CHAPTER 1

INTRODUCTION:

The prevalence of personality pathology in children and adolescents has increasingly become a topic of literature and study by numerous researchers and authors. This evidences mounting growth in the perception that personality pathology exists, and should be diagnosed in children and adolescents (Kernberg, Weiner & Bardenstein, 2000; Bleiberg, 2001; Zelkowitz, Guzder, Paris, Feldman, Roy & Schiavetto, 2004; Westen, Shedler, Durrett, Glass & Martins 2003).

Studies on this topic have indicated the influence of a negative early environment and its impact on early personality development (Harman, 2004; Zanarini, Williams, Ruth, Lewis, Reich, Vera, Marino, Levin, Yong & Frakenberg, 2001; Meekings & O'Brien, 2004). Other studies have looked at the links between a personality disorder diagnosis in children and that in adults. Some of the studies have evidenced the similarity between this diagnosis in adults and adolescents and that these disorders in children show stability over time from childhood to adulthood (Guile & Greenfield, 2004; Durrette & Westen, 2005). However, in contradiction of the DSM-IV-TR description of personality disorders as inflexible and pervasive (APA, 2000) studies have also shown that personality pathology over a lifetime shows mild fluctuations and periods of improvement (Paris, 2003).

Those who believe in the occurrence of personality pathology in children and adolescents argue that the symptoms of personality disorders are seen in this population and that they concur with DSM-IV-TR, in that they are pervasive, maladaptive and cause significant impairment (Kernberg et el., 2000; Bleiberg, 2001). These authors highlight the importance of making this diagnosis in this population so that the correct interventions can be made, early on.

However, clinicians are divided in their opinions with regard to the diagnosis of personality disorders in children and adolescents. According to Kernberg et al (2000), clinicians may not wish to make this diagnosis as they believe personality in children and adolescents has not yet crystallised, that this is viewed as a life long diagnosis that will have negative effects on the child's self esteem, family life and access to mental health care.

The DSM-IV-TR specifies that the symptoms used to make the diagnosis of a personality disorder in childhood and adolescence may not be part of a developmental stage. With relevance to this study, this may also inhibit the diagnosis of children and adolescents as symptoms are seen as developmentally appropriate or the result of an Axis I diagnosis. This is taken up by Kernberg et al (2000) who note that as with the adult personality disorder diagnoses, no one symptom is indicative of disorder, but rather a cluster of symptoms needs to be seen that exceed any developmentally appropriate symptom in intensity and duration. Guile (1996) explains that one needs to define developmentally appropriate behaviour outright, and once this has been done pathological symptoms can be seen.

Research on the presence of personality pathology in children and adolescents has been internationally based research. Three foundational studies have been conducted in South Africa. A study by Sosnovik (2007) assessed practitioners' perspectives on this diagnosis in children and adolescents, while Sosnovik (2008) and Card (2009) looked at the diagnosis of adolescent Axis II diagnoses in Johannesburg Hospitals, both of which found an occurrence of personality pathology being diagnosed in adolescents.

International research has been divided on the utility and validity of using the DSM-IV-TR to diagnose personality pathology in children and adolescents. Many note the similarity between adult and child symptoms and use the DSM-IV-TR, but question its comprehensive applicability to children and adolescents (Westen, 2003; Kernberg et al, 2000; Bleiberg, 2001). The Sosnovik (2007) study found that South African professionals concurred with international literature, that the DSM-IV-TR is being used to make personality

disorder diagnoses in children and adolescents, but that adjustments and revisions should be made so that it is more applicable to the younger population. As far as the researcher knows, no research has been done on the symptomology profile of personality disorders in children and adolescents in South Africa.

Thus this research intended to asses what South African Psychologists and Psychiatrists believe are the symptoms seen in children and adolescents believed to have Cluster B personality pathology.

Research Aims:

This research aimed to identify South African psychologists and psychiatrists opinions on Cluster B personality pathology symptomology in children and adolescents. It focused on Borderline, Narcissistic and Antisocial personality disorder symptoms. The first aim was to assess where psychologists and psychiatrists agree personality pathology presents in children and adolescents, how the symptoms they endorsed relate to the DSM –IV-TR diagnostic criteria for adult Cluster B personality disorders. The second aim was to explore differences and similarities in the types of symptoms noted for children and adolescents and the third aim was to consider whether clinicians more frequently note a pathology according to individual personality disorder types or an over all Cluster B personality disorder type. Finally, it was investigated whether South African psychologists and psychiatrists believe future revisions of the DSM IV TR should make provisions for the diagnosis of child and adolescent Personality Disorders.

CHAPTER 2

LITERATURE REVIEW

This literature review begins by looking at personality development and the structure of personality, and literature looking at how personality has been studied in childhood and adolescence. The link between early childhood experiences and attachment relationships and their influence on personality in later life will then be addressed. Following this, an outline of the DSM-IV-TR and its use in this study will be made and why this research focused on the Cluster B personality pathology specifically.

The views of clinicians for and against the diagnosis of PD's in children and adolescents will both be explored. Studies outlining the prevalence of PD diagnosis in children and adolescents internationally and in South Africa will then be discussed, after which the reasons why professionals believe this diagnosis in children and adolescents should be made will be investigated. Literature on the applicability of the DSM-IV-TR adult PD diagnosis to this population will then be investigated and what other measures of personality pathology are being used.

