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Assessing Criterion A in Adolescents Using the Semistructured Interview for Personality Functioning *DSM–5*

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Accumulating evidence supports the reliability and validity of the diagnosis of personality disorders (PDs) in adolescents, but whether the current *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5)*, criteria are optimal to capture and help detect emerging PDs in this age-group remains controversial. The Level of Personality Functioning Scale (LPFS), included in the alternative model for personality disorders, may provide a more developmentally sensitive way to identify impaired personality features in young people. This study investigates the feasibility of the LPFS in adolescents by examining the psychometric properties of the Semistructured Interview for Personality Functioning *DSM–5* in a clinical sample of referred adolescents ($N = 84$) and in a community sample ($N = 12$). Additionally, referred adolescents completed self-report questionnaires pertaining to symptom severity, personality functioning, and personality traits. In general, good interrater reliability and internal consistency were observed, and the associations with external variables largely followed theoretical prediction. Interestingly, and in contrast to data on adults, we found no significant associations between the LPFS scores on the one hand and traditional *DSM–5* PD diagnoses in the clinical sample on the other (except for borderline PD criteria). In discussing these findings, we argue that the assessment of personality functioning may be better suited for detecting personality pathology in adolescence than the traditional Section II criteria.

Keywords: alternative model for personality disorders, personality functioning, adolescence, personality disorders




Supplemental materials: <http://dx.doi.org/10.1037/per0000454.supp>

A growing body of research has provided evidence that personality disorders (PDs) are common in adolescents (Feenstra, Hutsebaut, Verheul, & Busschbach, 2011; Grilo et al., 1998; Johnson et al., 2000; Westen, Shedler, Durrett, Glass, & Martens, 2003). Collectively supporting the validity of the diagnosis in this age-group, research has shown that adolescents with putative PDs are at a greater risk of having a broad range of problems than adolescents without PDs, including problems at school (Westen et al., 2003), behavioral problems (Johnson et al., 2005), interpersonal difficulties and stress (Daley, Rizzo, & Gunderson, 2006), sub-

stance abuse (Serman, Johnson, Geller, Kanost, & Zacharapoulou, 2002), suicide attempts (Braun-Scharm, 1996; Westen et al., 2003), emergency admissions (Kasen et al., 2007), and deviant sexual behavior (Lavan & Johnson, 2002). These findings warrant for early detection, setting the stage for the recent development of early intervention programs aiming to tackle PD problems (Chanen & McCutcheon, 2008; Hutsebaut, Videler, Verheul, & van Alphen, 2019).

The discussion continues whether the current *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5)*, criteria are optimal to assess personality pathology in the adolescent population. Indeed, many manifestations of PDs in *DSM–5* seem to refer to adult roles and symptoms (Videler, Hutsebaut, Schulkens, Sobczak, & van Alphen, 2019). Examples of such adult-oriented criteria include several criteria for dependent PD; for example, “needing others to assume responsibility for most major areas of life” (Criterion 2) or “seeking another relationship as a source of care and support when a close relationship ends” (Criterion 7). Similarly, Criterion 1 of borderline PD (BPD) referring to “frantic efforts to avoid real or imagined abandonment” may typically apply to a late-adolescent- or adult-like expression of fear of abandonment. There is empirical evidence to suggest that

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current PD criteria are not completely age neutral, such that symptoms in the areas of affect dysregulation and impulse dyscontrol seem to manifest early in the course of the disorder, whereas symptoms of interpersonal disturbance only seem to be expressed later on (Debast, Rossi, Feenstra, & Hutsebaut, 2017; Sharp et al., 2015). These conjectures and observations call into question the validity of the current diagnostic criteria to detect PD expressions across the life span. Assessment of personality pathology could therefore benefit from more developmentally sensitive descriptors of personality dysfunction.

