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The Prevalence of Personality Pathology in Adolescence

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ABSTRACT

Over the past twenty years, there seems to have been an increased interest on the topic of adolescent personality pathology among researchers and clinicians in the field of psychiatry and clinical psychology. There have been many contentious debates on the topic, the most prominent being around the possibility of diagnosing a personality disorder or variant thereof in adolescence. With this in mind, the researcher attempted to understand some of the most pertinent debates as well as investigate some of the hypotheses proposed in the arguments. The main focus of the study was on the possibility of diagnosing personality pathology in adolescence and whether or not this was being achieved in an inpatient psychiatric ward.

The present study quantitatively investigated the prevalence of personality pathology as well as the extent to which health care professionals in South Africa are diagnosing various personality pathologies among adolescents admitted to an inpatient psychiatric ward. The data collected has been analysed using the statistical study of frequencies and correlations, in order to assess whether there were positive correlations between genders, Axis I disorders, a set of reported problematic or pathological behavioural symptoms and having an Axis II diagnosis. The results reveal that clinicians are cautiously diagnosing personality pathology in an inpatient adolescent psychiatric ward, with the borderline personality pathology being the most prevalent.

DECLARATION

I declare that this dissertation is my own unaided work. It has been submitted for the degree of Master of Arts (Clinical Psychology) at the University of the Witwatersrand, Johannesburg, South Africa. It has not been submitted previously for any other degree or examination at any other University.

……..

Melissa Card

February 2009

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CHAPTER 1: INTRODUCTION

1.1 Rationale

It is generally accepted that personality disorders are disorders associated with adult persons. The Diagnostic Statistical Manual IV-Text Revised (DSM-IV-TR, 2000) is a manual (approved by the American Psychiatric Association - APA) used by professionals to make a diagnosis of any psychiatric illness including personality disorders or pathology.[1] According to the DSM-IV-TR (APA, 2000), personality disorders should only be diagnosed in adulthood. However in recent years, theorists and researchers have questioned the parameters set by the DSM-IV-TR (APA, 2000) around diagnosing personality pathology (Kernberg, Weiner & Bardenstein, 2000; Rey, 1996). The perception is that personality disorders (within an adult population) have their origins much earlier in an individual's life and as such, research around the world has been looking at the possibility of personality pathology being entrenched by as early as late childhood or adolescence (Kernberg et al., 2000). The topic of personality pathology in adolescence is rather controversial due to both the fluidity of personality in late childhood and adolescence and as such research on the topic is in its infancy (Kernberg et al., 2000).

The current study will explore the arguments that support and criticise the idea of diagnosing personality pathology in adolescence. In exploring the topic, the current study will also provide information on the topic from a South African context, thus imparting inspiration for further research within this field.

[1] From here on the researcher will refer to personality pathology when addressing personality disorders and personality disorder traits unless otherwise indicated.

Adolescent personality pathology has been a contentious debate, with theoretical and empirical evidence both supporting and opposing the diagnosing of personality pathology in adolescence. As such the present research will provide theoretical and empirical evidence that support and oppose the diagnosis of personality pathology in adolescence. In the first and second chapter, the study will provide theoretical and empirical information on personality pathology in adolescence to demonstrate the importance of this research. Furthermore, there will be definitions of key concepts used in the present research such as different personality disorder types, their presentation in adults and how this may be applied to the adolescent population.

1.2 Adolescent Personality Pathology – A Contentious Debate

Personality disorders in adulthood have been recognised as having a profound deleterious and prolonged effect on an individual, the individual's family and on society (Kernberg et al., 2000). While the DSM-IV-TR (APA, 2000) definition of a personality disorder, primarily locates the pathology in adulthood it does allow for the possibility of onset during adolescence. The DSM-IV-TR (APA, 2000) defines personality disordered symptoms as "enduring subjective experiences and behaviour that deviate from cultural standards, are rigidly pervasive, have an onset in adolescence or early adulthood, are stable through time and lead to unhappiness and impairment"(p.686). According to Kernberg et al., (2000), the development of personality disorders in adolescence has not received the attention it merits and theorists such as Guilè (1996), Rey (1996), Helgeland, Kjeslberg & Torgerson (2005), agree, identifying the need for pursuing research that will locate and categorise personality pathology in adolescence. An important question to add to this debate is if personality disorders were diagnosed and treated in adolescence, would it change the

diagnostic prevalence of personality disorders or personality disorder traits in adults? Stated alternatively, would early intervention through early diagnosis help to inhibit the development of maladaptive and rigid behaviours that ultimately lead to adult functioning being impaired?

While theorists seem to disagree about the aetiology of the different personality disorder types, experts in the field tend to agree that personality disorders emanate from childhood (Rey, 1996; Kernberg et al., 2000; Westen & Chang, 2000). However, despite this agreement, little empirical evidence is available on the developmental profile of these disorders and as such, researchers and clinicians may avoid making a personality pathology diagnosis due to the lack of empirical evidence for such claims (Robins, 1991; Zoccolillo, Pickles, Quinton & Rutter, 1992). If there is indeed consensus that onset tends to occur during adolescence or early adulthood, why is there an ongoing reluctance to diagnose the disorder during the developmental phase at which it presents, such as adolescence?

This brief overview of the kind of debates surrounding the topic of personality pathology in adolescence provides some background to the understanding, thinking and quandary in which theorists and clinicians find themselves, with regard to diagnosing personality pathology. In response to the abovementioned questions, the current research chose to investigate the prevalence of personality pathology diagnosis on an inpatient psychiatric adolescent population. The next chapter will explore the theoretical understandings of adolescent personality; it will also delve into its stability and will provide empirical evidence for the prevalence of the pathology in

the said population. Several concepts central to this research study will now be briefly introduced and defined so as to identify the psychological features under study.

1.3 Psychological Concepts in this Study

1.3.1 Adolescence

Adolescence is defined as a transitional period between puberty and adulthood in human development, extending mainly over the teen years between ages 13 and 19 and terminating legally at the age of maturity (Oxford Dictionary, 2002).

1.3.2 Personality

Personality has generally been used as a broad descriptive label for an individual's observable behaviour as well as their inner subjective experience (Kaplan & Sadock, 2003). The individual as a whole may be described in this way and represents both public and private aspects of his or her life. The word personality may have certain qualifying adjectives (known as traits). Whilst several of these traits are devoid of psychiatric significance such as friendly, ambitious, etc., other adjectives (traits), such as aggressive or passive, are rich in pathological overtones (Kaplan & Sadock, 2003). These pathological overtones are more present and pronounced when describing an individual with personality difficulties or pathology as compared an individual without personality difficulties (Kaplan & Sadock, 2003).

1.3.3 Personality Disorder

According to Kaplan & Sadock (2003), a personality disorder diagnosis will consist of a coherent series of the pathological overtones making up the personality disorder diagnosis. This diagnosis may give the clinician the ability to make predictions about

how an individual will behave under a given set of circumstances. As previously mentioned, the DSM-IV-TR (APA, 2000) defines personality disorders as behaviours that represent long-standing ingrained personality dysfunctions characterised by maladaptive, pervasive and inflexible *personality traits* that deviate considerably from cultural norms, causing substantial distress or impairment. It has been suggested that personality disorders may manifest themselves in late childhood, adolescence or early adulthood and continue throughout one's life (Kaplan & Sadock, 2003; Kernberg et al., 2000). When personality traits have an early onset, are stable over time, maladaptive, detrimental and lead to functional impairment or subjective distress, a personality disorder may be diagnosed (Kaplan & Sadock, 2003).

1.3.4. Personality Disorder Trait(s)

A personality disorder trait is not the personality disorder itself but rather characteristics of a personality disorder type. A constellation of specific traits with pathological overtones indicate a personality disorder type; if all the traits (for a specific personality disorder) are not present, but the existing pathological traits that the individual presents with results in functional impairment, a diagnosis of a personality disorder trait can be made. For example, a person may be diagnosed as having histrionic personality disorder traits but may not have the histrionic personality disorder due to the individual not meeting all the criteria (according to the DSM-IV-TR, APA, 2000) for the histrionic personality disorder diagnosis (Kaplan & Sadock, 2003).

The DSM-IV-TR, (APA, 2000) makes provision for individuals that present with traits not from a specific disorder but rather from a range of personality disorders. It

provides for a clustering system where a cluster diagnosis can be made and therefore an individual can be diagnosed as having 'cluster B traits' or a cluster B personality rather than a specific personality disorder / personality disorder trait diagnosis (Kaplan & Sadock, 2003). The clustering system is a useful tool for clinicians when an individual does not meet the defined criteria for a specific disorder.

1.3.5. Personality Disorder Types DSM-IV-TR (APA, 2000) Cluster Classification

The DSM-IV-TR (APA, 2000) has grouped the personality disorders into three clusters:

- Cluster A consists of patients who appear to be eccentric and odd to others. The Paranoid, Schizoid and Schizotypal personality disorders make up the cluster A personality disorders.
- Cluster B consists of patients who objectively appear to be excessively emotive, erratic and unstable. The Antisocial, Borderline, Histrionic and Narcissistic personality disorders make up the cluster B constellation.
- Cluster C patients objectively appear to be tense and overtly anxious. The Avoidant, Dependent and Obsessive-Compulsive personality disorders make up this cluster.

1.3.6. Classification System

The current classification systems used by clinicians to diagnose and categorise pathology are the DSM-IV-TR (APA, 2000) and ICD-10[2]. As previously mentioned,

[2]The author is aware of the ICD -10 but has chosen to use the DSM IV-TR (APA, 2000) criteria, as psychiatrists on the University of the Witwatersrand circuit are still using the DSM-IV classification system (personal communication with supervisor and member of Wits clinical staff, R Gericke, June 27, 2007).

the DSM-IV-TR (APA, 2000) defines personality disorders as reflexive maladaptive and inflexible personality traits that are exhibited in a wide range of social and personal contexts. These traits cause significant functional impairment or subjective distress. To distinguish between lasting personality disorders and more episodic psychiatric disorders the DSM-IV-TR (APA, 2000) has two separate axes on which the disorders are recorded. Axis I lists all episodic psychiatric disorders such as schizophrenia, depression and V-code's (which consist of psychosocial stressors that may result in psychological distress), whilst the more established disorders, characterological and cognitive impairments are recorded separately on Axis II.

1.3.7. Types of Diagnoses

A diagnosis (provisional, tentative or definite) offers the clinician clues about the individual's disability and how they may be approached for treatment purposes (which may include: medication, interviews, therapy, surgery etc). A provisional diagnosis given by a clinician means that the diagnosis is temporary or conditional, pending confirmation or validation. A tentative diagnosis is rough and likely to undergo changes before a final or definite diagnosis is given. With a definite diagnosis, the clinician is certain about the decision of illness.

1.4. Aims of the Research Study

The first aim of the current research is to discover the diagnostic prevalence of personality pathology on an inpatient adolescent psychiatric ward. However, in investigating the diagnostic prevalence of personality pathology in adolescents, the research will also unavoidably confront the extent that psychiatrists and clinical psychologists on the ward are diagnosing personality pathology in adolescent patients.

Thus, the findings may be more of an indication of clinicians' practice rather than of epidemiology.

Furthermore, a second aim is to establish whether personality pathology diagnoses are being made, how they are being represented as a clear personality disorder, personality disorder trait or cluster personality disorder diagnoses, regardless of whether the diagnoses are provisional, tentative or definitive. Thirdly, what are the most common personality disorders or personality disorder traits diagnoses being made? The secondary aims of the study are: to establish whether there is gender bias with regard to certain personality pathology diagnoses as well as to establish if there are correlations between Axis I, gender and Axis II disorders.

In terms of its contribution to the field, it is hoped that the present study will stimulate interest in the area of personality pathology, particularly in South Africa. It appears that there is much pressure on the youth in contemporary society to perform in ways that were previously not expected of them, thus making them vulnerable to psychological illnesses (Kernberg, Hajal, Normandin, 1998).[3] There are a number of youth in psychiatric facilities for Axis I pathologies and it is the intention of this research to also investigate the prevalence of Axis II pathologies among this population in a South African psychiatric hospital.

[3] Professor R. Thom, had expressed that there has been an increase in the number of adolescent cases presented to the ward and it is her opinion that the difficulties adolescents face in today's society have become difficult for them to handle. The most common situations facing adolescents are: parental marital difficulties often culminating in divorce, abuse and scholastic difficulties that include bulling. Cyber-bulling seems to be a new phenomena and attention needs to be paid to these means of communication (personal communication with Professor R. Thom –Principal child psychiatrist on wards 1 & 2, Tara Hospital Johannesburg).

The following chapter will provide theory on adolescent personality and explore the most important concept in the study, that being personality pathology. Chapter Three will outline the methodology employed by the current research and Chapter Four will provide an overview of the results obtained. Chapter Five will take the form of a discussion, whilst chapter 6 will present the conclusion as well as limitations of the current study and recommendations for future research.

CHAPTER 2: LITERATURE REVIEW

The current chapter will provide a comprehensive review of literature on the topic of personality pathology that is in keeping with the aims of the research, which is to explore the possibility of personality pathology being diagnosed in adolescence.

2.1. Adolescent Personality

2.1.1. Theoretical Understandings of Adolescent Personality and Personality Pathology Development

The theoretical section of this chapter aims to provide an understanding of adolescent personality development as well as the possible personality pathology that could result from atypical development. In order to try and understand the pathways to adolescent personality and personality pathology development, theoretical aspects as well as empirical evidence that are relevant to the above will be reviewed. The following section will discuss the three key areas to understanding adolescent personality and personality pathology development as outlined by Westen and Chang (2000).

According to Westen and Chang (2000), there are key areas that need to be addressed before any effort can be made to understand, classify and treat adolescent personality pathology. Firstly, it is important to understand the nature of personality itself, what the elements of personality are and what kind of changes occur during adolescence. Secondly, and related to the previous issue, it is also important to address the question of whether adolescence is indeed a time of turbulence and stress, or a period of relative continuity between childhood and adulthood (Westen & Chang, 2000).