The literature review looks at symptoms that are seen to be relevant to the Borderline, Narcissistic and Antisocial diagnosis in children and adolescents and the relationship between Conduct Disorder and Antisocial PD in children and adolescents. Finally the concern about the developmental appropriateness of symptoms is considered.

2.1 Personality Development:

It is understood that personality develops out of a persons early life experiences and that personality itself becomes a cause of behaviour and, therefore, shows continuity over time, in recurrent behaviours, as it influences feelings, thoughts and behaviours (Maddi, 1996). Maddi (1996) differentiates between the core and the periphery of personality. The core of personality is that with which we are born and which leads us to interact in certain ways with our parents / caregivers and environment from early on, and this develops the

periphery of personality. Therefore, the best developmental environment leads to more optimal personality types and problematic developmental interactions lead to less optimal personality types, as personality is based on early learning experiences. From this it can be seen that personologists believe that children are born with attributes that influence how they interact with the world and that this is heavily influenced by the developmental environment.

Caspi, Roberts & Shiner, (2005) note that the study of personality in childhood and adulthood has in the past, occurred in different streams. This has meant that adult studies have focused on personality traits, while child studies have focused on temperament thereby hindering insight into the developmental progression of personality. Caspi et al (2005) point out the need for studies on each of these phenomena to link so that observations into personality prospectively and retrospectively can occur. They also point out the necessity of mapping personality from childhood to adulthood and the developmental insights that this leads to. Shiner (2005) explains that temperament is generally viewed as emerging early in life, while personality emerges later, yet temperament and adult personality traits have been seen to have a number of longitudinal commonalities. Widiger, Simonsen, Kreuger & Verheul (2005) note the numerous studies conducted that have used childhood temperamental traits and linked them to later adulthood development and outcomes and the need to integrate the existing DSM personality constructs with childhood temperament traits in order to allow for an awareness of childhood precursors of adult personality pathology.

A number of studies have looked at the early developmental environment of personality disordered patients. The notion that a less than optimal developmental environment can lead to personality pathology in later life is supported by studies which have found that early childhood experiences of severe neglect and abuse are significantly correlated with the development of Personality Disorders (Zanarini, Williams, Lewis, Reich, Vera, Marino, Levin, Young & Frankenberg, 1997; Ludolph, Westen, Misle, Jackson, Wixom &

Wiss, 1990; Kernberg, P.F., Weiner, A.S., Bardenstein, K.K, 2000; Bleiberg, 2001; Fall & Stephen, 1998).

When considering the development of the child and the development of personality, attachment must also be considered. As was previously stated, negative experiences in early development are believed to be linked to the development of personality disorders and many theorists acknowledge this. These experiences in early childhood are linked developmentally to personality disorders in adulthood through attachment theory, whereby an individual's interactional styles are learnt in the infants first interactions with the mother, and repeated in later relationships throughout life and development (Bowlby,1985). Thus, this influences the way a person manages developmental challenges, and is the mould for later interactional styles (Bowlby,1985; Lyddon & Sherry, 2001), and are thus implicated in personality theory. Although attachment theory is beyond the scope of this study, it is important to indicate that an increasing amount of literature exists that links attachment disorders to personality pathology in later life.

Sroufe (2005) and Lyddon & Sherry (2001), link attachment experiences to later life and indicate that disorganised and avoidant attachment styles are later implicated in severe forms of Bordeline PD, while Harman (2004) notes that an anxious-avoidant attachment style is linked to the development of Borderline PD in children. Lyddon & Sherry (2001) propose that a "Fearful and Dismissing" (pg 409) attachment style is implicated in the development of Narcissistic and Antisocial PD's. A study by Nakash-Eisikovits, Dutra & Westen (2000), found that disorganised attachment was correlated with a number of severe types of personality disorders in adolescents. Fall & Stephens (1998) also linked the mother child relationship to the development of Borderline PD in adolescents. South African studies on the presence of personality pathology in adolescents found that patients diagnosed with personality pathology were twice as likely than patients without PD diagnoses to have attachment difficulties noted on their case file (Sosnovik, 2008). Furthermore, the study by Card (2009) found that poor environment and

parental conditions were significantly related to the diagnosis of PD's in children and adolescents.

2.2 Personality Disorders

The Diagnostic Statistical Manual IV TR (DSM-IV-TR) is compiled by the American Psychiatric Association and is used to diagnose psychiatric disorders. This study will only make use of the DSM-IV-TR specifications with regards to PDs as a diagnostic tool, and not the ICD 10. The reason for this is that a large portion of the literature consulted uses the DSM – IV-TR as its diagnostic tool and, in South Africa, it is the diagnostic tool used most by clinicians and students (Renate Gericke, personal communication, 30th April 2009)

The DSM-IV-TR outlines personality disorders as a set of personality traits that are "inflexible and maladaptive and cause significant functional impairment or subjective distress" (American Psychiatric Association, 2000). The DSM-IV-TR categorises PDs according to Clusters, A, B and C. This research will focus on the Cluster B personality disorders. People with this diagnosis are said to appear "dramatic, emotional, or erratic" (APA, 2000). The reason for this focus is that previous research into the prevalence of PDs in children and adolescents highlighted that in the South African context, Borderline, Narcissistic and Antisocial PDs are those that are most frequently seen by clinicians (Sosnovik, 2008; Card, 2009). In the Sosnovik (2008) study the most frequently seen personality pathology diagnosis was that of Borderline pathology (39.19%) and Cluster B (27.03%), and in the Card (2009) study, the most frequently noted pathologies were also Borderline (20.8%) and Cluster B (20.8%). Histrionic PD has not been included in this study for the aforementioned reason and due to the lack of literature on children and adolescents with histrionic PDs as a separate subtype of the Cluster B disorder.