The fifth edition of the *DSM* (American Psychiatric Association, 2013) features in its Section III an alternative model for personality disorders (AMPD), which represents an interesting alternative for assessing personality pathology in adolescents. Central to this newly proposed classification of PDs is an assessment of the level of impairment in personality functioning (Criterion A). Impairments constituting personality pathology are assumed to manifest in self- and/or interpersonal functioning (Bender, Morey, & Skodol, 2011). To assess these impairments, *DSM-5* has introduced the Level of Personality Functioning Scale (LPFS). This scale uses 12 capacities of self- and interpersonal functioning to differentiate between five levels of severity of personality pathology, ranging from little or no impairment (Level 0) to extreme impairment (Level 4). The model reflects the viewpoint that these psychological capacities, much like maladaptive traits (De Clercq et al., 2014), develop over the life span and express themselves differently according to the developmental phase, paving the way for a life span perspective on PDs (Hutsebaut et al., 2019). As such, *personality pathology* is defined in terms of impairments in personality functioning, rather than in terms of their (age-related) behavioral manifestations (as in the *DSM-5* Section II model). The AMPD model has the potential to improve the assessment of personality pathology in adolescents, as it relates severity of personality pathology directly to personality processes, independent of behavioral manifestations, social and vocational outcomes, or experienced burden of disease. Finally, by adopting a dimensional conceptualization, the AMPD implicitly recognizes that normal and pathological development are not qualitatively distinct, and in so doing also posits a gradient model of healthy personality development (Hutsebaut, Kamphuis, Feenstra, Weekers, & De Saeger, 2017). Dimensionality may also contribute to early detection when the PD has not yet fully developed. On the other hand, one may also argue that many of the concepts of the LPFS, including intimacy and empathy, may refer to concepts of personality development that are still “under construction.” Such concepts may make it difficult to distinguish normative shortcomings in areas of personality development from expressions of “true” personality dysfunction, which is predictive for actual and future social and mental problems.

Emerging evidence shows that aspects of personality functioning may differentiate well between “normal” and “clinical” adolescents. For example, one study found that maladaptive aspects related to the LPFS, including identity integration and relational capacities as assessed by the Severity Indices of Personality Problems (SIPP-118), were more strongly related to clinical status than to age, and these dimensions appeared to improve during treatment, supporting the notion that they capture (personality) pathology rather than developmental issues (Feenstra, Hutsebaut, Verheul, & van Limbeek, 2014). More closely related to the AMPD,

Goth, Birkhölzer, and Schmeck (2018) developed the Level of Personality Functioning Questionnaire as an adaptation of their Assessment of Identity Development in Adolescence questionnaire. For both instruments, they showed a good capacity to differentiate clinical adolescents from community adolescents ($d = 0.7-2.2$). To our knowledge, to date only Goth et al. (2018) used specifically tailored AMPD instruments to study Criterion A in young persons.

This study used the Semistructured Interview for Personality Functioning *DSM-5* (STiP-5.1) to assess the LPFS in adolescents and tested its ability to distinguish normative developmental phenomena from psychopathology. The STiP-5.1 was specifically designed as a multi-item assessment of each of the 12 capacities of the LPFS (Hutsebaut, Berghuis, De Saeger, Kaasenbrood, & Ingenhoven, 2014). It has shown promising results in adults (Hutsebaut et al., 2017; Zetl, Taubner, Hutsebaut, & Volkert, 2019). We investigated aspects of the reliability of the STiP-5.1 to assess the severity of personality pathology in adolescents, expecting good interrater reliability and internal consistency. Furthermore, we investigated aspects of construct validity by studying the capacity of the STiP-5.1 to differentiate between clinical and community adolescents and by calculating the associations with theoretically relevant measures of personality pathology.

Method

Participants

Both a clinical and a community sample were recruited. Participants in the clinical sample ($N = 84$) were treatment-seeking adolescents, referred to de Viersprong, a mental health care center specialized in the assessment and treatment of adolescents and adults with personality-, conduct-, or family problems. Their age ranged from 12 to 17 years ($M = 15.60$, $SD = 1.39$) and 89.3% were female. Participants lived with both parents (45.2%), with one of their parents (28.6%), in a newly formed family (10.7%), with foster parents (8.3%), or in an institution (6.0%). Information on the educational level was available for only half of the sample. Of these participants, 11.9% had attained a low educational level, 40.4% an intermediate level, and 23.8% a high educational level.