Thirdly, one needs to consider whether or not the current classification system of personality pathology is appropriate for adolescents, given the presumed instability of personality in adolescence, which also calls for an in-depth discussion (Westen & Chang, 2000). The first theoretical concept that will be addressed is that of adolescent personality development and possible personality psychopathology that can occur. This will be addressed from a developmental perspective by exploring Erik Erikson's (1968) ego and identity development as well as Kernberg's et al., (1998) theoretical understanding of personality organisation. Addressing the developmental precursors to personality development provides background information to understanding and conceptualising the presence of possible personality pathology when the normal development of personality does not occur.

2.1.2 Adolescent Ego Development

Research on adolescent personality pathology seems to be in its infancy; however there is a large body of theory and research on related topics that are relevant to the understanding of adolescent personality pathology. An area of research that serves as a window into adolescent personality and personality pathology development is that of ego development. This concept was conceived of by Loevinger (1970), who proposed that ego development is a broad construct that includes impulse control, moral development, styles of interpersonal relating, and cognitive complexity (Loevinger, Wessler, and Redmore, 1970).

To explore this theory, Hauser (1993) followed up two samples of individuals for more than 20 years. The first sample was made of adolescents that were hospitalised for severe characterological disturbances, whilst the second sample consisted of

adolescents from a nearby school. From their research, Hauser and colleagues identified six pathways of ego development that, they proposed, encompassed a continuum of health and pathology (Hauser, 1993).

The six pathways are defined as follows: firstly, profound delays in development that is characterised by the fact that adolescents tend to understand morality in terms of what they could "get away with" (Hauser, 1993). The second pathway described adolescents who were either not problematic or exceptional, as they were largely governed by societal norms. Whilst these adolescents have friends and follow social norms and rules, they nevertheless seem stunted in their preoccupation with acceptance (Hauser, 1993).

The other four pathways were described in terms of progression through adolescence and characterised by shifts in ego development over the period. The study reported that adolescents who followed the path of "early progression" would begin with a concrete worldview and have a focus on immediate gratification but would eventually recognise and accept group norms and expectations (Hauser, 1993). This means that they would move from the first to the second pathway (described above) of ego development.

The "advanced progression" pathway could be used to describe adolescents who move from a more conformist position to recognising and valuing the complex nature of individuals as well as their differences, internal moral standards and principles. Hauser (1993) described this movement as conscience, with integrity being strived for rather than striving for acceptance and belonging. Adolescents who followed a pathway of "dramatic progression", moved from understanding the world in black-

and-white terms to acknowledging the complexity of others, relationships, and individual differences (Hauser, 1993). Adolescents on the above mentioned pathway seemed to have developed a deeper appreciation for more complex concepts such as feelings, motivations for behaviours and self-respect (Hauser, 1993).

Finally, those on the sixth developmental pathway of development (according to Hauser, 1993), also known as "accelerated development," are from the start unusually mature and comprehend complex personal relationships, thus reflecting their ability to articulate subtle aspects of their inner lives. One could say that these adolescents are able to tolerate and even value ambiguity without feeling overwhelmed or feel as though they are at risk of losing themselves (ego).

Empirically, the abovementioned pathways through adolescence seem to be related to patterns of family interaction (Powers & Noam, 1991). Adolescents, who are at the higher levels of ego development i.e. advanced progression, are more likely to be empathic, curious and more attuned to problem-solving during family interactions, whilst those at lower levels of ego development are more devaluing and restrained with their families, particularly with their parents (Westen & Chang, 2000). The implications of this would be that parent responses of acceptance, explanation, and empathy toward their teenage children would most likely be associated with higher levels of adolescent ego development (Westen & Chang, 2000). Conversely, those parents who lacked the abovementioned emotional or cognitive abilities and engaged in behaviours such as restraint, detachment, or denigration, tended to have adolescents at lower levels of ego development (Westen & Chang, 2000).

2.1.3 Identity Formation, Integration or Diffusion

According to Kernberg et al. (1998), the most important task for any health care professional that is examining a troubled adolescent, is to accurately assess the severity of the psychopathology. A differentiation needs to be distinguished between the process of emotional turmoil as part of a neurosis or an adjustment reaction to situations and severe character pathology (Kernberg et al., 1998). Varying degrees of behaviours (anxiety, depression, emotional outbursts and temper tantrums, dependency and impulsiveness) may present in adolescents with psychotic disturbances, no severe character pathology as well as in those with very severe characterological disturbances (Kernberg et al., 1998).

According to Kernberg (1975), identity integration is the key anchoring point of the differential diagnosis of milder types of character or personality pathology (neurotic personality organisation) on one hand, and severe character or personality pathology (borderline personality organisation) on the other. In psychiatric terms, this could be classified as the difference between Axis I and Axis II disorders. With this in mind, it is also important to differentiate between identity crises (a normal vicissitude of adolescence) and the syndrome Kernberg termed 'identity diffusion' (Kernberg, 1975).

An identity crisis reflects the impact of relatively rapid physical and psychological growth expected of adolescents in contemporary society (Kernberg et al., 1998). These changes may emerge with puberty, (which in itself can be a difficult period for adolescents) where individuals have to deal with an internal sense of confusion regarding the emergence of strong impulses and contradictory pressures regarding how to deal with them (Kernberg et al., 1998). There is also a widening gap between

the perception of the adolescent on the part of his or her traditional family environment and his or her self perception, thus causing further internal conflict (Kernberg et al., 1998). Adolescent identity crisis thus refers to a significant discrepancy between a rapidly shifting self-concept and the persistence of the adolescent's experience of how others perceive him or her (Erikson, 1968). Thus adolescence is potentially a time of rapid re-organisation of personality as well as the anchoring of intra-and interpersonal conflicts.

2.1.4 Erik Erikson's Psychosocial Theory of Development

Insofar as Erik Erikson's theory of psychosocial development (Erikson, 1968) describes different stages of normal and abnormal personality development, its relevance to the current study is that it describes and validates a hypothesis of the current research: that personality disorders could potentially have its origins and be diagnosed in adolescence, be persistent and negatively impact on the normal developmental trajectory of adolescents and young adults.

Erikson (1968) postulated predictable changes in personality development over the life span, based on a set of eight psychosocial crisis stages. Complimentary pairs of positive and negative ego qualities characterise the eight crisis stages that are determined by a combination of biological, psychological, and socio-cultural factors (Erikson, 1968). Successful resolution of each crisis is associated with the development of basic ego strengths. As successive crises are resolved, ego strengths accumulate and are integrated into the individual's personality, thus providing an internal foundation for a sense of well being (Erikson, 1968).

2.1.4.1 Ego Identity / Integration

The fifth and most critical stage in Erikson's stage theory, is the crisis of ego identity versus role confusion and this normally first appears in adolescence (Erikson, 1968). Successful resolution of this identity crisis provides the adolescent or young adult with a clear sense of themselves, their personal beliefs, values and their place in society (Erikson, 1968). Unsuccessful resolution of the crisis, according to Erikson (1968), leaves the adolescent or young adult with a diffuse sense of identity, confusion about social roles and uncertainty about internal subjective states and feelings. Individuals with diffuse identities also encounter difficulty selecting clear occupational goals and often adopt roles deviating from conventional social norms. The description of an individual with an unresolved identity crisis seems to be congruent with the definition that the DSM-IV-TR (APA, 2000) offers for an individual with a personality disorder.

An individual with personality difficulties has behaviours that reflect maladaptive and inflexible personality traits that are exhibited in a wide range of social and personal contexts; these traits cause significant functional impairment or subjective distress (Kaplan & Sadock, 2003). With the identity crisis having its origins during the adolescent phase of development and the presentation of the unresolved fifth crisis having a similar presentation to that of a personality disorder or personality disorder trait(s) in adults, it seems plausible to hypothesise that personality disordered behaviour or traits can present in adolescence and continue into adulthood. Furthermore, the presentation of the behaviours in adolescence may be similar to those present in adult presentations of personality-disordered behaviour. The current research study hypothesises that it may be possible to use the DSM-IV-TR (APA,

2000) as a tool for diagnosing possible personality pathology in adolescence given the similar presentation or characteristics of maladaptive behaviour symptoms found in adult presentations.

Researchers seem to agree that identity formation is a life-long process (Marcia, 1994) and that adolescence and young adulthood provide the first real opportunity to develop a sense of continuity with the past, create meaning in the present, and establish direction for the future (Marcia, 1994). Identity consolidation thus emerges as the cornerstone of the capacity to do well and forms the basis of self-acceptance and self-esteem. On the basis of this formulation, higher levels of well being are assumed to reflect greater levels of identity consolidation, while the opposite is true for the non-resolution of the crisis resulting in identity diffusion or role confusion.

2.1.4.2 Identity Diffusion / Role Confusion

The identity diffusion or role confusion described by Erikson (1968), may be reflected in the elevated personality disturbances observed during adolescence. Researchers and theorists have argued that identity diffusion is known to share many characteristics with personality disorder symptoms (Cohen, Cohen & Brook 1993). Given Erikson's theory and research evidence on the similarities between identity diffusion symptoms and personality disorder symptoms, it may be difficult to differentiate between identity diffusion as a passing stage in adolescence or as the development of personality disorder behaviour symptoms. Though the research in this particular area is scarce, the above phenomenon may be due to many confounding variables such as the fluidity of personality during adolescence that prevents definitive answers from being produced.

From a more clinical perspective, Kernberg (1975) developed a psychoanalytic model of borderline personality disorder based on the individual's underlying identity diffusion and inability to integrate alternating views of self and other into a cohesive whole. Other clinical theorists have also associated personality disorders with identity disturbances, especially when individuals present with a "false self" (Masterson, 1967; Winnicott, 1960). This “false self” (Masterson, 1967; Winnicott, 1960) concept refers to individuals who present with a self concept, that is not who they really are but rather a façade of who they feel society thinks they should be (Masterson, 1967; Winnicott, 1960; Kernberg, 1975). On the basis of the above proposition that at times certain personality disorder symptoms (particularly the borderline pathology) reflect underlying identity disturbances, the current research proposes that (certain) Axis II symptoms can be negatively associated with identity consolidation that manifests in the form of well-being.

According to Erikson (1968), successful resolution of developmental crises provides the foundation for successful resolution of later crises, a process he referred to as the “epigenetic unfolding of personality”. Indeed, the way in which young people undertake to resolve the developmental crisis of identity significantly affects their ability to meet new challenges or take on new opportunities as they progress into young adulthood i.e. achieving / establishing their role / place in society (Erikson, 1968). If identity diffusion were characteristic of Axis II symptoms then this may inhibit adolescents from achieving their desired place in society or role satisfaction (their individual life goals), which would ultimately also limit their ability to commit to any lasting relationship (social or intimate) in adulthood. Furthermore, it is hypothesised that Axis II traits may serve as an impediment to the acquisition of

appropriate interpersonal skills, thus making it difficult for young people to connect and interact with others; hence, this results in the non-mastering of some developmental tasks.

It would seem that interpersonal difficulties are present in adult manifestations of personality disorders and are one of the criterion set in the DSM-IV-TR (APA, 2000) as a maladaptive trait. Thus, the current research will try to ascertain if interpersonal difficulties along with other behavioural difficulties are associated with a diagnosis on Axis II. For this, the research will collate the most commonly reported disordered or pathological behaviours[4] and ascertain if there is a relationship between these reported symptoms and an Axis II diagnosis.

2.1.5 The Influence of Gender on Identity and Pathology

Since Erikson (1968) formulated his theory, research has revealed gender differences in the ways in which both men and women construct their identities (Cross & Madson, 1997; Franz & White, 1985). It has been reported that men in the United States of America generally construct identities that are more independent and autonomous from others, whilst the women tend to define themselves by being interdependent and related to others (Feiring, 1999). If identity formation or construction is different between male and females, then perhaps the type of personality disorders present in male and females would be different; i.e. certain disorders would be associated with men whilst others with women.

[4] The researcher has referred to behaviours of truancy, self-harming behaviours (parasuicides, self-mutilation) and interpersonal difficulties as "reported pathological behaviours" as these behaviours would have been reported as the main complaint when the adolescent was admitted onto the ward.

The DSM-IV-TR (APA, 2000) professes gender bias in the adult presentation of personality pathology, in that personality disorders such as Borderline, Histrionic (Cluster B traits and disorders) and Dependent personality disorders are thought to be more prevalent amongst women (Kaplan & Sadock, 2003). The DSM-IV-TR (APA, 2000) is rather even-handed as it also states that other personality disorders such as Narcissism, Antisocial, Obsessive-Compulsive and the Cluster A personality disorders are more prevalent amongst men (Kaplan & Sadock, 2003). The current research will provide empirical evidence in support of or opposition to the above gender conclusion. It will also ascertain if there is a relationship between gender and an Axis II diagnosis. In so doing it will attempt to ascertain which personality pathology is more commonly related to male and female adolescent patients in an in-patient psychiatric ward.

Till now, much of the discussion has focused on identity and forming a healthy sense of self, as well as the failure to do so. From the discussion above, the current research has hypothesised that the result of failure to develop a healthy sense of self would perhaps contribute to the development of maladaptive traits; if unchanged, this may lead to a personality disorder later on in life. The next section will focus on personality disorders and the characteristics or behaviours that need to be present in order for a personality pathology diagnosis to be made.

2.2 Personality Disorders

As previously discussed, the classification system used by clinicians to diagnose adult presentations of personality pathology is the DSM-IV-TR (APA, 2000). The DSM-IV-TR (APA, 2000) has defined personality-disordered behaviour as characterised by

maladaptive, insidious and firm personality traits that deviate considerably from cultural norms; these traits could cause substantial social and/or personal distress or impairment. It has recognised and categorised ten personality disorders with two further disorders in the category of 'personality disorder not otherwise specified' (DSM-IV-TR, APA, 2000).