Personality disorders are recorded on Axis 2 of the DSM-IV-TR and so are personality traits that do not meet the full diagnostic criteria. Frequently,

patients will present with personality traits across clusters and these are also noted on this Axis (APA, 2000).

The DSM-IV-TR states the diagnosis of a PD may be made in childhood or adolescence if the child meets the full criteria for a PD according to the symptoms and clusters outlined. However, it also states that symptoms must have been present for at least a year and not form part of a developmental stage. The reason given for this is, according to the DSM, that the PD traits seen in childhood are likely to change with development (APA, 2000).

With reference to the personality types being researched in this study, the DSM-IV-TR states that Antisocial PD is more likely to be seen in men, and that Borderline PD is more likely to be seen in women (APA, 2000). No reference is made to gender differences in children or adolescents. Harman (2004) notes that in children with borderline symptoms, girls are more likely to have depressive symptoms and boys are likely to show anxious behaviour and girls are more frequently diagnosed with Borderline pathologies than are boys. Bradley, Conklin & Westen, (2005), also found this with Borderline pathology in adolescents and added that Borderline PD in girls resembles that of Borderline in adults, but that this could not be found for boys in the study conducted and further gender relevant research was required. Sosnovik (2008) reported that twice as many females than males had personality pathologies in the clinical population assessed, but this was not cluster specific. However, due to the limited scope of this research, gender specific developmental symptomatology could not be further explored.

The DSM-IV-TR is an adult PD diagnostic tool and, although it makes provisions for the diagnosis of PDs in children, it assumes that children will present with the same symptoms that are used to classify adults. For this, and a number of other reasons which will now be outlined, clinicians are divided in their views on the validity and utility of diagnosing children and adolescents with a PD.

2.3 Clinicians for and against a diagnosis of PD in children and adolescents

There are a number of reasons why clinicians do, and do not want to make the PD diagnosis in children and adolescents which need to be carefully considered.

The diagnosis of a PD implies, by definition, according to the DSM-IV-TR, that the disorder is “enduring, inflexible, and pervasive” (APA, 2000). Kernberg et al. (2000), acknowledges this as a reason why some clinicians will avoid giving a diagnosis of this severity to a child. The labelling of a child with a disorder such as this can also have negative effects on the child’s family life and self esteem. Parents may be granted access to view the clinicians’ file, and a diagnosis may appear throughout the child’s life on their records and have negative consequences for the child’s future. Sosnovik (2007) found that this reluctance is not just limited to the child population as clinicians may also not want to diagnose adults with PDs as they can too, have access to their files.

With regard to an antisocial PD pathology in adolescents, it is feared that such a diagnosis would prevent these individuals from rehabilitation or result in even harsher sentences by the criminal justice system (Taylor, Elkins, Legrand, Peuschol & Iacono, 2007). Another rationale inhibiting clinicians from making a PD diagnosis in children or adolescents is that they do not believe that personality has crystallised yet and, therefore, the personality is still likely to change. It is also argued that PD diagnoses cannot be made because the neurological development of the brain is not complete and, thus, neither are the parts of the brain that function in personality (Kernberg, et al., 2000). A reason cited by Sosnovik (2007) is that some clinicians are not using nosological approaches to the diagnosis of PDs and are, therefore, not making use of the DSM criteria used for diagnosis.

Clinicians, who are trained according to specific theoretical models such as Psychodynamic theory, would not necessarily employ a diagnosis of PD in children and adolescents because of the theoretical model that is employed in

understanding development and the view of the aetiology of personality pathology (Sosnovik, 2008). In the Sosnovik (2007) study, it was found that none of the participants believed that a diagnosis of PD in children and adolescents was contrary to their theoretical training, although, two participants adhered to an object relations approach and this sometimes conflicted with what is seen with regard to their patients.

Fonagy & Target (2003) explain the psychodynamic approach as an understanding that individuals interact with their environment based on both conscious and unconscious interpretations' and meanings as the result of earlier interactions with his or her environment. Psychoanalysis emphasises the role of the unconscious as a determinant of behaviour. Psychoanalysis is a conflict theory, where individuals are seen to want to indulge in pleasurable experience while shying away from painful ones, and defence mechanisms' enable people to manage unconscious drives. In serious personality pathology, these drives can be understood as inflexible and entrenched. From this perspective personality pathology is the result of earlier psychological trauma that inhibits the development of the child's ability to manage conflict intra-psychically, where defences are needed to prevent fragmentation of the personality (Fonagy & Target, 2003).