In the community sample ($N = 12$), participants' age ranged from 13 to 17 years ($M = 15.08$, $SD = 1.16$), and 75% were female. Almost all participants lived with both parents (91.7%). All had an intermediate (8.3%) or higher educational (91.7%) level. No participants were in treatment or had ever received individual or group psychotherapy. Comparisons on demographic variables (age, sex, and educational level) showed no other significant differences between the two samples.

Procedure

In addition to the standard admission procedure, which included administration of semistructured interviews for the assessment of *DSM-IV-Text Revision* Axis I and Axis II disorders and of selected self-report questionnaires (Severity Indices of Personality Problems–Short Form [SIPP-SF], Brief Symptom Inventory [BSI], Level of Personality Functioning Scale–Brief Form 2.0 [LPFS-BF 2.0], and Personality Inventory for *DSM-5*–Brief Form [PID-5-BF]; see “Measures”), all adolescents in the clinical sample were administered the

STiP-5.1 interview. The STiP-5.1 was administered after the adolescents and their parents had received an initial consultation with a clinician. The STiP-5.1 was integrated into the standard admission procedure and administered by a psychologist who was only given the name and age of the participant. The interviewer asked permission to videotape the interview and obtained informed consent from the adolescent and his or her parents to use the recording for scientific purposes, including rescoring of the interview by an independent rater. The second rater, who was equally uninformed concerning the adolescent's personal and clinical background, scored the LPFS independently based upon the videotaped interview.

Based upon previous effect sizes (Hutsebaut et al., 2017), a desired level of power of $\beta = .80$, and using a false-positive rate of $\alpha = .05$, we included 12 youngsters in the community sample to study the STiP-5.1's ability to differentiate between clinical and community youngsters. The participants from the community sample were recruited through a call among schools, sports clubs, and relatives of personnel working at the treatment center. We asked mentors/teachers of different classes (first–sixth grade) and different levels of education to inform their students about the study and to ask for volunteers. To match the community sample as much as possible, we asked them to recruit adolescents from specific ages and educational levels for our study.

Participants from the community sample were contacted by the interviewer and were administered the STiP-5.1. They were also asked permission to videotape the interview, and the interviewer obtained the informed consent from the adolescent and his or her parents. Additional sociodemographic information (age, level of education, and living situation) was collected. No additional diagnostic interviews or self-report questionnaires were administered. All participants were interviewed in the same or a similar consultation room to make second raters as blind as possible to clinical status, preventing bias.

This study has been approved by the Ethics Committee of the University of Amsterdam. Data was collected between January 2018 and July 2019.

Measures

Semistructured Interview for DSM-5 Personality Functioning. The STiP-5.1 (Hutsebaut et al., 2014) is an interview schedule assessing the level of personality functioning as operationalized by the LPFS in Section III of the *DSM-5*. Its format is sufficiently user friendly that after only a brief training, clinicians without specialized experience are able to competently administer it (Hutsebaut et al., 2017). The diagram of the interview, which is organized around the capacities of the LPFS, is divided into three columns. The left column features the criteria for the different levels of each of the capacities. In the outer right column, the aspects of information that should be collected to rate the different LPF levels are described. Specific questions that should be posed to the patient are displayed in the middle column. Sixty descriptors of severity are encompassed in the LPFS, divided into 12 facets (capacities), each with five levels. A “funnel” strategy is applied during the interview, which allows the interviewer to narrow down to the level of impairment through the questioning sequence, instead of having to check each of the 60 descriptors separately (Hutsebaut et al., 2017). The interview consists of 28 open questions, with optional clarifying questions. A broad open question is

used at the start of each section of the interview. Auxiliary questions may be used, contingent on the previous answer to the starting question, to subsequently focus on the remaining levels. Reframing the respondents' information in terms that correspond with the exact description of the level in the LPFS may be used as an additional strategy to check the assumed level of impairment. Ratings of each capacity should be performed during the interview, interviewers are encouraged to give one score per capacity ranging from 0 (*little or no impairment*) to 4 (*extreme impairment*). The average interview duration is about 45 min. Internal consistency of the STiP-5.1 was high in an adult sample, with Cronbach's α of .97 for the total scale, and .94 for both the Self-Functioning and Interpersonal Functioning subdomains. Interrater reliability was good, with intraclass correlation coefficients (*ICCs*), ranging from .81 to .92 in the total sample, and *ICCs* ranging from .58 to .81 in the clinical sample (Hutsebaut et al., 2017).