Individuals may exhibit traits that are not limited to any single personality disorder but rather could meet the criteria for more than one personality disorder (Kaplan & Sadock, 2003). For this, the DSM-IV-TR (APA, 2000) has thus provided clinicians with a clustering system that has previously been outlined and discussed on page 6. However, the clustering system does not mean that all patients can be fitted neatly into one of the three clusters but may present with symptoms across the clusters (cluster symptom traits). Therefore it is possible for individuals to have symptoms of more than one personality disorder within a cluster or to have symptoms from different personality clusters (Frey, 2002).

The current research study has previously provided a summary of the personality disorders in the DSM-IV-TR (APA, 2000) and a full description of each of the individual personality disorders can be found in the appendices section (appendix A). The DSM-IV-TR (APA, 2000) gives a comprehensive list of symptoms that patients or individuals need to present with in order for a diagnosis of a personality disorder to be made. Often a personality pathology diagnosis is made without the presence of any florid Axis I disorder i.e. psychosis or mood disorder. Should an individual present with a florid Axis I disorder as their primary reason for admission, an Axis II diagnosis is often deferred until the patient has stablised and has been observed for

any overt Axis II symptoms, which will then be recorded as a differential diagnosis on Axis II (Boyle & Offord, 1991).

The current research proposes that perhaps the adolescent presentations of maladaptive behaviours may be similar to the behaviours found in adult presentation of personality disordered behaviours. In order to diagnose a personality disorder in an adult, clinicians would need to use the criteria set out in the DSM-IV-TR (APA, 2000). The current research begs the question: are clinicians able to use the DSM-IV-TR (APA, 2000) as a tool to diagnose personality pathology in adolescents, given the assumption that it is an adult pathology? The above discussion points to the criteria needed for a personality disorder diagnosis to be made which is i) a particular set of symptoms; and ii) specific duration (length of time) of the symptoms (this information is provided in the DSM-IV-TR, 2002). The researcher will refer to these criteria as the 'key elements of diagnosis'.

In order for a clinician to diagnose personality pathology in an individual there has to be a set of one or more symptoms present for a prescribed length of time (Kaplan & Sadock, 2003). If a patient does not meet the criteria or the 'key elements' necessary for making a personality pathology diagnosis, the individual cannot be diagnosed with a personality disorder. However, should the individual present with traits of a personality disorder that are maladaptive and have led to some impairment in functioning, then the individual can be said to have personality disorder traits and is at greater risk of developing a full blown personality disorder. For example, to be diagnosed with Anti-Social Personality Disorder (ASPD) an individual must present with a pervasive pattern of disregard for and violation of the rights of others occurring

since age 15. This criterion, together with three or more of the symptoms (behaviours/traits) listed in the DSM IV-TR (APA, 2000), is enough for the individual to be diagnosed with ASPD. If this is true for adults, can the same set of criteria or 'key elements of diagnosis' be used to diagnose or classify personality pathology in adolescents?

The premise of the current research is that clinicians are using the DSM-IV TR (APA, 2000), albeit cautiously so, to diagnose personality pathology on an inpatient adolescent psychiatric ward. The question that remains unanswered is: can personality pathology be diagnosed in adolescence, given the fact that professionals in the field are hesitant to provide a personality diagnosis, as previous literature and research pointed to personality during childhood and adolescence as being unstable? The next section will look at the debates surrounding the reticence that governs the diagnosing of personality pathology in adolescence.

2.3 Debates Surrounding the Diagnosis of Adolescent Personality Pathology

2.3.1 Reluctance to Diagnose

According to Kernberg et al., (2000) clinicians have been reluctant to make a diagnosis of personality pathology in adolescents due to a number of theoretical and personal reasons. One of the reasons may be due to the fact that labelling an adolescent with a personality disorder diagnosis may suggest to both the adolescent and the parent that something is desperately wrong. This may ultimately impact on the adolescent's self-concept and future plans, as the diagnosis will appear on the personal record of the individual and may be very distressing if s/he knows the diagnosis (Kernberg et al., 2000).

Theorists would argue that during childhood and adolescence personalities are being formed and developed. This argument may account for the seemingly persistent and understandable reluctance to believe that a developing child may have a disorder of such a magnitude and that it could interfere with his/her relationship to the environment and the self (Kernberg et al., 2000). However, if it were possible that an adolescent could have detrimental maladaptive behaviours, the argument would be, if one were to make a personality pathology diagnosis during this stage, there is a chance that the behaviours may be modified sufficiently to halt their continued maladaptive development and destructive influence on patients' lives.

The current study wonders what would happen when the full diagnostic meaning of an adolescent's maladaptive behaviours are not acknowledged and therefore not treated with the necessary focus but left to become further entrenched during adolescence. Are clinicians obliged to wait until the adolescent reaches early adulthood to make the diagnosis, due to the fact that it is more acceptable to give a personality disorder diagnosis to adults? If personality disorders exist in adolescence, which the DSM-IV-TR (APA, 2000) does not deny occurring, should resources not be directed towards treating early personality pathology, both to relieve the adolescent's present suffering and to prevent further negative development (Shiner, 2005)? With the ongoing debate between diagnosing and not diagnosing personality pathology in adolescence, the current study aims to add to the modest data available on the presence and practice of diagnosing personality pathology in adolescents. If personality pathologies are indeed present during adolescence but not treated, it may in all possibility lead to a full blown personality disorder in adulthood that becomes

increasingly difficult and costly to modify.

2.3.2 Arguments Supporting Personality Pathology Diagnoses

2.3.2.1 Cost of Treatment

Kernberg et al, (2000) argues that failure to diagnose a personality disorder in adolescence could jeopardise future access to medical health care. In America, treatment for personality disorders are not usually supported by third party / medical – aid schemes as this condition is too costly to treat. Statistics on the exact cost(s) of this disorder to the South African society are not yet available.

Treatment is very costly for the family to maintain and as a result, they do not continue with the treatment plan, making compliance a big part of the practitioner's decision to place an adolescent on a treatment program that s/he knows the family may not be able to support. Personality disorders are difficult to treat (Rey, 1996) and individuals with personality pathologies consume vast resources within their society (Rey, 1996). Some countries have registered up to 6% of the population as having serious mental disorders that include personality pathologies (Sainsbury Centre for Mental Health, 2003)**.** There are unfortunately no available statistics for the South African population or more specific indicators of the cost of personality disorders to the South African society. However, the gravity of the situation is not confined to other countries and could have a similar prevalence profile in South Africa. The importance of conducting this type of research is indicated by the treatment and other costs to society, should the maladaptive behaviours develop in adolescence but be left to persist into adulthood.

The psychiatric ward accessed for the current research study has a referral system for all individuals referred to the ward. In order to be admitted to the ward, the individual would need to be referred by a clinician - psychiatrist or clinical psychologist- and this would entail costs of having to be assessed by the clinician before being referred for admission. This may result in a costly matter for the families especially if there are issues of non-compliance, relapses and repeat admissions. Often, individuals admitted to the adolescent ward are done so on an 'involuntary or assisted' status which would ultimately mean that the medical aid may not pay for these types of admissions. With the third party not paying for the treatment, the onus of payment will fall on the family and with an average admission of 5-6 weeks, the costs involved could be too much for most families to manage.[5]

2.3.2.2 Early Onset of Behaviours

The ambivalence around diagnosing personality pathology in adolescents has led to very little empirical studies being conducted on the subject. Epidemiological studies of mental disorders in adolescents do not typically search for the presence of personality disorders, which could be attributed to the paucity of personality pathology studies in research (Cohen, Cohen & Brook, 1993). However, Kernberg et al. (2000) postulate that when personality disorders are looked for in adolescents, their prevalence could be considerable. From the sparse research conducted in the area, reports have indicated a high prevalence of personality pathology between the ages of nine and nineteen (Bernstein, Cohen, Velez, Schwab-Stone, Siever & Shinsta, 1993). Clinical and research findings on adult personality disorders emphasise their early

[5] Information on the Ward accessed was obtained through personal information and discussion with the senior child psychiatrist on wards 1 & 2, Professor R. Thom (May 2008).

developmental precursors and yet the very existence of personality disorders in children and adolescents has been questioned (Kernberg et al., 2000).

As much as there has been a reluctance to research personality pathology in adolescence, there have been a number of researchers (Shiner, 2005; Cohen & Crawford, 2005, Geiger & Crick, 2001, Rey, 1996) who have recently provided evidence that personality pathology exists in the youth in one form or another and that the pathways leading to adult personality disorders begin in adolescence, at least for some individuals (Kernberg et al., 2000). While clinicians are hesitant to apply psychiatric labels to individuals, the personality label has value for the clinician dealing with the individual (Kaplan & Sadock, 2003). As an early diagnosis albeit tentative, may facilitate better management with appropriate interventions at the time help is sought, which may lead to a better prognosis than when the individual seeks treatment as an adult (Kernberg et al., 2000).

Individuals with personality disorders are far more likely to refuse psychiatric help and deny their problems than individuals with Axis I disorders such as anxiety or depression. Personality disorder symptoms are alloplastic[6] and ego-syntonic[7], (Kaplan & Sadock, 2003) and thus individuals with personality disorders do not feel anxiety about their maladaptive behaviour. They tend not to acknowledge the pain caused from their behaviours and often seem disinterested in treatment that may impact on the recovery process (Kaplan & Sadock, 2003). This type of behaviour may be

[6] When symptoms are alloplastic, they are able to adapt to and alter the external environment to become acceptable to the individual (Kaplan & Sadock, 2003).
[7] Alloplastic symptoms are often ego-syntonic i.e. they do not cause any distress to the ego or individual but are acceptable to the self as normal ways of interacting with others (Kaplan & Sadock, 2003).

present in adolescence but is often dismissed, as there is a presumption that the child or adolescent will eventually outgrow the behaviours (Kernberg et al., 2000).

One cannot underestimate the importance of supporting a developmentally appropriate diagnosis with the relevant research, as this will authenticate tailoring interventions and treatment programs that will assist adolescents in modifying patterns of maladaptive behaviours so as to prevent a possible full blown personality disorder later in life. This would contribute to a healthier prognosis and ultimately reduce long-term treatment costs, as the maladaptive behaviours would be modified through early intervention. It is the intention of this research to add to the limited body of knowledge on the presence of personality pathology in adolescents in a South African context. This study can perhaps begin to provide a more accurate indication of the emergence of personality pathology in adolescence, from which further research can be stimulated.

The above discussion explored the ambivalence around diagnosing personality pathology in adolescence, especially when the perceived consensus is that personality is not yet formed until adulthood. The next section will provide information and evidence for the argument that personality and personality psychopathology could have its origins in adolescence and may progress to a precarious state before help is sought by the then adult.

2.4 Stability of Psychopathology in Adolescence

According to Kernberg et al. (2000), there is a general assumption made by practitioners that children are unpredictable and acquiescent, so that as a child

continues to develop, change will occur. If this development does not result in a healthy outcome, practitioners and society generally assume that psychological and behavioural problems displayed by children will be outgrown (Kernberg et al., 2000). Nonetheless, there are children and adolescents who do indeed fulfill the DSM-IV-TR (APA, 2000) criteria for a personality disorder in which the inflexible personality trait(s) appears to be pervasive and persistent (Kernberg et al., 2000). The DSM-IV-TR (APA, 2000) traces the onset of a personality disorder to early adulthood and adolescents but not to early childhood (Kernberg et al., 2000). Kernberg postulates that even though some childhood problems may resolve themselves, not all children's problems are transitory and given the complexity of development, it is remarkable that there is nonetheless the ability to link adult psychopathology to adolescence (Kernberg et al., 2000).

According to the DSM-IV-TR (APA, 2000), personality disorder categories may be applied to adolescents in relatively unusual instances where the individual has particular maladaptive personality traits that appear to be omnipresent, insistent and unlikely to be limited to a particular developmental stage or an episode of an Axis I disorder (DSM-IV-TR, 2002). The DSM-IV-TR (APA, 2000) also states that it should be recognised that disordered personality traits that emerge in childhood will often not persist unchanged into adult life; thus there is the possibility of the behaviours not advancing into adulthood. Therefore, the DSM-IV-TR (APA, 2000) allows for diagnosing adolescent personality pathology, albeit cautiously so.

According to the DSM-IV-TR (APA, 2000), when diagnosing a personality disorder in an individual under the age of eighteen years, one must ensure that the features

have been present for at least one year and that behaviours are maladaptive. The only exception to the age rule is Antisocial Personality Disorder (ASPD), which cannot be diagnosed before the age of eighteen years. Adolescents displaying anti-social personality disorder traits are commonly diagnosed with 'conduct disorder' and there has to be a constant disregard or violation of the rights of others. Many of these adolescents are eventually diagnosed with ASPD (DSM-IV-TR, APA, 2000; Kernberg et al., 2000).

A study conducted by Grilo, Mcglashan, Quinlan, Greenfield & Edell (1998) had systematically researched adolescent personality disorders using adult criteria. In the study they compared the frequency of inpatient adult and adolescent personality disorder diagnoses based on criteria set out in the DSM-III-R (APA, 1987) and Personality Disorders Examination (PDE; Loranger, Susman, Oldham & Russakoff, 1987) which are intended for diagnosing adult symptomatology. The study revealed similar rates of personality disorders (around 14%) in both the adolescent and adult inpatient samples, thus supporting the hypothesis that clinicians were able to use the Diagnostic Statistical Manual as a tool for diagnosing personality disordered behaviours in adolescence.

In more recent research, Westen, Shedler, Durrett, Glass, & Martens (2003), conducted a similar study in which they examined the applicability and limits of the DSM-IV axis II personality disorder diagnoses in adolescents in the hope of developing an alternative classification system to the DSM. From the research, they proposed that personality pathology in adolescence resembles that in adults and is diagnosable in adolescents between ages of 14 and 18. They argue that

epidemiological and longitudinal studies have suggested that roughly 15% of adolescents in community samples would meet adult criteria for axis II disorders which is a similar rate to that found in adult samples (Westen et al., 2003).