Object relations theory looks at the intra-psychic process of the relationships between internalised relationships and representations of individuals in the external world, and how these internalised object relationships affect the way we interact with the environment (Watts, Cockcroft & Duncan, 2009). Thus clinicians with such orientations may be less inclined to use the DSM-IV-TR for diagnostic purposes, and, instead, work with patients using a developmental understanding of their pathology and a working through of this.

A hypothesis in this research is that psychologists with particular types of training (Clinical, Counselling or Educational Psychologists) may be less likely to believe that PDs are seen in children and adolescents, and that those with eclectic approaches may be more likely to believe in this diagnosis. Psychiatrists, who will make diagnosis' based on symptomology, as opposed

to being influenced by theoretical constructs, may be more likely to diagnose PDs in children and adolescents.

The diagnosing of PDs in children and adolescents has come into question in recent years. There has been an increase in the view that personality disorders do occur in childhood and adolescence, and that there is a need to recognise this (Bleiberg, 2001; Bondurant et al., 2004; Bernstien, D.P., Cohen, P., Skodol, A., Berziganian, S., Brook, J.S. 1996; Bernstein, D.P., Cohen, P., Valez, C., Schwab-Stone, M., Siever, L.J., Shinsato, L. 1993; Cohen, P., Crawford, T.N., Johnson, J.G., Kasen, S. 2005; Daley, S.E., Rizzo., C.J., Gunderson, B.H. 2006; Greenman, Gunderson, Cane, Saltzman, 1986; Guile & Greenfield, 2004; Kernberg, et al., 2000; Ludolph et al., 1990).

Clinicians in support of a diagnosis of child and adolescent PD argue that personality traits are evident from a young age in children and that these traits can be consistent over development. Some studies have found that personality and temperament show relative stability and continuity during preschool years and through adolescence (Shiner, 2005), and that personality disorder symptoms in adolescence show similar stability (Johnson, Cohen, Smailes, Kasen, Oldham, Skodol & Brook, 2000). It is their view that personality pathology can be seen in children and adolescents and these personality characteristics meet the DSM criteria as being maladaptive, pervasive and persistent (Kernberg et al., 2000, Bleiberg, 2001; Westen, Shedler, Durrett, Glass & Martens, 2003). When looking at personality disorders retrospectively, Paris (2003) acknowledges that, in childhood, patients showed abnormalities in temperament, unusual traits, or other clinical symptoms. In contradiction to the DSM, studies have found that Cluster B personality disorders in children and adolescents had shown an over all stability from adolescence into adulthood (Guile & Greenfield, 2004; Sharp & Romero, 2007; Shriner, 2005; Zelkowitz, Gudzer, Paris, Feldman, Roy & Schiavetto, 2004; Durrett & Westen, 2005).

Cohen, Winograd & Chen, (2008), found that adolescents with early onset Borderline symptoms had lower levels of academic ability, lower occupational

obtainment and fewer intimate relationships over a 20 year period prognosis. It was also shown that adolescent Borderline symptoms led to adult Borderline symptoms and a Borderline diagnosis in adulthood. Furthermore, recent research is showing neurological abnormalities, particularly in frontal lobe functioning, in children diagnosed with Borderline PD (Coolidge, Segal, Stewart & Ellett, 2000).

Kernberg et al. (2000), emphasises that personality traits emerge in childhood from as young as three years of age. These include the ability to have a sense of self, as well as evidence of shame, impulsivity, and empathy. The child's thinking style is said to be evident from school age and consistent with personality type. Also evident in childhood are the traits of introversion, egocentricity, sociability, novelty seeking, as well as a number of others. It is when these traits are inflexible, maladaptive, chronic, cause significant impairment and produce severe distress in the child, that a diagnosis of personality disorder can be made, irrespective of the child's' age (Bleiberg, 2001).

Although personality pathology has in some studies shown stability over time, with regard to the perspective that PDs are inflexible and pervasive, as is stated by the DSM-IV-TR, and is one of the reasons clinicians are against making this diagnosis in children and adolescents. Studies have also shown that in adulthood, PDs show patterns of "waxing and waning" and can show periods of improvement (Paris, 2003). It has been found that symptoms become less prevalent with age in childhood, adolescence and in adulthood (Kernberg et al. 2000; Paris, 2003; Cohen et al., 2005). Approximately one third of Antisocial PDs show some symptom recovery with age, and Borderline PDs show a good prognosis for remission within a fifteen year period, as age increases (Paris, 2003; Cohen et al., 2008). There is evidence that personality pathology in children and adolescents' decreases over time and with age (Cohen et al., 2005), however, Paris (2003), acknowledges that while these changes can occur, their behaviours still tend to fall within the Axis 2 DSM-IV-TR diagnosis. The Cohen et al. (2005) study, Children in the Community (CIC), found that symptom stability in Cluster B adolescents from

ages 14-16 was .65, but that this dropped to .55 from mean age 22 to mean age 33. Therefore, this study shows symptom stability in Cluster B disorders can fluctuate during development, but is slightly more stable during adolescence.