Structured Clinical Interview for DSM-IV Axis I Disorders (The SCID-I). The SCID-I (First, Spitzer, Gibbon, & Williams, 1997; translated by Groenestijn, Akerhuis, Kupka, Schneider, & Nolen, 1999) is a semistructured interview to measure *DSM-IV* Axis I disorders. The SCID-I has demonstrated good interrater reliability in various samples, especially when interviewers had received a formal training; overall $\kappa = .85$ (Ventura, Liberman, Green, Shaner, & Mintz, 1998).

Structured Clinical Interview for DSM-IV Axis II Personality Disorders. The SCID II (First, Gibbon, Spitzer, Benjamin, & Williams, 1997, translated by Weertman, Arntz, & Kerkhofs, 1996), which is essentially identical to the current SCID-P (*DSM-5*), was used to diagnose Axis II PDs. Criteria were scored if they were pathological, pervasive, and persistent. PD not otherwise specified was classified when five PD criteria were present (Verheul, Bartak, & Widiger, 2007). The SCID-II has good interrater and test–retest reliability in PD samples (Maffei et al., 1997; Weertman, Arntz, Dreessen, van Velzen, & Vertommen, 2003) with sum *ICCs* of .90 for avoidant and .95 for borderline PDs (Lobbstaal, Leurgans, & Arntz, 2011).

Severity Indices of Personality Problems–Short Form. The SIPP-SF (Feenstra et al., 2011; Verheul et al., 2008) is a dimensional self-report measure assessing the generic and changeable components of personality functioning. It consists of 60 items, all rated on a 4-point Likert scale, ranging from 1 (*fully disagree*) to 4 (*fully agree*). Respondents are asked to answer to what extent they agree with the statements, referring to the last 3 months. The SIPP-SF comprises five higher order domains: Self-Control, Identity Integration, Responsibility, Relational Functioning, and Social Concordance. High scores (sum scores) on the facets indicate more adaptive personality functioning, whereas lower scores suggest more maladaptive functioning. The SIPP-SF is the shortened version of the SIPP-118, which has good psychometric features in both adults and adolescents. Internal consistency in the current sample was high, with Cronbach's α s of .87 (Self-Control), .93 (Identity Integration), .83 (Responsibility), .85 (Relational Functioning), and .85 (Social Concordance), respectively.

Brief Symptom Inventory. The BSI (Derogatis, 1975; translated by De Beurs, 2011) is used to assess symptom severity. It consists of 53 items covering nine symptom dimensions, but the present study uses the Total score (sum score) that provides an index of the intensity of distress by psychological symptoms during the past week. Respondents rank each item on a 5-point

scale ranging from 0 (*not at all*) to 4 (*extremely*). Internal consistency in the current sample was high, with Cronbach's $\alpha = .96$ for the total score.

Level of Personality Functioning Scale–Brief Form. The LPFS-BF 2.0 (Bach & Hutsebaut, 2018; Weekers, Hutsebaut, & Kamphuis, 2019) is a brief self-report questionnaire for assessing the LPFS as described in Section III of the *DSM-5* (American Psychiatric Association, 2013). It consists of 12 items corresponding to the 12 capacities of the LPFS. Participants are asked to rate the 12 items on a 4-point Likert scale from 1 (*completely untrue*) to 4 (*completely true*). Both a total score and subdomain scores (Self-Functioning and Interpersonal Functioning) can be calculated. Internal consistency in the current sample, as measured by Cronbach's α , was .64 for the LPFS-BF total scale, and .73 and .58 for the Self and Interpersonal subscales, respectively.

