contact with significant others. This is a task for modern society in which loneliness is the highest mortality risk for human beings (Holt-Lunstad, Robles, & Sbarra, 2017).

Directions for future research

Adolescence is a period of life in which personality disorders often manifest themselves (Kessler et al., 2005; Newton-Howes, Clark, & Chanen, 2015). Despite this knowledge, clinical attention is focussed mainly on adults and BPD. Research investment is needed on personality disorders with comorbidity in adolescence by means of preventive and treatment evaluation using not only quantitative but also qualitative research methods, or a combination of both. Since the validity of

a questionnaire in high-risk adolescents with varying mental states seems doubtful in this study, qualitative research methods seem to offer more clarity on how to optimise prevention and treatment programs and reduce dropout. Future research could also investigate the dimensional model as proposed by the DSM-5 for clinical adolescents with co-morbidity. The research advice is to adjust criterion A for adolescents. This criterion is divided into four aspects of personality functioning: 1) identity, 2) self-direction, 3) empathy, 4) intimacy. These aspects could be described in the developmental context of adolescence.

So far, no studies have followed the course of personality disorder from childhood through puberty to later life, although child and adolescent personality disorder is the strongest predictor of young adult personality disorders (Newton-Howes et al., 2015). Applying staging models (Scott et al., 2013) on personality pathology could be a research direction. However, considering the high co-occurrence found, research should focus on the heterogeneity of problems from a dimensional and developmental point of view of clinical adolescents and not on one classification. With this broader view, staging models among high-risk adolescents can help clinical practice select interventions appropriate to the life phase and to the stage the adolescent is in. Ideally, this information can also help us in the future to differentiate between those adolescents who show temporary symptoms of personality pathology belonging to puberty and those who are at the onset of a chronic problem. Therefore, the focus should be on descriptive diagnosis and treatment, and future research on staging models for adolescent personality disorders from a dimensional and developmental point of view for early detection, prevention and treatment of personality pathology in adolescence

Finally, research investigating moderators of outcome among psychotherapy treatments for adolescent personality disorders is needed. Understanding for whom and under what conditions and dosages, clinicians can employ these working elements of treatments to exert their greatest effects and enhance development of personalised psychiatry. The role of parents and other significant others could especially be an important factor of influence on the commitment and outcome of adolescent personality pathology treatment and needs further study. Research should also focus on moderators of dropout of treatment among these adolescents.

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