Findings from both the above-mentioned studies are important for research on the topic of adolescent personality pathology as the DSM criteria for personality pathology is based on adult presentation and as such, there is currently no system of classification for adolescent presentations. The current study has a similar hypothesis to both Grilo et al. (1998) and Westen et al. (2003), in that it proposes that clinicians are using the adult criteria in the DSM-IV-TR (APA, 2000) as a diagnostic tool or classification system for adolescent personality pathology due to the fact that there is no classification system available for the adolescent population.

As there currently is no classification system for a psychiatric adolescent population presenting with possible personality pathology, the condition does not typically come to clinical attention until relatively late in life due to symptoms being ego-syntonic (Kaplan & Sadock, 2003). Adolescents' early personality difficulties could potentially be conceptualised and understood in terms of their specific developmental presentations and treated accordingly. This is often not the case, as researchers or clinicians dismiss the possibility of personality pathology emerging in adolescence (Kernberg et al., 2000; Shiner, 2005). If adolescents exhibit similar personality traits to adults, it would be more helpful to detect disordered traits and to prevent them from becoming disordered ways of relating to others as well as providing the possibility of making more direct links between early manifestations of personality disorder traits and later entrenched pathological behaviours in adults (Rey, 1996). Addressing the

developmentally determined variance in presentation is beyond the scope of the current research but strengthens the argument that much more research in this area is needed.

If professionals are alert to and address personality pathology in adolescents it could significantly minimise the distress, social dysfunction and destructiveness in these patients' lives. If adult personality pathology originated early in adolescence as many researchers seem to postulate (Shiner, 2005; Kernberg et al., 2000; Rey, 1996), then resources should be directed toward longitudinal studies of the pathways leading to personality pathology in both adolescents and adults (Shiner, 2005). According to Kernberg et al. (2000), Westen et al. (2003) and the DSM-IV-TR (APA, 2000), the presentations of Cluster A, B and C personality disorder traits in adolescents, are fairly similar to the presentation of the traits in adults. Researchers and theorists have been able to provide empirical evidence to support claims of similar presentations and prevalence rates of personality pathology in both adults and adolescents (Becker, 2006; Westen et al., 2003).

The current study is interested in determining whether clinicians on an adolescent psychiatric ward are using the DSM-IV-TR (APA, 2000) as a diagnostic tool to make diagnoses on the ward. As such, the criteria set in the DSM-IV-TR (APA, 2000) are mainly for adult presentations of disordered behaviours and if clinicians on the adolescent psychiatric ward are using the DSM-IV-TR (APA, 2000) to diagnose personality pathology, then it may be assumed that the adolescent symptom presentations are severe enough to warrant a diagnosis and that their symptom presentations are similar to that of adult presentations.

2.5 Research Findings on the Similarities between Adult and Adolescent Presentations of Personality Pathology

Bernstein, Cohen, Skodol, Bezirganian & Brook (1996) and Johnson, Cohen, Skodol, Oldham, Kasen & Brook (1999) had over a number of years undertaken the largest study of personality disorders in adolescents (N = 641), following up a community sample of adolescents and young adults years after they were initially studied. The project had important information to share regarding data on the nature, prevalence, antecedents, comorbidity, and continuity into adulthood of adolescent personality disorders (Johnson et al., 1999). Instead of presenting findings on the individual disorders the investigators mainly analysed their data using the three Axis II clusters (as previously defined) identified in DSM-IV (APA, 2000). Due to the absence of structured interviews for adolescent personality disorders other than borderline, and that the research was initially not designed to investigate personality pathology, the researchers drew upon items from many components to gain information. They made use of extensive interviews and self-report protocol that tapped most of the axis II criteria and relied on both patient and parent reports to make diagnoses. Categorical diagnoses were made based on extreme scores relative to others in the sample (elevation of two standard deviations) rather than DSM-III-R or DSM-IV cutoffs (Westen & Chang, 2000). The major findings from the above studies were as follows: consistent with earlier studies (Grilo et al., 1998) of personality disorders, Johnson et al. (1999) supported the observation that personality disorders seem to be diagnosable in adolescence. It was reported that around fifteen percent of adolescent subjects met study criteria for the presence of a personality disorder prior to the onset of adulthood (Kasen, Cohen, Skodol, Johnson & Brook, 1999).

Kasen et al. (1999) argued that an Axis II diagnosis was predictive of increased odds of having an Axis I or Axis II diagnosis in young adulthood. Almost half of the patients in late childhood or early to mid adolescence that were diagnosed with a personality disorder in their study retained the diagnosis two years later. Subjects initially diagnosed with a personality disorder were at substantially elevated risk for having a personality disorder diagnosis upon reassessment (Bernstein et al., 1996). This finding is consistant with more recent research conducted by Westen et al. (2003) who suggest personality disordered symptoms are stable over time and that patients with personality disorders are at greater risk for both Axis I and Axis II conditions in young adulthood.

The studies also revealed that childhood behavioural and emotional problems were predictive of adolescent personality disorders. Children with conduct problems or those with a pattern of "immaturity" (distractibility, low persistence at tasks, low achievement motivation, and noncompliance with adult demands), were likely to develop a broad range of personality disorders in adolescence across all three clusters (Westen & Chang, 2000). Children diagnosed with depression and symptoms of anxiety in childhood were more likely to specifically develop cluster B disorders in adolescence (Westen & Chang, 2000). It is also important to note that these findings were within the general population and the current study is trying to ascertain the prevelance rates of personality pathology on an inpatient psychiatric adolescent unit, where there seems to be a general lack of research.

Although theorists have argued that adolescent personality is unstable, a considerable amount of research supports the view that personality shows substantial continuity

from at least the age of three years old, through the adolescent years and beyond (Caspi, 1998). However, there are arguments that maintain that young children who are shy and inhibited are more likely to be anxious and inhibited in adolescence (Kagan and Snidman, 1991; Gest, 1997). It was hypothesised by Caspi, Elder, and Herbener (1990), that boys who are aggressive and show features of (or diagnosed with) conduct disorder in childhood are more likely to be antisocial or dysfunctional adults. Boys who are undercontrolled and impulsive, or girls who are overcontrolled and constricted, are more likely to be depressive in late adolescence and early adulthood (Block and Gjerde, 1991). Bernstein et al. (1996) reported that childhood Axis I symptoms (e.g., conduct disorder, major depression) are highly predictive of later (adolescent) personality pathology as assessed by using Axis II criteria. All these studies suggest considerable continuity over time between childhood and adolescent personality; could the same not be said from adolescence to adulthood?

Some of the first (sustained) empirical research on adolescent personality disorders appeared in the early 1990s, on Borderline personality disorder (Ludolph, Westen, Misle, Jackson, Wixom, & Wiss, 1990). The major findings of these studies revealed that borderline personality disorder is in fact diagnosable in adolescence, with only minor modifications of adult diagnostic criteria or interviews. According to Westen & Chang (2000), the above studies showed that the aetiology of borderline personality disorder is very similar in both adolescents and adults, beginning at around 14 years of age. It seems that both Borderline adolescents and adults share a high rate of sexual trauma in childhood as well as a greater probability of a childhood history of disrupted attachments, such as extended separations from the primary caregiver (Westen & Chang, 2000). It was also noted that both Borderline adolescents and

adults exhibited similar object-relational disturbances (notably, a tendency to activate malicious interpersonal stress, a relative incapacity to understand causality in the social realm, a difficulty telling coherent and interpersonal narratives, and a tendency to have a need-gratifying orientation to relationships). However, it seems as though various aspects of object relations appear to mature between adolescence and adulthood (Westen & Chang, 2000). Lastly it was reported that borderline adolescents and adults share a similar quality of depression, which is characterised by diffuse negativity and liability in affect, a sense of inner badness, and a tendency to be triggered by perceived abandonment or aloneness (Westen & Chang, 2000).

There should not be the dismissal of the possibility of comorbid borderline personality disorder in adolescents with severe psychiatric problems, argues Chanen (2007). It is argued that borderline personality disorder (BPD) is often diagnosed in adults, but data in adolescents are limited. In an attempt to define the psychiatric symptoms and functional abilities of adolescents with BPD, the researchers interviewed 177 psychiatric outpatients aged 15-18 years. The sample was then divided into three groups: 46 patients (26%) with BPD, 88 patients (50'%) with a personality disorder other than BPD, and 43 patients (24%) with no personality disorder at all. The adolescents in the BPD group met at least three of the DSM-IV criteria for BPD (Chanen, 2007).

The study reported that the BPD patients had significantly greater impairment compared to adolescents in the other two groups (Chanen, 2007). They argue that BPD patients averaged more psychiatric diagnoses than patients in either of the other two groups, and were significantly more likely to have mood disorders, substance abuse/dependence, disruptive behavior disorders, and anxiety disorders than the

patients without personality disorders (Chanen, 2007). In addition, they argue that adolescents with BPD were significantly more likely than others to be impulsive, emotional and struggle to differentiate between internal and external states of anxiety (Chanen, 2007).

According to Splete (2006), Becker (2006), reported that four factors appear to account for 67% of the variance of psychopathology seen in borderline personality disorder adolescent inpatients as compared with hospitalized adults with borderline personality disorder. The factors were: 1- negative or self-deprecating aspects of BPD presentation, such as suicidal threats and gestures, and feelings of emptiness or boredom. Factor 2 - affective dysregulation or irritability, including uncontrolled anger. Factor 3- interpersonal problems, such as unstable relationships and factor 4 - impulsiveness. The researchers interviewed a total of 123 adolescent inpatients, aged 13-18 years (mean age of 15.9 years). Based on the interviews conducted, the researchers postulated that 53% (N=65) of the adolescents could be diagnosed with borderline personality disorder (BPD), of which, 40% were male and 60% were female (Splete, 2006). The researchers questioned whether BPD is different in its nature and underlying structure in adolescents who are undergoing an active developmental process, than it is in adults (Splete, 2006).

Theoretically, it has been hypothesised that the difficulties of differentiation between temperament, character formation (identity) and mental disorders has made diagnosing personality disorders in adolescents difficult (Rey, 1996). These components (temperament and identity/character formation) theorists argue form components of personality. Temperament has often been understood as behaviours that would normally appear early in a child's life, usually the first year. These

behaviours would be instinctual or biological, are stable across situations and over time (Kernberg et al., 2000). Temperament contributes an emotional component to the formation and expression of personality. According to Kernberg et al. (2000) it is the management of emotions over the course of development that makes temperament a constant contributor to personality development. If one is not able to the control the emotional aspect of one's personality, emotional instability may result, which is a component of personality-disordered behaviour.

Identity or character formation is not a unitary concept and theorists from different schools of thought may describe this concept differently. Akhtar and Samuel (1996) describe a healthy sense of identity or character formation that would consist of individuals (adolescents) having realistic ideas of body image, authentic self-experience, genuineness, gender clarity, consistent attitudes and behaviours. This understanding of character formation or identity is similar to Erikson's (1968) idea of a healthy resolution of the identity crisis stage (as previously discussed on page 17). If an individual is seen as excessively temperamental and not having formed a healthy character or sense of self, one can assume that the pathway of 'normal' personality development has not occurred.

Childhood mental disorders are believed to increase the risk of the affected children developing a personality disorder when they grow up (Rey, 1996). Due to the fact that personality is shaped by experiences during childhood and adolescence, it follows that childhood mental disorders will influence a child's personality development. Factors that contribute to children developing personality pathology include the presence of

an Axis I disorder at a young age (such as depression) and environmental disruptions (such as punitive handling or possible abuse) (Rey, 1996).

The question of attachment comes into play, as many theorists have formulated links between attachment styles and possible personality traits or behaviours later on in life (Westen & Chang, 2000). Infants who have insecurely attached between the first year or two of life, are more likely than their securely attached peers to have interpersonal difficulties in childhood (Jacobsen & Hofmann, 1997). They may also have lowered self-esteem, ego resiliency, and peer competence as adolescents (Sroufe, Carlson & Shulman, 1993). This may be an area of study that researchers could address, as attachment styles and their impact on personality development are beyond the scope of the current research study.

The above-mentioned factors often play a role in impeding a diagnosis of a personality disorder in adolescents, as the Axis I disorder will be diagnosed as primary thus clouding the results of epidemiological studies. With this having been said, the topic of "adolescent personality disorders" was only really studied in the 1990's, hence the sparse summary of the research literature on adolescent personality disorders (Westen & Chang, 2000). Researchers may not know what the actual prevalence of personality disorder diagnoses are among the adolescent population due to a lack of empirical evidence. The current research hopes to establish the diagnostic prevalence of personality pathology within the adolescent population at a South African in-patient psychiatric ward.

Rey (1996) points to the importance of establishing links between child and adolescent manifestations of personality symptomatology, and adult symptomatology. However, it should be recognised that personality traits and personality disorders can and often do change, not only in childhood and adolescence but also in adulthood. Theorists like Kernberg et al. (2000) suggest the use of a differential diagnosis as opposed to a definitive personality disorder diagnosis to allow for the fluidity of personality pathology during development from childhood into adulthood. One can assume that abnormal development continues through abnormal pathways and that children tend to maintain their psychological disturbances, especially when untreated, which in turn leads to the meeting of criteria for persistence and pervasiveness of maladaptive traits (Kernberg et al., 2000).

In a study of the persistence of childhood disorders by Cohen et al. (1993), concluded from their epidemiological data that psychiatric disorders in childhood could be as stable as those found in adulthood (as cited in Kernberg et al., 2000). Costello and Angold (1995) indicated that the presence of a childhood disorder significantly increased the likelihood of a disorder in adolescence, thus alluding to the child's vulnerability. Other studies cited in Kernberg et al. (2000) found that the presence of Axis I disorders earlier in childhood, especially if more than one diagnosis is present, greatly increases the likelihood of a personality disorder in later adolescence and young adulthood.