Personality Inventory for DSM-5–Brief Form. The PID-5-BF (American Psychiatric Association, 2013; Dutch version: van der Heijden, Ingenhoven, Berghuis, & Rossi, 2014) describes 25 trait facets organized in five higher order domains: Negative Affectivity (vs. Emotional Stability), Detachment (vs. Extraversion), Antagonism (vs. Agreeableness), Disinhibition (vs. Conscientiousness), and Psychoticism (vs. Lucidity). The PID-5-BF measures the *DSM-5* trait domains using a total of 25 items (five per domain), computed following the American Psychological Association guidelines. Items are measured on 4-point Likert scales. The PID-5-BF has been validated in a sample of adolescents (Koster et al., 2019). Cronbach's α s in the current sample ranged from .64 (Detachment) to .73 (Antagonism).

Results

Clinical Characteristics of the Sample

Table 1 provides an overview of diagnostic information. The majority of participants met criteria for at least one Axis I disorder

Table 1
Prevalence of DSM Diagnoses in the Clinical Sample
($N = 64-83$)

Clinical characteristics	<i>N</i>	%
Syndrome disorders		
Anxiety disorders	35	45.5
Mood disorders	49	75.4
Somatization disorders	7	8.8
Eating disorders	20	25.3
Substance use disorders	13	17.6
Conduct disorder	5	5.2
Oppositional-defiant disorder	2	2.5
Attention-deficit/hyperactivity disorder	6	7.4
Autism spectrum disorder	3	3.6
Any Axis I diagnosis	69	92
Personality disorders		
Avoidant PD	17	20.7
Obsessive-compulsive PD	3	3.6
Borderline PD	23	27.4
PD not otherwise specified	22	26.2
Any PD	53	63.1

Note. *DSM* = Diagnostic and Statistical Manual of Mental Disorders; PD = personality disorder.

(92%), with mood disorders (75.4%) and anxiety disorders (45.5%) being the most prevalent. Fifty-three (63.1%) of the adolescents from the clinical sample had a PD, whereas the remaining 31 adolescents did not meet criteria for a PD diagnosis (25 of whom met at least one PD criterion). BPD (27.4%) and PD not otherwise specified (26.2%) were most prevalent.

Reliability

Interrater reliability was assessed using a one-way random, absolute agreement, single-measures *ICC* (McGraw & Wong, 1996). Twenty-six interviews were scored by a second rater (16 and 10 interviews of the clinical sample and community sample, respectively). Internal consistency of the STiP-5.1 was high, with $\alpha = .96$ for the total score and $\alpha = .94$ and $\alpha = .92$ for the Self- and Interpersonal Functioning subdomains, respectively. Interrater reliability was high for the total sample, with *ICCs* ranging from .88 to .99 (see Table 2). For the clinical sample, interrater reliability was acceptable to good, with one exception for "Experience of oneself as unique" (*ICC* = .47). *ICCs* for the remaining Self-Functioning capacities ranged from .57 to .96, and *ICCs* for the Interpersonal Functioning subdomain ranged from .73 to .97.

Construct Validity

Table 3 shows associations of the STiP-5.1 with SCID-I and SCID-II indices. No significant correlations were observed between the STiP-5.1 on the one hand, and the number of PDs, number of PD criteria, or number of Axis I disorders on the other. However, the number of BPD criteria was significantly associated with the STiP-5.1 total score as well as its subscales.

As expected, self-report measures of personality problems generally showed moderate positive associations with the STiP-5.1, with higher levels of self-reported personality problems being associated with more severe levels of personality functioning. More specifically, the STiP-5.1 was positively associated with the LPFS-BF 2.0 and most of the SIPP-SF and PID-5-BF domains (see Table 4 for correlation coefficients). The SIPP-SF Identity Integration domain, and the PID-5 Negative Affectivity and Antagonism domains were not significantly associated with the STiP-5.1. Symptom severity, as measured by the BSI, was significantly related to the level of personality functioning as measured by the STiP-5.1, particularly the Self-Functioning subdomain, but not to the Interpersonal Functioning subdomain. For means and *SDs* of the STiP-5.1 and the self-report questionnaires, see online supplemental materials.