2.4 Prevalence

Research has shown that children and adolescents are meeting the criteria for PD diagnosis. A study by Golombek (1986) as cited in Kernberg et al (2000), found that of the children they assessed, at age thirteen years, 46% met DSM III PD diagnosis. Bernstein (1993) found that significant proportions of young adolescents and children (9 -19 years) were diagnosed with moderate PDs, a portion of which were severe, according to the DSM criteria (Kernberg et al., 2000). The use of unstructured interviews found that adolescents between 12 and 17 years of age are meeting PD criteria at the same rates, and almost equivalent proportions, to young adults who are 18 – 37 years old in the clinical population (Durrett & Westen, 2005). Westen et al. (2003), found that 15% of adolescents in the clinical population they assessed met criteria for a PD diagnosis that showed stability over time and which are similar to the rates seen in adult population samples. Studies conducted by Bondurant et al. (2004), found Borderline PD to be a valid diagnosis in childhood, showing internal consistency and differences to the adult construct, as well as high concurrent validity. This finding is supported by Levy, Becker, Grilo, Mattanah, Garnet, Quinlan, Edell & McGlashan, (1999) which found good concurrent validity for the diagnosis of PD's in adolescents.

Within the South African context, and internationally, clinicians will consider the onset of PD traits in adolescents but not readily in children (Westen et al 2003; Sosnovik 2007). The only studies done on this topic in South Africa thus far are those by Card (2009) and Sosnovik (2007; 2008), under the supervision of Miss Renate Gericke at the University of the Witwatersrand. The Sosnovik (2007) study found that practitioners would err on the side of caution and were unlikely to diagnose a PD in early childhood. However, one clinician did mention that the severity of some children's pathology has meant that they have been seen from as young as 3 or 4 years old, through their

adolescence, and that their personality pathology has never improved nor changed.

The Sosnovik (2008) and Card (2009) studies focused on the presentation of PD's in adolescents, and not in children, and have found that in South Africa, clinical psychologists and psychiatrists acknowledge and report on the presence of personality pathology in adolescents but will note in a patients file that "Emerging Cluster B disorder traits / Cluster B traits" are present as opposed to making a full PD diagnosis (Card, 2009). In the Sosnovik (2007) study 59.46% of files made use of the term "Traits Present"

In South Africa, a result of the study by Sosnovik (2008) on the prevalence of personality pathology in clinical adolescents was found to be (15.95%). The prevalence of full PD criteria being met was (2.6%). These rates are significantly lower than that of international prevalence rates (Sosnovik, 2008). This may indicate an under diagnosis of personality pathology in the South African adolescent population which may be related to the Sosnovik (2007) findings that clinicians are hesitant to diagnose full PDs in children and adolescents, even when these personality pathologies exist. Research conducted by Card (2009), found that (50.8%) of the clinical adolescent case files assessed made reference to personality pathology. This also highlights the incongruence found in the research between clinicians saying they are not making a formal PD diagnosis in adolescence, while a quantitative analysis done of patient files in their units indicates otherwise (Sosnovik, 2008).

2.5 Reasons for PD diagnosis in children and adolescents

The reasons cited for the utility of earlier diagnosis of child and adolescent personality disorder include early interventions that can assist the child in gaining access to long term, intensive psychotherapy and thus obtaining a better prognosis and potentially decreasing morbidity. Earlier diagnosis can give the clinician insight and clarity into what problems need to be addressed more clearly than when no diagnosis is made (Kernberg et al., 2000; Sosnovik, 2007; Guile & Greenfield, 2004; Sharp & Romero, 2007; Fall & Stephen, 1998).

In terms of the time needed to see improvements, adherence to treatment, client motivation, and treatment of severe co morbid Axis I disorders (Taylor, Elkins, Legrand, Peuschold & Iacono, 2007) is important for improving prognosis for this population group. These children may often experience extreme social and academic difficulties as well as deficits in problem solving abilities (Kernberg-Bardenstien, 2009). According to Cohen et al. (2005), while adolescents have a higher than adult symptom level, this tends to decrease with age but these adolescents have a more negative prognosis and are, therefore, in need of earlier intervention. Thus, given the intensity of the distress experienced and the duration of intervention needed, the earlier intervention, the better the prognosis is likely to be.

Bleiberg (1990) notes that at some point many Borderline children and adolescents will need inpatient treatment, as their behaviour becomes dangerous to self and others and cannot be managed on an outpatient basis. According to Bleiberg, (1990) Borderline children and adolescents recover from fragmentation in the inpatient setting quite quickly when the environment is experienced as safe and consistent. Narcissistic youth on the other hand are noted as “going through the motions” (pg 108) of the therapy, and prompting their early discharge, and the need for this to be managed. However, he does also highlight that inpatient treatment may become maladaptive in these patients, and that this, and inappropriate management, are both stages on the way to severe adult personality pathology. Bleiberg (1990) highlights the necessity of a holding environment for the treatment of personality disordered children and adolescents which allows for the development of the therapeutic alliance, and the strengthening of the self.