As highlighted in the above research by Costello & Angold (1995), one of the most important findings is the relation between the presence of multiple comorbid conditions in childhood and the likelihood of Axis II diagnoses in adulthood

(Lewinsohn, Rohde, Seeley & Klein, 1997). Across clusters, subjects with only one Axis I condition tended to have relatively little personality pathology. Each additional disorder diagnosed in childhood on Axis I, typically doubled the chance patients had of being diagnosed with an Axis II condition in adulthood (Lewinsohn et al., 1997). In general, these findings suggest that the distinction between Axis I and Axis II disorders may be problematic in adolescents as it is with adults, with comorbidity essentially a sign of the presence of personality pathology (Westen et al., 2003).

Research findings indicate that the presentation of personality pathology may be similar in both adolescents and adults. The findings also suggest that having an Axis I disorder or presenting with certain symptoms would add to the likelihood of an individual being diagnosed with some kind of personality pathology. Finely-Belgrad & Davids (2006), argue that the presence of an Axis II personality pathology in an individual, particulary borderline personality disorder, doubled their risk of receiving three or more current Axis I disorders. They also aruge that approximately 70-75% of patients with borderline personality disorder have a history of at least one act of deliberate self-harming behaviour and that there is a 9% rate of completed suicides among patients with borderline pathology (Finely-Belgrad & Davids, 2006).

The current study has tried to test this hypothesis by attempting to establish whether there is a relationship between having a number of Axis I diagnoses and being diagnosed with an Axis II disorder as well. The research will also try to establish if there is a relationship between specific disordered symptoms or disordered behaviour traits (self-mutilation, parasuicide behaviours, low mood, interpersonal and scholastic problems) and the potential of being diagnosed with an Axis II pathology. These

results will be further explored and discussed in chapters three and four of the research.

2.6 Conclusion

The reluctance of psychiatrists and clinical psychologists to diagnose personality pathology in adolescents has been based on a number of theoretical, practical and personal reasons (Kernberg et al., 2000). On a practical level, personality disorders often require more extended treatment that is often costly and not covered by medical aid schemes (Kernberg et al., 2000). Personality disorders are both frequent and difficult to treat and individuals with personality problems consume substantial resources within their society. If personality conditions are not recognised or treated early on in an individual's life, it will in all likelihood lead to a full blown personality disorder in adulthood that becomes increasingly difficult to modify. If one is able to make a diagnosis based on the key elements of diagnosis of a personality disorder or personality disorder trait in adolescence, then professionals can tailor interventions and treatment programs to assist the adolescent in modifying the patterns of maladaptive behaviour. This would possibly prevent a full-blown personality disorder later in life and would ultimately contribute towards a healthier prognosis. According to Kernberg et al. (2000) whilst the features of a particular behaviour may change with development, the maladaptive impact of the personality disorder on the self and others may persist.

CHAPTER 3: METHODOLOGY

The previous chapter delineated the theoretical context of the variables investigated in this study, namely personality pathology, gender and the relationship between behaviour symptoms or traits, and a diagnosis of Axis II personality pathology. In the present chapter, aspects of the research design and characteristics of the sample will be discussed. The instruments, procedure and method of data analysis will also be explored.

3.1 Research Design

3.1.1 Research Aims

The current research is aimed at discovering the diagnostic prevalence of personality pathology on an inpatient adolescent psychiatric ward. Whilst investigating the prevalence of personality pathology in adolescents, the research will explore to what extent psychiatrists and clinical psychologists on the ward are diagnosing personality pathology in adolescent patients. Furthermore, if personality pathology is being diagnosed, what specific personality pathology diagnoses are being made? Secondary aims of the study include establishing whether there are relationships between the main variables under study namely: gender, reported pathological behaviours, Axis I and an Axis II diagnosis.

3.1.2 Parameters

The present study was conducted as a retrospective, non-experimental, ex-post facto inquiry (Howell, 2004), aimed at discovering the relations and interactions among psychological variables in patient lives. The researcher accessed patient records from

the registry department at Tara Hospital and thus no measurement instruments were used. However in order to obtain the data needed for the study, the researcher made use of a data collection sheet on which the necessary information was recorded.

3.1.3 Specific Research Hypotheses

- Personality pathology diagnoses are prevalent amongst an adolescent psychiatric population.
- Clinicians are cautiously using the DSM-IV-TR classification system to make Axis II diagnoses on account of i) there being no other classification system to use and ii) the characteristics or symptom presentation of personality pathology in an adolescent population are similar to those of an adult population.
- There will be a positive correlation between certain reported pathological behaviours (self-mutilation, low mood, parasuicide and interpersonal difficulties) and a diagnosis of Axis II pathology.
- The professed gender bias found in adult personality pathology (according to the DSM-IV-TR, APA, 2000) will be found in the adolescent presentation as well.
- Having an Axis II personality pathology diagnosis tends to be associated with one or more diagnosed disorders on Axis I.

3.2 Sample Information

The sample used in the study was obtained from Wards 1 and 2 at Tara Hospital. Ward 1 and 2 is divided into two units: ward 1 consists of patients who have been diagnosed with a form of eating disorder, while ward 2 is known as the ‘other

disorders' or adolescent unit. The sample did not contain any files from the eating disordered unit, as the adolescents on that ward would have already been diagnosed with an Axis I disorder as the primary reason for referral and an Eating Disorder diagnosis could be a confounding variable. Given the higher incidence of cluster B personality pathology in this population group, their inclusion is also likely to skew the epidemiological findings. The 'other disorders' unit of the ward consist of adolescents with Axis I disorders (that excludes eating disorders) and / or Axis II disorders.

There was no random selection of the sample files as there was no equal probability of any file being chosen, thus non-probability sampling was used (Rosenthal and Rosnow, 1991). The files needed were back dated from 2005 to 2008. Originally, the researcher had requested records from 1 February 2006 to 31 January 2007 to make up the intended sample; however, there were insufficient files to produce a large enough sample size from which data could be analysed during the intended time period. The researcher thus requested permission to extend the time period in which files could be used to obtain a large enough sample size from which statistical information could be deduced. The researcher went through approximately 220 files of which 120 were suitable for the current research; the other files did not meet the criteria for inclusion into the study i.e. adult patients or admission for an eating disorder.

3.2.1 Sample Description

The sample was made up of only adolescent patients from ward 2 – adolescent unit and the data for the sample representation as a whole is presented below:

Table 1: *Sample Age*

Sample Size	Minimum Age	Maximum Age	Mean Age
N= 120	12	19	15.42

Table 2: *Gender Composition of Sample*

Sample Size	Male	Female
N= 120	N = 47 (39.17%)	73 (60.83%)

3.3 Procedure

3.3.1 Ethical Considerations

The study was granted ethical approval by the Medical Ethics Committee of the University of the Witwatersrand. After receiving ethical approval from the University of the Witwatersrand, the researcher applied for permission to conduct research on Tara Hospital's adolescent ward. The researcher prepared an information letter, which was presented to the institution (Appendix B). The researcher obtained permission from the CEO of Tara Hospital, Dr. Otieno, to conduct her research on Tara Hospital's wards 1 and 2. The researcher was then granted access to archived records (back dated for 3 years) of adolescent patients who received treatment at Tara Hospital, wards 1 & 2 - adolescent unit. This time period allowed for a sufficient quantity of records to be processed so that a more accurate indication of personality pathology being diagnosed could be obtained. During this time period, certain hospitals included consent forms allowing for the use of patient information for research purposes.

3.3.2 Research Procedure

The researcher recorded the data onto a data collection sheet and into a personal file from which frequency and statistical correlation analysis were conducted. As the main sources of information, the researcher used the clerking intake form as well as the

discharge summary forms found in patient files. From the clerking and discharge summary forms, certain information was extracted, namely: date of birth, age, gender, reason for referral (reported pathological symptoms) and any diagnosis given (Axis I and Axis II diagnosis). This information allowed the researcher to answer the research questions at hand.

3.3.3 Source of Data and Data Collection

The researcher did not interview patients as the study is retrospective and all the necessary information was obtained from the patient record files. There were no measurement instruments used by the researcher. However, the researcher used the Tara Clerking Intake Summary Form (Appendix C) as well as the Discharge Summary Form (sample provided – Appendix D) in each patient file to obtain the necessary information. The researcher recorded the required information onto a Data Collection Record Form (Appendix E). The researcher used the information from the data collection sheet to conduct the necessary statistical procedures to answer the research questions.

The files from which the data was extracted varied according to the recorded information inside. It was noted by the researcher that files between years 2005 and early 2007 used a different intake and discharge summary to the one with which the researcher was familiar. As such, the researcher was not always able to extract accurate details for the needed data. The main areas that were lacking in the older intake forms were the ‘duration of symptoms’, section and this was often not accurately filled in. The recorded answers would range from more accurate ‘one week’ answers to vague ‘not a very long time’ answers. With some of the information

being unreliable it was difficult for the researcher to draw accurate conclusions, especially when speaking of the 'key elements' of diagnosis (as previously discussed on pg.28). One of the key elements – duration of symptoms - was compromised due to the inaccurate recordings of the duration of symptoms.

3.4 Research Questions

1. To what extent, if at all, are clinicians on the ward diagnosing personality pathology in adolescents?
2. How is personality pathology being specified: as a full blown personality disorder, personality disorder cluster / trait or personality disorder cluster traits?
3. Which types of personality disorders diagnoses are most commonly being made?
4. What is the presentation of personality pathology diagnoses according to gender?
5. What are the most commonly reported pathological behaviours or symptoms recorded when an Axis II diagnosis is made?
6. Is there a relationship between any type of personality pathology diagnosis and gender?
7. Is there a relationship between the most commonly reported pathological behaviours and the diagnosis of Axis II pathology?
8. Is there a relationship between Axis I and Axis II pathologies?
9. Would an Axis II diagnosis tend to be associated with having one or more Axis I disorder/s?

3.5 Statistical Analysis

To answer the above research questions, frequency and non-parametric Spearman correlation (Howell, 2004) statistical procedures were employed. The study of frequencies provided insight into the number and recurrence of diagnoses, while the study of correlations provided information on any relationship between variables (Howell, 2004). Apart from the quantitative analysis, no other method of data collection or analysis was utilised. The researcher intended to use a chi-squared method of analysis however, the test is a parametric test of association and as such the data obtained was not appropriate to yield any significant results due to the small data sample obtained.

CHAPTER 4: RESULTS

The aims of the research are to discover diagnostic prevalence of personality pathology on an inpatient adolescent psychiatric ward as well as to understand to what extent psychiatrists and clinical psychologists on the ward are diagnosing personality pathology in adolescent patients. Furthermore, if personality pathology diagnoses are being made, what are the specifics of these personality pathologies? A secondary aim of the current study is to establish if there are any relationships between the main variables under study: gender, reported pathological behaviours, Axis I and an Axis II diagnosis.

The research study investigated five central hypotheses. The first hypothesis is that personality pathology is being diagnosed among an in-patient adolescent population. Secondly, clinicians are making use of the DSM-IV TR classification system to make Axis II diagnoses (albeit cautiously so) on account of i) there being no other classification system to use and ii) the characteristics or symptom presentation of personality pathology in an adolescent population are similar to those of an adult population. Thirdly, there exists a positive correlation between the most commonly reported pathological behaviours (self-mutilation, low mood, parasuicide and environmental or interpersonal difficulties) and a diagnosis of Axis II personality pathology. Fourthly, the professed gender bias found in adult personality pathology (according to the DSM-IV-TR) will also be found in the adolescent population. The final hypothesis of the study is that the higher the number of disorders recorded on Axis I, the greater the tendency for a comorbid Axis II diagnosis.

In order to investigate these hypotheses, a series of research questions (see p. 42) need to be answered. To answer these questions, two main statistical techniques, namely frequency counts and non-parametric Spearman correlations (Howell, 2004) were used. The results obtained for each research question will be tabulated and discussed below.

4.1. Frequency of Personality Pathologies

Research Question 1: To what extent, if at all, are clinicians on the ward diagnosing personality pathology (i.e. personality disorders or personality disorder traits) in adolescents?

Table 3: *Sample Frequency of Personality Pathology Diagnoses*

Personality Pathology Diagnosis	Yes	No
N = 120	N = 61	N = 59
Percentage Value	50.8 %	49.2%

Research Question 2: How is personality pathology being specified: as a full blown personality disorder, personality disorder cluster / trait or personality disorder cluster traits?

Processing of the files revealed that there appeared to be other methods that clinicians were using to classify personality pathology in adolescence and this is reflected in the table below. Some 51% of the sample was diagnosed with an Axis II pathology diagnosis; the results below indicate what types of personality pathology diagnoses constituted the 51%.

Table 4: *Type of Axis II Diagnoses*

Axis II Diagnosis Type	Percentage
Personality Disorder	1.7 %
Personality Disorder Trait(s)	6.7%
Emerging Personality Disorder	4.2%
Emerging Personality Disorder Trait(s)	14.2%
Cluster Personality Disorder	2.5%
Cluster Personality Disorder Trait(s)	8.3%
Emerging Cluster Personality Disorder	4.2%
Emerging Cluster personality Disorder Trait(s)	9.2

The most commonly diagnosed personality disorder type was that of an 'emerging' personality disorder trait(s).

Research Question 3: Which types of personality disorder diagnoses are most commonly being made? To ascertain the specific personality disorder type being diagnosed, a frequency analysis was run.

Table 5: *Type of Personality Disorders*

Personality Disorder Type	Percentage
Schizoid	0.8%
Anti-social	4.2%
Borderline	20.8%
Dependent	0.8%
Cluster B	20.8%
Cluster A	1.7%
Cluster C	1.7%

Below are the results of a combination of the above two tables (Tables 4 & 5). The table below illustrates both how personality pathology is being specified and the type of personality disorder being diagnosed, thus providing an overall view of the results obtained of personality pathology being diagnosed on the adolescent psychiatric ward.