Independent samples *t* tests showed the community sample had significantly healthier STiP-5.1 scores ($M = 0$, $SD = 0$) than the clinical sample ($M = 2.61$, $SD = 0.60$), $t(83) = -39.72$, $p < .001$, $d = 4.68$, with a very large effect size. Subsequently, in the clinical sample there was no significant difference on STiP-5.1 scores between adolescents with a PD diagnosis ($M = 2.66$, $SD = 0.59$) and adolescents without a PD diagnosis ($M = 2.52$, $SD = .63$), $t(82) = -1.06$, $p = .292$.

Discussion

This study investigated the potential utility of the LPFS in adolescents by exploring reliability and validity of the STiP-5.1 in

Table 2
Interrater Reliability: Intraclass Correlation Coefficients of STiP-5.1

Scale	Clinical (<i>N</i> = 16)	Total (<i>N</i> = 26)
STiP-5.1 total score	.69	.95
Domain Self-Functioning	.57	.95
<i>Identity</i>	.65	.96
Experience of oneself as unique	.47	.92
Self-esteem	.96	.99
Emotions	.80	.98
<i>Self-direction</i>	.79	.93
Goals	.76	.94
Norms	.76	.91
Self-reflection	.76	.88
Domain Interpersonal Functioning	.75	.96
<i>Empathy</i>	.92	.98
Understanding others	.92	.95
Perspectives	.73	.91
Impact	.93	.98
<i>Intimacy</i>	.85	.97
Connection	.90	.99
Closeness	.79	.95
Mutuality	.97	.99

Note. STiP-5.1 = Semistructured Interview for Personality Functioning *DSM-5*; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*.

this age-group. We found moderate to excellent interrater reliability in the clinical sample and excellent interrater reliability in the total sample, supporting the reliability of assessment of personality functioning using the STiP-5.1. An exception was observed for a "Unique sense of self" with a comparable lower *ICC* in the clinical sample. Construct validity was supported by the instrument's ability to differentiate clinically referred from community youngsters, and by a theoretically meaningful pattern of associations with related constructs of personality pathology. More specifically, we found significant correlations between the STiP-5.1 scores and the majority of self-report measures of personality pathology, including total and scale scores of the LPFS-BF-2.0, SIPP-SF, and PID-5-BF. Higher scores on these personality functioning and trait measures (indicating greater dysfunction) covaried with higher levels of impairments in personality functioning (STiP-5.1). No associations were found between Negative Affectivity and Antag-

onism (PID-5-BF) and the STiP-5.1 scores in the current sample. Restriction of range (associated with high levels of Negative Affectivity and low levels of Antagonism) may account for this null finding. Furthermore, the STiP-5.1 clearly distinguished healthy adolescents from adolescents in the clinical sample. Impairments in personality functioning are indeed distinguishable from normal adolescent struggles.

Of note, as opposed to findings observed in an adult sample in our clinic (Hutsebaut et al., 2017), the STiP-5.1 was not associated with (Section II informed) traditional PDs. Moreover, the STiP-5.1 did not differentiate between adolescents with and without a (full) Section II PD diagnosis in the clinical sample. An exception was observed for features of BPD, such that adolescents who displayed more features of BPD were also rated as more disturbed on level of personality functioning using the STiP-5.1.

Arguably, these results suggest that the STiP-5.1 does not adequately capture the severity of personality pathology in younger populations or even that the LPFS does not capture the common core of PDs in adolescents. However, we deem this explanation less plausible, as the STiP-5.1 did show theoretically consistent associations with validated self-report questionnaires assessing personality pathology. As an alternative explanation, we would argue that the Section II and III assessment approaches capture different aspects of personality pathology. Whereas in adults those different aspects generally converged strongly (Hutsebaut et al., 2017), meaning that impairments in personality functioning co-occur with classic diagnostic criteria of PD diagnoses, in adolescents these aspects were only loosely connected, if at all. Given the highly impaired and severe LPFS scores in this study, we propose that severe impairments as assessed by the STiP-5.1 do not necessarily express or manifest themselves in traditional *DSM-5* criteria of PDs in youngsters. This discrepancy may be related to the reliance on formal diagnostic criteria whose behavioral manifestations are more prevalent in adults than in adolescents and that in fact may be more representative of adult personality impairments in personality functioning (e.g., avoiding social situations, being dependent on another adult, impulsive drug and alcohol use; Videler et al., 2019).