Studies have shown that adolescents with PDs are at greater risk for developing DSM-IV-TR Axis I disorders later in life (Westen et al. 2003, Bondurant et al., 2004). In particular it has been found that the earlier the onset of Borderline Personality disorder and the more severe the symptoms the more likely the disorder is to be chronic and continue into adulthood (Zelkowitz et al., 2004). Comorbidity of Axis I disorders in adolescents with Borderline PD near doubled the chances of PD in adulthood (Bondurant et al.,

2004). Cluster B personality disorders, and particularly narcissistic symptoms in adolescents, have shown high levels of violent behaviour that persist into early adulthood (Johnson, J.G., Cohen, P., Smailes, E., Kasen, S., Oldham, J.M., Skodol, A.E., Brook, J.S, 2000). This highlights the need for early intervention, especially as relatively effective treatments are available for Cluster B PDs (Johnson et al., 2000). Fall and Stephen. (1998) note that treatment of adolescent Borderline PD is likely to improve prognosis, as later in adulthood these maladaptive ways of being are more entrenched in functioning.

A number of authors emphasize early psychotherapeutic interventions with PD children and adolescents is necessary. Fall and Stephen (1998) note that in working with Borderline adolescents, confrontation, coping and group skills training are most beneficial and it must not be insight focused but, rather, reality focused. In addition, this will be facilitated by intensive management of the therapeutic relationship, as these adolescents are likely to be manipulative and fragment often. Kernberg et al. (2000) emphasize in Borderline patients the use of psychodynamic treatment that includes focus on an integrated sense of self, individuation, autonomy, increasing tolerance for emotional difficulties experienced as well as pharmacological treatment. In narcissistic children, the aim is to return children to developmentally normal levels of narcissism and the resolution of grandiosity and self centeredness. Group therapy is also seen as beneficial. In Antisocial children and adolescents, family interventions, contracting and play therapy are used (Kernberg et al., 2000). Bleiberg (2001) also identifies methods of long term treatment as an intervention in children and adolescent populations.

As can be seen from the above literature review, there are arguments that exist for both the stability of personality traits in childhood, and the stability of personality pathology over development, as well as for the notion that personality pathology symptomology decreases with age and development. Both of these arguments support the view that personality pathology exists in childhood. These arguments have been presented to indicate that a lack of cohesive professional agreement exists with regard to this topic, and to note

that there are arguments in favour of diagnosing children and adolescents and those that emphasise reasons why this diagnosis in children and adolescents should not be made. Furthermore, the researcher acknowledges that many clinicians would not be willing to diagnose a PD in children and adolescents for any number of the aforementioned reasons. Therefore, this study aims to focus on what clinicians recognise the symptoms of personality pathology to be, as have been found to be noted in the studies conducted in South Africa by Sosnovik (2008), and Card (2009), and not whether or not they are making a formal DSM–IV-TR diagnosis.

2.6 The DSM IV TR as a measure of PDs in children and adolescents

As there are differences in agreement among professionals regarding PD diagnoses in children and adolescents so, too, are there differences in opinion on whether or not the DSM-IV-TR is a valid diagnostic measure of PD symptomology in children and adolescents.

Kernberg et al. (2000) and Bleiberg (2001) both make use of the DSM-IV-TR in their discussions on PDs in children and adolescents, and use it as a reliable measure as have other clinicians (Cohen et al., 2008, Bondurant et al., 2004). They do, however, acknowledge that it has limitations in its application to these patients, and may inadvertently prevent clinicians from making the PD diagnosis. Also, that it is “non developmental” as it does not acknowledge childhood personality traits that are consistent with adult PDs and that these childhood traits are placed on a different Axis, thereby excluding it from being associated with an Axis II diagnosis. Furthermore, it is noted that the differentiation of adult and child depression has greatly helped working with this disorder in children and it is questioned as to why this wouldn’t therefore be appropriate for PDs in children and adolescents (Kernberg et al., 2000). Kernberg et al. (2000) claim that the DSM-IV has clear developmental implications but fails to directly address them, and that it does not identify the age in which personality pathology traits are first seen, nor its similarities, or lack thereof, to the adult traits.

A study by Westen et al. (2003) found that adolescent PD diagnosis strongly resembled the adult DSM-IV-TR categories for adults. However, the study also queried its findings whereby using the DSM-IV-TR may have over pathologised adolescents' personalities as it does not take into account developmental norms. A number of studies have found that the DSM-IV-TR can be used to diagnose adolescents but question whether it is the most feasible diagnostic tool (Durrett & Westen, 2005; Greenman et al.,1985). However, a study by Levy et al. (1999) claimed that although adolescent and adult symptoms of PD may be similar, it is unlikely that the adolescent criteria would exactly replicate the adult criteria, and therefore, adolescent PD should have its own diagnostic criteria and should consider normal developmental criteria.

Cohen et al. (2005) recommend that the DSM should distinguish between adult PDs and adolescent PDs, as adolescent PDs represent important short and long term identifiers of psychopathology and are at greater risk for other problems later on. Therefore, a different set of diagnostic criteria may be needed to ensure correct diagnosis of PDs in children and adolescents. Westen et al. (2003) also propose employing other methods rather than simply assuming the use of the DSM-IV-TR adult based criteria in diagnosis.