Table 6: *Axis II Personality Type Diagnoses*

Axis II Personality Type Diagnosis	**Percentage**
Borderline Personality Disorder	1.5%
Borderline Personality Disorder Trait(s)	9.0%
Emerging Borderline Personality Disorder	7.5%
Emerging Borderline Trait(s)	19.4%
Anti-social Personality Disorder	1.5%
Anti-social Personality Disorder Trait(s)	1.5%
Emerging Anti-social Trait(s)	4.5%
Dependent Personality Disorder Trait(s)	1.5%
Emerging Schizoid Trait(s)	1.5 %
Cluster B Personality Disorder	3.0%
Cluster B Personality Disorder Trait(s)	11.9%
Emerging Cluster B Personality Disorder	7.5%
Emerging Cluster B Personality Disorder Trait(s)	14.9%
Cluster A Personality Disorder	1.5%
Cluster A Personality Disorder Trait(s)	1.5%
Cluster C Personality Disorder Trait(s)	1.5%
Emerging Cluster C Personality Disorder Trait(s)	1.5%

The results from Table 6 reveal that the labels most used by clinicians were those of the ‘emerging’ and ‘traits’ personality labels. Interesting findings from processing the data revealed that 11% of the total sample was diagnosed with cognitive impairment on Axis II. Furthermore, 2.2% of the 11% diagnosed with cognitive impairment were simultaneously diagnosed with personality pathology.

4.1.1. Age Specific Personality Pathology Diagnoses

To provide further insight into clinical patterns of diagnosing, the tables below provide diagnoses according to the age at which specific diagnoses were made.

Table 7: Age Specific Axis II Personality Type Diagnoses

Personality Diagnoses	**Age 13**	**Age 14**	**Age 15**	**Age 16**	**Age 17**	**Age 18**	**Age 19**
No Diagnosis	53.8%	66.64%	42.85%	55.55%	45.80%	33.3%	-
Borderline Personality Disorder	-	-	-	-	-	16.7%	-
Borderline Personality Traits	-	11.12%	7.14%	3.70%	4.17%	-	-
Emerging Borderline Personality	-	11.12%	3.57%	3.70%	12.50%	-	-
Emerging Borderline Traits	7.7 %	5.56%	17.85%	11.1%	4.17%	-	-
Emerging Antisocial Traits	7.7%	-	3.57%	-	-	-	-
Cluster B Personality	-	5.56%	-	-	-	-	-
Cluster B Traits	-	-	10.71%	-	12.50%	33.3%	-
Emerging Cluster B Personality	7.7%	-	7.14%	8.4%	-	-	-
Emerging Cluster B Traits	23.1%	-	3.57%	14.8%	8.34%	-	-
Anti-Social Personality Disorder	-	-	-	-	-	-	100%
Dependent Personality Traits	-	-	3.57%	-	-	-	-
Emerging Schizoid Personality	-	-	-	-	4.17%	-	-
Cluster A Personality Disorder	-	-	-	-	-	16.7%	-
Cluster A Traits	-	-	-	-	4.17%	-	-
Cluster C Traits	-	-	-	3.70%	-	-	-
Emerging Cluster C Traits	-	-	-	-	4.17%	-	-
Total Percentage of Personality Pathology per Age	46.2 %	33.36%	57.15%	44.45%	54.2%	66.7%	100%

4.2. Gender Specific Personality Diagnoses

Research Question 4: What is the presentation of personality pathology diagnoses according to gender?

The tables below illustrate the prevalence of Axis II personality type pathology across genders.

Table 8: *Frequency of Personality Pathology among Male and Female inpatients*

Personality Pathology Diagnosis	**Yes**	**No**
Male Patients	40.4%	59.6%
Female Patients	65.8%	34.2%

Table 9: *Axis II Personality Type Diagnoses across Male and Female Inpatients*

Axis II Personality Type Diagnosis	**Male Patients**	**Female Patients**
Borderline personality disorder	-	2.1%
Borderline personality disorder trait(s)	15.8%	6.3%
Emerging borderline personality disorder	-	10.4%
Emerging borderline trait(s)	5.3%	25%
Cluster B personality disorder	-	4.2%
Cluster B personality disorder trait(s)	10.5%	12.5%
Emerging cluster b personality disorder trait(s)	21.1 %	22.9%
Emerging schizoid trait(s)	5.3 %	-
Anti-social personality disorder	-	2.1%
Anti-social personality disorder trait(s)	-	2.1%
Emerging anti-social trait(s)	10.5%	2.1%
Dependent personality disorder trait(s)	-	2.1%
Cluster A personality disorder	-	2.1%
Cluster A personality disorder trait(s)	5.3 %	-
Cluster C personality disorder trait(s)	1.5%	2.1%
Emerging cluster c personality disorder trait(s)	-	2.1%

4.3. Most Commonly Reported Pathological Behaviours

Research Question 5: What are the most commonly reported pathological behaviours or symptoms recorded when an Axis II diagnosis is made?

Table 10: *Chart Representation of the most Common Pathological Behaviours Reported*

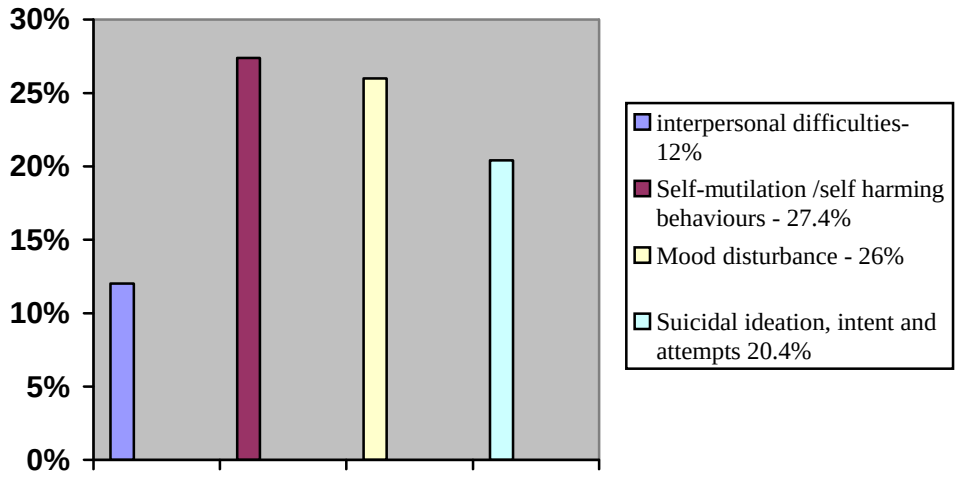

Table 11: *Age Specific Results of Reported Pathological Behaviours*

Age	**Percentage of Reported Pathological Behaviour / symptoms**
13	38.5%
14	50%
15	42.9%
16	33.3%
17	50%
18	50%
19	100%

The table above is a representation of age specific features of the pathological behaviours reported within the sample diagnosed with personality pathology.

4.4. Correlation Results

Due to the sample not meeting the criteria for a parametric correlation analysis, a non-parametric Spearman correlation analysis (Howell, 2004) was performed on all correlation analyses.

Research Question 6: Is there a relationship between any type of personality pathology diagnosis and gender?

A Spearman correlation result of 0.096 ($p > 0.05$) indicates that there is no significant relationship between the variables of personality pathology diagnosis and gender.

Research Question 7: Is there a relationship between the most commonly reported pathological behaviours and the diagnosis of Axis II pathology?

The symptoms represented in table 11 (pg 60) were grouped together to make up the variable 'most commonly reported pathological behaviours'.

The result revealed that there is a significant negative correlation of -0.472 ($p<0.001$) between the most commonly reported pathological behaviours and an Axis II diagnosis.

4.5. Relationship between Axis I and Axis II Diagnoses

Research Question 8: Is there a relationship between Axis I and Axis II pathologies?

Table 12: Spearman's Correlations between Axis I and Axis II Disorders

Axis I Disorders	**Axis II Pathologies**
Substance Abuse	-0.25 <0.0059**
Bipolar Mood Disorder	0.207 <0.023*
Adjustment Disorder	0.209 <0.022*
*Correlation is significant at the 0.05 level **Correlation is significant at the 0.01 level	

Table 12 demonstrates that there is a significant negative relationship between substance abuse and Axis II pathologies. Suggesting that as one variable increases the other decreases, this means that as the level of substance abuse increases, there would

be a greater tendency to diagnose an Axis I diagnosis of substance abuse rather than an Axis II pathology; hence the decrease of the Axis II variable. The tabulated results also reveal significant positive relationships between bipolar mood disorder, adjustment disorder and an Axis II pathology diagnosis, which is an interesting finding and will be further discussed in chapter 5. Whilst there were a total of 43 correlations run between Axis I disorders and Axis II pathology diagnosis, the above three disorders were the only statistically significant correlations found.

Research Question 10: Is there a relationship between having more than one diagnosis on Axis I and an Axis II diagnosis?

Table 13: *Relationship between number of Axis I Diagnoses and an Axis II Diagnosis*

Number of Axis I diagnoses	**Axis II**
1 Axis I diagnosis	17.9%
2 Axis I diagnoses	32.8%
3 or more Axis I diagnoses	49.3%

The above results in Table 13, illustrate the relationship between the comorbidity of Axis I and Axis II diagnoses. The results revealed that 17.9% of the sample presented with singular diagnoses on both Axis I and Axis II. The results also revealed that patients who had three or more Axis I diagnoses had a greater Axis II comorbidity rate of 49.3%.

CHAPTER 5: DISCUSSION

In this chapter, the findings of the present study are briefly reviewed and then discussed in light of the literature pertaining to personality pathology in adolescence.

5.1 Discussion of Results

5.1.1 The Prevalence of Personality Pathology in Adolescence

Kernberg et al. (2000) postulated that when personality disorders are looked for in adolescence, their prevalence could be considerable. However, epidemiological studies on psychiatric or psychological disorders do not typically include personality disorders. It has been the intention of this research to investigate the above assumption of Kernberg et al. (2000). The DSM-IV-TR (APA, 2000) traces the origins of personality disorders in adults to early adulthood and adolescence, and states that personality disorder categories may be applied to adolescents in relatively unusual circumstances. These include the emergence of maladaptive personality traits that appear to be pervasive, unrelenting and unlikely to be limited to a developmental stage, appear to be rigid and remain unchanged into adulthood, therefore allowing a personality pathology diagnosis (Kaplan and Sadock, 2003).

It was hypothesised by the current study that clinicians are diagnosing personality pathology on an inpatient adolescent psychiatric ward. The results confirmed the validity of the first hypothesis of the study, which was that personality pathology is being diagnosed in an inpatient psychiatric adolescent population. Beyond this, it sought to explore to what extent diagnoses are being made and which personality diagnoses are the most common.

The results confirmed that personality pathology is prevalent in an adolescent psychiatric population and that clinicians are diagnosing the pathology, with a very high incidence of 51% of the sample being diagnosed with some form of personality pathology. The most commonly diagnosed Axis II personality disorders are emerging borderline trait(s), emerging cluster B personality trait(s), followed closely by borderline personality disorder trait(s). The results revealed that the borderline personality and cluster B personality pathology together, constituted 41.6% of the total sample (51%) diagnosed with personality pathology. The result of borderline personality pathology being the most commonly diagnosed pathology seems to be consistent with international research findings (Becker, 2006; Johnson et al., 1999; Kasen et al., 1999 & Grillo et al, 1998).

As previously mentioned research on adolescent personality pathology is in its infancy, the current study researched personality pathology on an inpatient adolescent unit. There is a sparse amount of empirical information available on personality pathology on an inpatient adolescent population and as such the current research has very little comparable statistics. Nevertheless from the meagre research obtained, Becker (2006) conducted interviews on inpatient adolescents (n=123) comparing their experiences to that of adult inpatients. From the interviews conducted the researchers concluded that 53% of the adolescents interviewed could be diagnosed with borderline personality disorder (BPD). This result indicates a higher prevalence rate of BPD than what the current research findings suggest as borderline personality pathology constituted 20.8% of the current study's sample diagnosed with personality pathology. However the cluster B personality pathology (which comprised of diagnosed borderline and anti-social personality disorders) also yielded a result of

20.8% of the sample. Thus 38.6% of the sample group (diagnosed with personality pathology) could be said to have a form of borderline personality pathology as the other 3% were diagnosed with anti-social personality pathology under the cluster B personality diagnosis.

The results suggest a somewhat cautious or tentative approach in diagnosing adolescents with a full personality disorder label. This tendency may indicate that clinicians are taking the fluidity of adolescent personality into account (Kernberg et al., 2000), hence the use of words such as 'emerging' and 'traits'. The term 'emerging' is not a label used in diagnostic psychiatric terms, it would seem that clinicians are using this term as a tentative form of diagnosis within an adolescent population.

Overall the results show that although clinicians are diagnosing personality pathology in adolescence, it is done very cautiously. The results may also be indicating that perhaps clinicians are more open to early detection of maladaptive traits and by identifying them as 'emerging personality disorder traits', it may provide information on the gravity of the symptoms, for if they are not treated soonest they may in all likelihood result in a personality disorder. This kind of diagnosis may be a hopeful one in that it suggests that these traits could be modified with early detection and intervention thus possibly preventing a full-blown personality disorder.

Theoretically, it has been argued that personality is a fluid concept and that it is bound to change as the child matures, therefore, applying the personality label to adolescents may have adverse affects (Kernberg et al., 2000; Westen & Chang, 2000). These,

together with the lack of substantial empirical evidence prevent clinicians from making a personality pathology diagnosis in adolescence (Robins, 1991; Zoccolillo et al., 1992; Kernberg et al., 2000). However, researchers have argued that personality pathology does exist among the youth and that the symptoms can be stable over time (Shiner, 2005; Cohen & Crawford, 2005, Geiger & Crick, 2001) thus allowing Westen & Chang (2000) and Westen et al. (2003) to profess that personality pathology does exist in adolescence and that there should be a classification system developed for this population.