An implication of this hypothesis would be that an approach toward the assessment of personality functioning, for example, through the STiP-5.1, may be better suited to detect the severity of

Table 3
*Correlations of STiP-5.1 Scores (*N* = 77–84) With Axis I and PD Disorders*

Variable	STiP-5.1 total	Self	Interpersonal
STiP-5.1 Self-functioning	.78***		
STiP-5.1 Interpersonal functioning	.84***	.66***	
SCID-II Number of PDs	.19	.14	.11
SCID-II Number of PD criteria	.19	.17	.15
SCID-II Number of avoidant PD criteria	.06	.08	.03
SCID-II Number of borderline PD criteria	.38**	.29**	.36**
SCID-I Number of Axis I diagnoses	.16	.01	.17

Note. STiP-5.1 = Interview for Personality Functioning *DSM-5*; PD = personality disorder; SCID-II = Structured Clinical Interview for *DSM-IV* Axis II Disorders; SCID-I = Structured Clinical Interview for *DSM-IV* Axis I Disorders; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; *DSM-IV* = *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. *N* varies due to missing values.

** Correlation is significant at the .01 level. *** Correlation is significant at the .001 level.

Table 4
Pearson Correlations of STiP-5.1 With Self-Report Measures of Personality Problems and Symptom Severity in the Clinical Sample (N = 59–64)

Scale	STiP-5.1 total score	Self-functioning	Interpersonal functioning
LPFS-BF 2.0 Total score	.49***	.46***	.43***
LPFS-BF 2.0 Self	.21	.29*	.14
LPFS-BF 2.0 Interpersonal	.57***	.43***	.56***
SIPP-SF Self-Control	-.46***	-.46***	-.39**
SIPP-SF Identity Integration	-.19	-.20	-.13
SIPP-SF Responsibility	-.32*	-.26*	-.35**
SIPP-SF Relational Capacities	-.33**	-.16	-.32*
SIPP-SF Social Concordance	-.53***	-.46***	-.44***
PID-5-BF Total score	.44***	.44***	.46***
PID-5-BF Negative Affectivity	.19	.28*	.19
PID-5-BF Detachment	.26*	.12	.30*
PID-5-BF Disinhibition	.43***	.50***	.46***
PID-5-BF Antagonism	.21	.17	.25*
PID-5-BF Psychoticism	.27*	.29*	.26*
BSI total score	.25*	.31**	.17

Note. STiP-5.1 = Semistructured Interview for Personality Functioning *DSM-5*; LPFS-BF 2.0 = Level of Personality Functioning Scale–Brief Form 2.0; SIPP-SF = Severity Indices for Personality Problems–Short Form; PID-5-BF = Personality Inventory for *DSM-5*–Brief Form; BSI = Brief Symptom Inventory; *DSM-5* = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

* Correlation is significant at the .05 level. ** Correlation is significant at the .01 level. *** Correlation is significant at the .001 level.

personality pathology at a young age and may be more informative for planning treatment than an exclusive *DSM-5* Section II-based approach. Although the SCID-5-P relies heavily on behavioral manifestations of PD, the STiP-5.1 allows the clinician to assess core aspects of personality functioning and adjust questions and severity ratings to the developmental level of the adolescent, for example, by taking into account that interpersonal impairments, as described by the LPFS criteria, may express themselves differently at 14 or 28 years of age. Further studies should investigate the predictive value of both Section II and III criteria for early identification of youngsters at risk for developing full, chronic, and severe personality pathology.

Features of BPD were moderately associated with impaired personality functioning as assessed by the STiP-5.1, and as such, constituted an exception to the nonrelation between STiP-5.1-assessed LPFS and Section II PDs. These findings may support the notion that features of BPD represent a rather generic marker for the severity of personality pathology (Sharp et al., 2015). Moreover, these findings provide suggestive evidence that the core components of PDs, in general, are first expressed in features of BPD (Chanen & McCutcheon, 2013). Such a hypothesis aligns well with the notion of clinical staging, with the core vulnerability in personality development expressing itself primarily in affective and impulsive dysregulations, captured by some of the criteria of BPD (Hutsebaut et al., 2019). Other Section II PD criteria may only emerge later in the course of the disorder, either because the criteria are not age neutrally formulated or because these problems only arise later in life. An implication may be that BPD features are more sensitive than other PD criteria to detect personality impairment earlier in life, but these conjectures are in need of empirical testing.