Westen et al. (2003) do acknowledge that the DSM adult and adolescent diagnoses overlap at some points, such as in the high rates of co morbidity of other disorders (on Axis I as well as of other personality disorders), and that in these ways, adolescent and adult data were similar. Bradley et al. (2005) also found Borderline symptoms in adolescents to be similar to that of adult Borderline diagnosis by the DSM-IV-TR, but that the DSM-IV-TR does not acknowledge the inability to self soothe and regulate emotions that is seen in this population, nor does it emphasis the high level of psychological distressed experienced.

As can be seen from the above literature review, the DSM-IV-TR does seem to have some applicability to this age demographic, but a clearer outline needs to be made with regard to symptomology, age and gender differences,

as well as prognosis. This need has been echoed by South African psychologists and psychiatrists (Sosnovik, 2008). They acknowledge the use of the current DSM-IV-TR adult diagnostic criteria for understanding personality disorder constellations. Therefore, the DSM-IV-TR is being used as a tool to guide clinicians in their understanding and assessment of PDs in children and adolescents but may also be hindering appropriate, timely diagnosis due to lack of clear age and gender relevant symptomology, as well as the DSM-IV-TR's chronic and severe life long prognosis. As mentioned this study will be focusing on age and not gender specific developmental symptomology.

At this point, it is also important to recognise that a number of studies have looked at the applicability of the DSM-IV-TR personality disorder diagnosis generally, as the categorical organisation of within cluster and between cluster groups has been questioned. Shedler & Westen (2004) note that the current DSM-IV-TR diagnosis does not encompass the range of personality pathology seen in clinical practice and nor does it address any implications for treatment. This finding is supported by Russ, Shedler, Bradley, & Westen, (2008), whose study on Narcissistic PD as a construct of the DSM-IV-TR found the DSM criteria to be too narrow. Furthermore, these authors point out that a patient receiving one Axis II diagnosis generally meets the criteria for more, and that this may be because the current diagnostic criteria has been cut down so as to minimise co morbidity between diagnoses. For example, as the DSM-IV-TR only allows 9 or 10 symptoms per category, *lacks empathy* and *grandiosity* were excluded from the Antisocial diagnosis to prevent overlap with the Narcissistic diagnosis when, in fact, these symptoms are traits strongly associated, according to the authors, with Antisocial and Narcissistic PD (Shedler & Western, 2004).

Critchfield, Clarkin, Levy & Kernberg (2008) note the overlap seen between the Borderline PD diagnosis and that of other PD diagnoses, as extensive. These authors also note the treatment implications one needs to consider when Borderline patients fall into other clusters as well, such as Cluster C, and thus differing significantly in functioning from a Borderline patient with

other Cluster B traits. For example, a Borderline patient with Cluster C traits is a higher risk for suicide than Borderlines with Cluster B traits who are more likely to be reckless, impulsive, and fearing abandonment (Critchfield et al. 2008). Dimaggio & Norcross (2008) also underline the need for research to help clinicians to treat PD patients with more than one PD.

According to Shedler and Westen (2004), because some traits are central to more than one PD diagnosis and because this is not addressed by the current DSM-IV-TR, the authors propose an expansion of criterion sets to a continuum so that the need to acknowledge the complexity of the PD diagnosis clinically is not lost.

This view is supported by Widiger & Louw (2007) and Krueger, Skodol, Livesley, Shrout & Huang (2007) who note the problems associated with the current PD diagnosis and the need to shift diagnosis to dimensions. Widiger & Louw (2007) highlights that this would allow PD's to be measured in terms of thresholds, so that patients who present meeting only a few of the criteria for diagnosis can be included and noted as sub threshold, and that this allows for inclusion of developing PD's or PD's not fully present.

With reference to this study and the use of the DSM-IV-TR, Shedler and Westen's (2004) study found that professionals' believed that for the Antisocial diagnosis, symptoms such as *lacks empathy*, *sadism*, and a *tendency to manipulate the emotions of others* are symptoms seen that are not part of the DSM-IV-TR. These findings were repeated for the Borderline diagnosis where symptoms not in the DSM-IV-TR but indicative of the diagnosis in adults, were *emotional dysregulation*, *tendancy to become disorganised or irrational when strong emotions are present*, and *victimisation* were some of the symptoms, while for the Narcissistic diagnosis, *externalises blame, holds unrealistic standards of perfection and feels misunderstood or mistreated* were symptoms noted by respondents (Shedler & Westen, 2004). Thus the utility and validity of the DSM-IV-TR axis II diagnostic category has been questioned for both the adult population and the child and adolescent population.

Although the DSM-IV-TR is a measure of PD that is used in this research, it is worthy to note some of the other measures that are being used in children and adolescents to asses PD symptomology. Bondurant et al. (2004) list the following tests as measures of adolescent PD: The Diagnostic Interview for Borderline Patients, (Gunderson, Kolb and Austin, 1981); The Millon Adolescent Clinical Inventory (Millon et al, 1993; Blumentritt, Angle, Jeffrey & Brown, 2004); Personality Disorder Examination (Loranger & Sartorius, 1997) and the Personality Diagnostic Questionnaire (Bondurant et al, 2004). Other tests that the researcher found being used were the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD); the Borderline Personality Questionnaire (BPQ) (Chanen, Jovev, Djaja & McDougall, 2008); the MMPI – Adolescent (Butcher, Williams, Graham, Archer, Tellegen, & Ben-Porath, 2000); the Social Cognition and Object Relations Scale (SCORES); the Thermatic Apperception Test (TAT) (Ackerman, Clemence, Weatherill and Hilsenroth, 1999); and the Shedler-Westen Assessment Procedure-200 for Adolescents (SWAP-200-A) (Westen et al, 2003).