According to Westen et al (2003) community based longitudinal and empirical studies on adolescent personality pathology suggest that around 15% of adolescents can be diagnosed with personality pathology. One such study was conducted in 1993 by Bernstein, Cohen, and colleagues (Bernstein et al., 1993; Bernstein et al., 1996; Johnson et al., 1999; Kasen et al., 1999). The researchers embarked on the largest study of personality disorders in adolescents; they followed up a community sample of adolescents and young adults years after they were initially studied. The studies suggest that personality disorders cannot only be diagnosed in adolescence but show considerable continuity over time (Bernstein et al., 1996; Johnson et al., 1999). Major findings of studies that emerged from this longitudinal project are as follows: consistent with earlier studies of borderline personality disorder, personality disorders do seem diagnosable in adolescence. Roughly fifteen percent of adolescent subjects met study criteria for the presence of a personality disorder before adulthood (Bernstein et al., 1996). An Axis II diagnosis was predictive of increased odds of receiving an Axis I or Axis II diagnosis in young adulthood (Bernstein et al., 1996). Fewer than half of the patients diagnosed in late childhood or early to mid

adolescence with a personality disorder retained a personality disorder diagnosis two years later and subjects diagnosed initially with a personality disorder were at substantially elevated risk of having a personality disorder diagnosis upon reassessment (Bernstein et al., 1996).

The findings of the above longitudinal study suggest that personality pathology in adolescence exists and having personality disordered behaviours or traits earlier in life, substantially increases one's vulnerability to being diagnosed with a full-blown personality disorder later in life. The current study has shown that the diagnostic prevalence rate of personality pathology among in-patient adolescents are high and as such early treatment should be sought for maladaptive behaviours so as to prevent behaviours from becoming entrenched, which could in all possibility lead to personality disordered behaviours (Rey, 1996; Bernstein et al., 1993; Kernberg et al., 2000; Westen et al., 2003).

Despite the research evidence there is still the ongoing hesitation to diagnose, however the current research is showing that this trend seems to be decreasing and clinicians are inclined to diagnose personality pathology in adolescence where it is warranted. It would appear from the results obtained that clinicians could use the tentative personality labels to inform their treatment programme. If the label is tentative or provisional then perhaps the adolescent has a trait or two that is maladaptive but not rigid. Thus with a proper focus of treatment, these maladaptive traits could be altered, possibly preventing future disordered behaviours. Kernberg et al. (2000) and Rey (1996) would argue that seeking treatment and receiving it at this point (early detection) is beneficial to the adolescent and his/her family, especially

with the cost of treatment for personality disorders often not supported by third party medical aid schemes.

Previously discussed literature on adult personality disorders emphasise early developmental precursors to personality-disordered behaviours and yet there is a hesitation around the existence of personality disorders in adolescents (Kernberg et al., 2000). From the meager research conducted in the area of adolescent personality pathology, research reports have indicated a high prevalence of personality pathology between the ages of 9 and 19 (Bernstein et al., 1993) and 14 and 18 (Westen et al., 2003). The current study conducted an analysis to ascertain i) at what age clinicians felt more comfortable with the personality pathology diagnostic label and ii) at what age greater incidence of personality pathology diagnoses could be found.

From the results (set out on pg. 56), it would appear that between the ages of 13 and 14 years, clinicians are hesitant to mete out a personality diagnosis and if they do diagnose, it is done very tentatively and cautiously with 'emerging' and 'trait(s)' labels in place of the disorder label. For adolescents from the age of 15 years, clinicians are still cautious but where it is warranted and appear to be more accepting of the personality label as 57.15% of the 15 year olds in the sample were diagnosed with an Axis II pathology. Overall the prevalence rates of diagnosed personality pathology at specific ages are as follows: of the sample aged 15, 57.15% was diagnosed with personality pathology. The emerging borderline traits diagnosis was the most common with an incidence rate of 17.85%. At age 16, 44.45% of the sample was diagnosed with personality pathology and the emerging cluster B trait(s) diagnosis as the most common with an incidence rate of 14.8%. At age 17, 54.2% of

the sample (within the age group) was diagnosed with personality pathology, with the most common diagnoses being the cluster B traits and emerging borderline personality diagnoses at an equal incidence rate of 12.50%. Interestingly, the study noted that at age 18 there seemed to be an increase in the prevalence of diagnoses (as compared to other age groups) as 66.7% of the age group was diagnosed with personality pathology, with the incidence rate cluster B traits diagnosis recorded at 33.3%. At age 19, 100% of the age group was diagnosed with personality pathology, with antisocial personality disorder as the most prevalent. The results show a marked increase in the prevalence of personality pathology from age 18 and this may be due to the assumption that 18 is a more acceptable age for a personality pathology diagnosis to be made. The results also show that between ages 17 and 19, more than half of the sample (per age group) was diagnosed with personality pathology, perhaps indicating that clinicians are more open to diagnosing personality pathology within this age group (17 – 19).

The age specific findings of the current research seems to be consistent with the findings of Westen et al. (2003), where they argue that personality pathology is diagnosable in adolescence and that there is a higher prevalence rate between the ages of 14 and 18 years. The diagnoses seem to centre on the emerging borderline personality traits and cluster B traits, suggesting that the sample may be presenting with symptoms that encompass the cluster B (DSM-IV-TR, APA, 2000) personality disorder group. The above results are consistent with international research findings that suggest that borderline personality disorder is in fact diagnosable in adolescence, with only minor modifications of adult diagnostic criteria and that the etiology of the symptoms are around the age of 14 years (Ludolph et al., 1990; Westen et al. 1990).

The results of the current study suggest that in adolescence the most commonly diagnosed personality pathology is the borderline range of personality pathology. This kind of diagnosis may not be surprising given the earlier discussion on Erik Erikson's (1968) developmental theory. The current study focused mainly on the identity crisis stage of Erikson's (1968) developmental theory, wherein adolescents have to negotiate the crisis of 'ego identity and diffusion' (Erikson, 1968). A resolved identity crisis would result in the individual having successfully gained ego strength and an integrated sense of self or personality. According to Erikson (1968), an unresolved identity crisis would result in the adolescent having a diffuse sense of self and confusion about his/her social role and internal feelings (Erikson, 1968). Put differently, adolescents with an unresolved identity crisis would have interpersonal difficulties, an unintegrated sense of self, and internal feeling states that are foreign to the individual and cause confusion about their place in the society. The description of an adolescent with an unresolved identity crisis is similar to that of an individual with borderline personality pathology where the adolescent (and later adult) is not able to resolve the identity crisis.

Given the above theory as well as the criteria provided in the DSM-IV-TR (APA, 2000), it is possible to think that perhaps the behaviours or symptoms exhibited in adolescents with an unresolved identity crisis may resemble maladaptive personality disorder traits found in adults. These symptoms could possibly be the origins of disordered personality traits and one could perhaps have the understanding that by treating the symptoms when they present themselves (during adolescence), there may be the possibility of preventing the symptoms from becoming full-blown personality disorder behaviours later on in life (Kernberg et al., 2000 & Rey, 1996). Westen and

Chang (2000) argue that personality disordered behaviours can have its origins in adolescence and when the behavioural symptoms begin at a young age and continue untreated, the symptoms are much more difficult to treat. Kernberg et al (2000) and Rey (1996) in conjunction with Westen and Chang (2000) argue that early intervention through early detection may assist adolescents in preventing the maladaptive traits from becoming further entrenched, rigid and impervious to change. If no treatment is sought and the adolescent has disordered behaviours, this may harm the adolescent later in life when the maladaptive traits are entrenched and lead to functional and social impairment (Rey, 1996).

Theoretically, it has been agreed that identity formation is a life-long process (Erkison, 1968; Kernberg 1998) and that adolescence may be the first real opportunity for an individual to develop a sense of self through exploring the past, creating meaning in the present, and establishing direction for the future (Marcia, 1994). Therefore it is argued that identity consolidation or formation emerges as the cornerstone of the capacity to do well and forms the basis of self-acceptance and self-esteem i.e. healthy sense of self (Marcia, 1994). This formulation thus suggests that higher levels of well being are assumed to reflect greater levels of identity consolidation, while the opposite is true for individuals who are unable to resolve conflicts that arise during the identity crisis resulting in identity diffusion or dysfunctional sense of self. If the basis of a personality disorder is a dysfunctional sense of self or ‘false self’ (Winnicott, 1960; Masterson, 1967), should treatment programs therefore not be focussed on developing a healthy sense of self when adolescents first present with maladaptive behaviours?

It is the hope of the current research to provide insight into the prevalence of personality pathology among adolescents, that could potentially stimulate further research into effective treatment programs that could assist individuals with maladaptive behaviours or personality disordered traits before the symptoms develop into full-blown personality disorder behaviours.

5.1.2 Gender and Adolescent Personality Pathology

The DSM-IV-TR (APA, 2000) acknowledges gender bias in adult presentation of personality pathology. It states that the Borderline, Histrionic and Dependent personality disorders are more common among women while Anti-social, Narcissistic and Cluster A personality disorders are more prevalent among men (DSM-IV-TR, 2002). The current research attempted to ascertain whether the gender presentation and distribution of adolescent personality pathology was similar to that of adult personality disorder presentations.

Results relating to the above query revealed that the patterns of distribution of specific personality pathologies were similar across the genders in adolescents. It would however seem that personality diagnoses are more prevalent among the adolescent female population on the ward. Of the sample's female adolescents 65.8% had a personality pathology diagnosis on Axis II, as compared to 40.4% of the adolescent males, thus 25.4% more females were diagnosed than males. The incidence rate of female adolescent personality pathology diagnoses being much higher than that of male patients seems to be consistent with international research (Becker 2006). Becker (2006) found a remarkably similar rate, where it was reported (in the study of borderline personality disorder in adolescence) that of the 58% of the sample

diagnosed with BPD, 60% were girls and 40% were boys. Thus suggesting that perhaps personality pathology diagnoses are more commonly recorded and / reported within the female population. The personality pathology most commonly diagnosed among adolescent males were the emerging cluster B personality disorder trait(s), followed by borderline personality disorder traits and emerging anti-social traits. The female presentation was very similar with the most commonly diagnosed personality pathology being emerging borderline traits. Overall the results reflect a higher incidence rate of the borderline personality pathology type as well as a lower percentage of antisocial personality pathology in females as compared to males.

With the largely similar presentation of the personality pathology across gender, there was no correlation found between the two variables – gender and Axis II personality pathology diagnosis. Thus refuting a hypothesis of the study - that gender bias will be found in adolescent presentations of personality pathology, as is the case in an adult population. The results, however, revealed some biases (although not statistically significant) in that the borderline personality pathology was more prevalent among adolescent female patients, which is consistent with previous empirical studies conducted on adolescent and adult personality pathology (Westen & Chang, 2000; Ludolph et al., 1990). Other interesting findings were that 15.8% of the male sample was diagnosed with borderline personality disorder trait(s) compared 6.3% of the female sample. Of the female sample 25% were diagnosed with an emerging borderline trait whilst only 5.3% of the males were diagnosed with the same label.

The above results are theoretically interesting, as there seems to be a larger number of males diagnosed with a predominately accepted female disorder (borderline

personality disorder trait) (DSM-IV-TR, APA, 2000; Westen & Chang, 2000; Ludolph et al., 1990). Clinicians also seem rather tentative in meting out a definitive borderline personality disorder label for females opting to rather use the emerging label for 25% of the sample. It was not possible to ascertain the statistical significance of the above results due to the sample size not being large enough to yield significant results. Cluster A personality constellations (Schizoid, Schizotypal and Paranoid personalities) were only diagnosed among the male adolescent in-patients, which is consistent with the assumption in the DSM-IV-TR (APA, 2000) among the adult population.

The results indicate that gender may not be a factor in the presentation of personality pathology among an adolescent population and that perhaps the symptoms are more 'borderline' in nature given the age or time period during which the symptoms are assessed. But why borderline personality pathology is more commonly diagnosed remains unanswered. Are the overt borderline symptoms of acting-out, self-harming and destructive behaviours so confrontational that clinicians are forced to acknowledge its presence, whilst the more introverted types go undetected to only be given more attention in adulthood? Westen and Chang (2000) postulated that the intensity or level of exertion of symptoms vary between adolescent and adult populations. They argue that adolescents present with milder symptoms of behaviours that are not as impairing as behaviours at an adult level, thus further identifying the need for early intervention and treatment of symptoms before they become entrenched (Westen & Chang, 2000). If the symptoms adolescents present with are milder in intensity than those adults present with, it is understandable that clinicians are using

tentative labels such as ‘emerging’ and ‘traits’, as the symptoms are not as intense as when they present in adulthood.

Are the presentations of personality-disordered behaviours similar between adult and adolescent populations? Is it possible to use the DSM-IV-TR (APA, 2000) as a diagnostic tool for personality pathology on an adolescent population given the fact that the manual guidelines are primarily for adult presentations? These are questions the current research cannot accurately answer but certain inferences can be made from the findings of the research. The results have shown that personality pathology is being diagnosed among an adolescent inpatient population and that as much as there is a hesitation to apply the personality label it is being done with caution, perhaps as a tool for informing the clinician’s treatment program. Thus clinicians on the ward seem to be using the DSM-IV-TR (APA, 2000) as a diagnostic tool or guideline at the very least to inform their diagnosis. The DSM-IV-TR (APA, 2000) recognises that disordered personality traits can emerge in adolescence but will often not persist unchanged into adult life. Therefore, the DSM- IV-TR (APA, 2000) allows for diagnosing adolescent personality pathology, albeit cautiously so.