Of note, interrater reliability differed across subdomains and capacities. Most capacities seem to be easy to score reliably, for

example, self-esteem or mutuality of regard. One exception seems to be a “Unique sense of self,” with a remarkably lower *ICC* (.47), probably explaining the somewhat reduced *ICC* for the Self-Functioning subdomain too. The emergence of a unique sense of self throughout adolescence may be affected by normal developmental struggles, apparently troubling clinicians whether to consider the answers of the young person reflective of true personality pathology or (relatively) within the normal developmental range. This might also explain null findings for associations between STiP 5.1 severity scores and self-reported identity integration (SIPP-SF). It seems that different clinicians may use the LPFS criteria somewhat differently to assess the level of personality pathology, given this dilemma. As an implication, it may be that the LPFS criteria might be enhanced by adding developmentally specific criteria that could assist clinicians in making these decisions.

A number of strengths and limitations of this study deserve mention. It is the first interview-based study of the level of personality functioning in adolescents. Interviews were integrated in the regular intake procedure, supporting the ecological validity of the study and demonstrating the usefulness of the STiP-5.1 in regular clinical practice. However, several limitations should be mentioned. First, due to the design of the study, the interviewers were not blind to the clinical status of the adolescents. This may be a potential source of bias. Second, as in most clinical samples, some types of personality pathology (i.e., borderline/avoidant PDs) are more prevalent than others (i.e., Cluster A and antisocial PDs). Although this clinical sample may be representative of a severe and complex personality disordered clinical sample, it does not cover the whole range of personality pathology and, for example, it remains questionable whether the STiP-5.1 may be useful in samples of antisocial youngsters too. Indeed, in a study by Bach and Hutsebaut (2018), incarcerated adults reported healthier levels

of personality functioning than outpatients, calling into question the validity of the LPFS self-report instrument in antisocial samples. Third, this study mainly draws on self-report and does not include informant-based assessments of personality pathology. A multi-informant approach for assessing personality pathology is recommended, particularly for youngsters who may have some introspective and motivational limitations (Shiner & Allen, 2013; Weekers, Hutsebaut, Bach, & Kamphuis, 2020). Moreover, we recommend future studies include developmentally sensitive, age-specific measures such as the Level of Personality Functioning Questionnaire (Goth et al., 2018) to assess the construct validity of the STiP-5.1. Furthermore, for the purpose of this study—focusing on the psychometric qualities of the STiP-5.1 interview schedule—except for clinical status, interviewers were kept uninformed of any other information (e.g., living situation, treatment history, reasons for seeking help), to not bias them toward certain levels of severity. However, in clinical practice, it would be recommended to include all sources and types of information to make a comprehensive and valid assessment of someone's personality pathology (Weekers et al., 2019). Also, although our a priori power analysis deemed the sample size of the community sample large enough to detect a large effect (as was also observed in adults; Hutsebaut et al., 2017), we acknowledge that this comparison group was small and invariably in good mental health, which limits its representativeness and generalizability. Moreover, the SCID-P was unfortunately not administered to the community sample, which precludes testing to what extent Section II criteria would also have the discriminant ability with respect to the clinical and community samples. Finally, possibly due to the tertiary, specialist nature of the setting, we included mostly high-end severity cases of adolescent personality pathology. Future studies may include a more heterogeneous sample of adolescents.

In sum, this study provided (preliminary) support for the reliability and validity of the STiP-5.1 in adolescents. Additionally, it lends support to the use of the LPFS to detect personality pathology at an early stage and accordingly may provide a framework for detecting young people at risk, even before their vulnerability to personality pathology is expressed in classic symptoms of PD. We recommend further research be aimed at cross-validating the added value of the LPFS to detect adolescent personality pathology in a developmentally sensitive way.

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