The efficacy of using the DSM criteria as a diagnostic tool, within an adolescent population has been tested internationally. Grilo et al. (1998) had systematically studied adolescent personality disorders using adult criteria. They compared the frequency of DSM-III-R (APA, 1987) Axis II disorders assessed by the Personality Disorders Examination (PDE; Loranger et al., 1987) using adult criteria in a large (N = 255) series of adolescent (aged 12-17) and adult (aged 18-37) inpatients. Similar rates of personality disorders (around 14%) emerged in the two samples.

Westen et al. (2003) embarked on a similar experiment by trying to ascertain the applicability of the DSM-IV (APA, 2000) Axis II personality disorder diagnoses in adolescence. The study revealed that Axis II diagnoses in adolescence resembled those in adults and that the DSM-IV (APA, 2000) criteria appeared to over diagnose anti-social and avoidant persoanlity disorders in adolescents (Westen et al., 2003). The study confirmed that the DSM-IV (APA, 2000) may be used as a diagnostic tool for adolescent personality pathology, however the researchers caution against the direct application of the criteria set in the DSM-IV (APA, 2000) (Westen et al., 2003). They argue that the DSM-IV (APA, 2000) is not an optimal way of classifying or diagnosing adolescent personality pathology and should be used as a guideline on account of the criteria being set for an adult population (Westen et al., 2003). As there is currently no other recognised classification system for adolescent personality pathololgy, clinicians are coerced into cautiously using their clinical judgement and the DSM-IV-TR (APA, 2000) when assessing personality pathology in adolescence. However, what remains unanswered is whether the DSM-IV-TR criteria can be developmentally applied to an adolescent population and whether clinicians are using the DSM-IV-TR because no other diagnostic tool exists. This may be a premise for future research on the topic of diagnosing personality pathology in adolescence.

5.1.3 Symptom Presentation of Personality Pathology

The DSM-IV-TR (APA, 2000) provides clinicians with the 'key elements' of diagnosis i.e. prescribed symptoms and symptom duration, required for making a diagnosis of personality pathology. It provides a list of symptoms as well as the duration of time for which the symptoms have to be present in an individual's life before a personality disorder diagnosis can be made. As previously discussed (on

p.50), the data collected for the current study, pertaining to the 'duration of symptoms' was for the most part insufficient, thus making it difficult for the researcher to draw more accurate conclusions about the similarities and differences of personality pathology presentation in both adults and adolescents.

As an example, according to Kaplan and Sadock (2003), the adult presentation of pathological or behavioural symptoms within the cluster B range of personality pathology, particularly the borderline personality disorder, include; mood disturbances, impulsivity, suicidal behaviour, inappropriate anger, poor/unstable interpersonal relations. The above symptoms need to be present in an individual's life for a continuous period of time before a cluster B or borderline personality diagnosis can be made. The current research study tried to ascertain if certain behaviours recorded within an adolescent population would be similar to adult presentations to yield a personality pathology label and recorded the most common behavioural / pathological symptoms reported by the adolescents and their families. There was not an intention by the current study to specifically search for the cluster B range of symptoms, the findings from the data collected indicated that the cluster B range of symptoms were more prominent and commonly reported by adolescents and their families.

The results of the current study revealed that the most commonly reported behaviour / pathological symptoms included: low and aggressive moods, suicidal behaviour (ideation, plans and attempts), self-mutilation and interpersonal difficulties. The research findings suggest that there is a similar presentation of behavioural / pathological symptoms relating to cluster B personality pathology in both adolescent

and adult presentations (Kernberg et al., 2000). It has been argued that as much as there may be similarities in the presentation of symptoms, the severity and intensity of the behaviours may vary between adolescence and adulthood (Westen & Chang, 2000). This variation in severity or intensity may have an effect on the severity of the diagnosis given to a patient presenting with personality-disordered symptoms. Perhaps the milder less intense presentations may be diagnosed as 'emerging personality disordered traits' while more severe presentations may be diagnosed as 'personality disorder traits' or personality disorder within an adolescent population.

The research questioned whether there would be a relationship between the variables of reported pathological behaviours and an axis II personality diagnosis. The results revealed that there is a negative correlation between reported pathological behaviours (self-mutilation, low mood, suicidal behaviours and environmental or interpersonal difficulties) and an Axis II personality pathology diagnosis. This negative relationship could suggest that as there is an increase in reported pathological behaviours, there is a decrease in Axis II diagnoses as perhaps there may be a tendency to diagnose an Axis I disorder such as a mood disorder.

Kernberg et al. (1998) identified the need for clinicians working with adolescents to examine them carefully so as to accurately assess their presentation as part of emotional turmoil or severe psychopathology. To assist the clinician, a good history taking and collateral received from family members would assist greatly in making that distinction, as severe psychopathology would have a long-standing history of symptoms compared to an acute stage of emotional turmoil (Kernberg et al., 1998). Therefore, clinicians need to be able to distinguish between Axis I behavioural

disorders, such as an adjustment disorder or V-codes (these diagnoses are more socially orientated e.g. parent-child relationship problems), and Axis II behavioural personality symptoms.

5.1.4 Comorbidity of Axis I and Axis II Disorders

The final part of the results looked at the comorbidity of Axis I and Axis II disorders. Costello and Angold (1995), in their study of Axis I disorders in childhood and adolescence, proposed that childhood disorders could be as stable as those in adult presentations. In conjunction with Kernberg et al. (2000), they found that the presence of Axis I disorders (especially if there is more than one) in childhood or early adolescence increases the likelihood of developing a personality disorder in later adolescence or young adulthood. A study by Lewinsohn et al. (1997) highlighted the relation between the presence of multiple comorbid conditions in childhood / adolescence and Axis II personality pathology later in life. The study revealed that individuals with only one Axis I condition had very little personality pathology. However, with each additional disorder diagnosed on Axis I in childhood or early adolescence, the chances of the individual being diagnosed with an Axis II condition in adulthood typically doubled (Lewinsohn et al, 1997).

The current study attempted to ascertain if an Axis I diagnosis increased the possibility of an Axis II diagnosis being made. Results revealed similar findings to those of Lewinsohn et al. (1997). The current research is not able to predict their adult psychopathology but is able to provide insight into the comorbidity of Axis I and Axis II pathologies. To obtain results on comorbidity, the current study had grouped the sample of patients who had an Axis II diagnosis and ran a frequency count on the

number of Axis I diagnoses associated with these patients. The result revealed that 17.9% of the sample diagnosed with an Axis II pathology had only one Axis I diagnosis. Individuals with two and three or more diagnoses on Axis I, however, had a comorbidity rate of 32.8% and 49.3% respectively on Axis II. Thus, these results indicate that there is a tendency for the comorbidity rate to increase when there are two more diagnoses on Axis I. As mentioned previously, these results are consistent with results from preceding studies (Costello and Angold, 1995; Lewinsohn et al., 1997 and Kernberg et al. 2000).

In more recent research, Finley-Belgrad & Davis (2006) reported similar findings among borderline personality disordered (BPD) patients. They argue that patients with BPD were twice as likely to have three or more current Axis I diagnoses (Finley-Belgrad & Davis, 2006). These included mood disorders, anxiety, substance abuse, somatoform and eating disorders (Finley-Belgrad & Davis, 2006).

The current study also assessed the relationship between specific diagnosed Axis I disorders and an Axis II diagnosis. The study revealed that there were significant correlations between substance abuse (negative correlation), bipolar mood disorder and adjustment disorders. The significant positive correlation between bipolar mood disorder and an Axis II diagnosis is interesting as it is general practice to defer a personality diagnosis in the presence of a florid Axis I disorder (Boyle & Offord, 1991). Patients who are diagnosed with a florid Axis I disorder are often left to settle, then observed for any overt Axis II symptoms, which are then recorded as a differential diagnosis on Axis II (Boyle & Offord, 1991). Perhaps this result indicates the severity of Axis II symptoms within an adolescent population or the strength of

supporting collateral information on premorbid functioning. The significant negative relationship between substance abuse and Axis II pathology, suggests that as one variable increases the other decreases i.e. that as the level of substance abuse increases, there would be a greater tendency to diagnose an Axis I disorder of substance abuse rather than an Axis II pathology; hence the decrease of the Axis II variable. This is in keeping with best clinical practice to diagnose and stabilise the Axis I diagnosis (Boyle & Offord, 1991).

CHAPTER 6: CONCLUSION

The present study has five main hypotheses that have been tested and empirically confirmed or infirmed through systematic consideration of a series of research questions. The study tested the main hypothesis, which is that personality pathology was being diagnosed on an inpatient adolescent psychiatric ward. Beyond this, it sought to ascertain the extent to which clinicians have been diagnosing personality pathology and which of the personality pathologies are the most commonly diagnosed.

This hypothesis is supported by empirical data, which has shown that clinicians have been diagnosing personality pathology among the adolescent population on the ward. The borderline and cluster B range of personality pathology has been the most commonly diagnosed Axis II pathology, which is consistent with previous research findings (Ludolph et al., 1990; Westen et al., 1990). Clinicians are cautious when diagnosing personality pathology and would prefer to provide tentative diagnoses of 'emerging personality' and 'personality traits' rather than a disorder label. Perhaps this cautious approach is useful given the theory that childhood personality is fluid, malleable and easily influenced until adulthood (Kernberg et al., 2000).

With clinicians diagnosing personality pathology in adolescence, it was a hypothesis of the study that they were using the DSM-IV-TR (APA, 2000) system of classification to make the diagnoses as the symptom presentation of personality pathology in adolescence are somewhat similar to those of adult presentations. Clinicians seem to be using the key elements of diagnosis in the DSM-IV-TR (APA,

2000) as a guideline for diagnosing personality pathology in adolescence, hence the attraction towards the 'emerging' personality diagnosis as theory professes the fluidity of personality until adulthood (Kernberg, et al., 2000). By using the emerging personality diagnosis, it provides both clinicians and families hope that the personality disordered traits are not as entrenched but indicate that they may become entrenched and maladaptive if not treated when they are diagnosed (Kernberg et al., 2000, Rey, 1996).

Overall, the study provides insight into the prevalence of personality pathology among adolescents in a South African psychiatric institute, thus stimulating future research on the topic. All the hypotheses of the study have been validated through empirical evidence, except for the third hypothesis that postulated that the gender bias found in adult personality pathology presentation would also be found in adolescent presentations.

Nonetheless, the research has been able to ascertain that clinicians are diagnosing personality pathology in adolescence - albeit cautiously so - and have been using the DSM-IV-TR (APA, 2000) classification system. The DSM-IV-TR is not a classification system for adolescent personality pathology and as such, clinicians have therefore been using their clinical judgement and guidelines provided by the DSM-IV-TR (APA, 2000) when diagnosing personality pathology in adolescence. The presentation of behavioural symptomatology of both adolescent and adult personality pathology provides support for the argument that early detection and treatment of these maladaptive behaviours in adolescence may well result in fewer adult presentations of personality-disordered behaviour. The study raised the question of

treatment programs and how to best intervene when one is faced with an adolescent displaying maladaptive behaviours. From the literature, it would seem that personality disorders emanate from a basis of a diffuse sense of self (Erikson, 1968) and dysfunctional environmental conditions (Power & Noam, 1991). There has been empirical evidence that suggests that the above conditions are often always present in personality pathology presentations (Rey, 1996; Lewinsohn et al., 1997; Westen & Chang, 2000). If this is the case then perhaps intervention strategies should focus on building self-esteem or sense of self and try to incorporate the social environment as well so as to bring about effective change.

As the researcher became immersed in theory and previous research findings, it became clearer that there is a need for the research to identify and present current findings on the topic of personality pathology in childhood, adolescence and/or early adulthood. Most of the research and data from previous research studies are from the late 1990's thus confirming the infancy and relevance of the current topic from a research perspective.

6.1 Limitations

Sample Size

Although the current study found statistically significant correlations between variables of interest, the sample size was small (120 files). A small sample makes it difficult to draw conclusions and to generalise the findings and may account for the somewhat weak significance level of findings. It should be noted, however, that the researcher had collected 220 backdated files over the three-year period (2005 – 2008) and given the specific sample (adolescents without eating disorders) needed for the

research, about 40% of the collected files could not be used. There was no random sampling nor randomisation of the files as the study had a specific population in mind. This has made it difficult to generalise the results. The findings are limited to an inpatient psychiatric facility, providing insight into the prevalence of personality pathology among an acutely ill adolescent population. Perhaps it is easier to diagnose personality pathology in a psychiatric facility as the adolescents have been brought in for evaluation and are acutely ill, while adolescents in the general population who have maladaptive behaviours that are alloplastic and ego-syntonic may not seek treatment, thus their behaviours do not receive clinical attention.

Research Design

The study was a retrospective study, thus utilising a non-experimental, ex-post facto design. There was neither a control group nor manipulation of the IV, which could also account for the weak correlation results.

Instruments

There were no measurement instruments used during the study as the study relied on archival data. The data was often in poor condition and there were often areas where information was not recorded, which could also account for some of the weak results obtained.

6.2 Recommendations for Future Research

It would be useful to replicate the present study using a bigger sample in order to verify the results and to expand the research population to include other psychiatric facilities that provide psychiatric healthcare to adolescents.

It may be helpful to use a different research design method, as a more qualitative approach may be more valuable in ascertaining reasons for the reluctance of clinicians to diagnose personality pathology in adolescence.

It may be useful to conduct similar research on the developmental precursors that may lead to individuals developing personality pathology, thus solidifying the argument that personality pathology can emanate in childhood and adolescence.

Considering the reluctance to use the DSM-IV-TR (APA, 2000) as a diagnostic tool, research should be directed towards developing a system of classification of adolescent personality pathology.

Given the results of the current study as well as previous studies conducted on the topic, there seems to be a need to acknowledge the importance of pervasive and maladaptive functioning that could lead to the beginnings of the crystallisation of personality functioning. Therefore making tentative diagnoses lends severity to the condition and highlights the need for more tailored interventions to target the personality pathology, should it present itself during adolescence.

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