As far as the researcher can gather, although these measures, and others, are used as part of PD assessments in adolescents or adapted to measure PD traits in adolescents, with the exception of the MMPI – A, (which is used to test adolescents from 14 -18 years old and uses five subscales to measure pathology according to Aggression, Psychoticism, Disconstraint, negative emotionality / Neuroticism and Introversion / low positive emotionality) none of these measures have been formed specifically to measure Cluster B PDs in children and adolescents and would, therefore, not be standardized to the South African population.

In addition to the DSM-IV-TR PD diagnostic criteria, this research focuses centrally on the work of Kernberg et al. (2000) and employs parts of Achenbach's Child Behaviour Checklist (ACBCL), organised according to Kernberg et al. (2000), and her clustering of the checklist relative to Cluster B PD symptoms in children and adolescents. Achenbach's behaviour checklist is for children between the ages of six and eighteen, and relies on the reports of parents / caregivers, on the child's behavioural and emotional problems,

and competencies. A 118 point rating scale is used, according to the frequency of a behaviour or symptom that is seen. The test rates an over all competency as well as internalising and externalising problems (Achenbach System of Empirically Based Assessment). Symptoms and behaviours of the ACBCL have been used, according to Kernberg et al. (2000), in this study as a comparison to the DSM IV TR symptomology. The questionnaire used in this study is a measure of clinicians' opinions of Cluster B symptoms in children and adolescents and is, thus, not standardised or validated.

2.7 Symptoms relevant to Borderline, Narcissistic and Antisocial Personality Disorders in children and adolescents

Kernburg et al. (2000) outlines how the differences between normal childhood symptoms, such as narcissism, differ from that of the PD narcissistic child in the early onset of symptoms, severity, intensity and excessiveness of the symptom, as well as lack, or irregularity of normal emotional developmental milestones. The normal childhood symptoms such as anxiety, being demanding, narcissistic tendencies, impulsivity, clinging and neediness, become pathological when they are not out grown as they should be over the phase of development and are persistently present for a long period of time (DSM-IV-TR specifies one year). In adolescents, anger is characterised by a heightened sensitivity to negative stimuli, and emotional responses in Borderline patients are intense and extremely unpredictable (Fall & Stephen, 1998).

The normal developmental narcissism in children is contrasted by the PD narcissistic child whose needs are unrealistic and cannot be fulfilled and who show few if any, genuine attachments to adults or peers in their lives (Kernberg – Bardenstein, 2009). The symptoms cause the child or adolescent distress or impairment, as is in line with the DSM criteria. It is also stated by Kernberg et al. (2000) that as a result of development children are more likely to present with a number of pathological personality traits, as opposed to meeting the full diagnostic criteria for a particular PD. Kernberg et al. (2000) use the DSM as a reliable classification measure, while citing its shortcomings when diagnosing children and adolescents. However, the authors also make

reference to a number of age specific symptoms in their texts that are not represented in the DSM.

Both Bleiberg (2001), and Kernberg et al. (2000), two of the most renowned authors in the field of child personality pathology, refer to symptoms that are present in the DSM-IV-TR personality disorder checklist while also including symptoms not listed. This indicates that where clinicians subscribe to the diagnosis of PDs in children and adolescents, and believe that the DSM is a valid diagnostic tool, they view the application of the adult diagnostic criteria in a child population to be problematic.

Bleiberg (2001) and Kernburg et al (2000) list the symptoms that are seen in this age cohort, for Cluster B disorders. Some of these symptoms are: *screams a lot, physically attacks others, complains of loneliness, feeling that one has to be perfect, vulnerability of self esteem, extreme sensitivity to criticism of others, selective deafness, makes excessive demands, and inability to tolerate failure*. Kernbergs' regrouping of Achenbach's behaviour checklist according to the PD's relevant to this study, for Borderline, include: *argues a lot, complains of loneliness, deliberately harms self and cruelty, bullying or meanness to others. In the Narcissistic group symptoms include: bragging and boasting, disobedient at home / school and feels he / she has to be perfec*t. The Antisocial symptoms include: *cruelty to animals, doesn't experience feelings of guilt, fights, lies, impulsive and destroys things belonging to others*. The symptoms seen in the questionnaire used in this study are all of the symptoms in Achenbach's checklist and Kernberg et al. (2000) and Bleiberg's (2001)'s writings (see Annexure F).

What must also be noted is the variance of symptoms seen across authors for each Cluster B type, with different sets of symptoms being highlighted as essential for the diagnosis to be made. Bleiberg (2001), emphasise a lack of *reflective function* and an *unstable sense of self and others* as key in diagnosing Borderline and Narcissistic children and adolescents. Kernberg et al. (2000) highlight *identity disturbance* and *sudden shifts in level of ego functioning* in the child as the two most important factors in making a

diagnosis of Borderline PD in children and adolescents, while Zelkowitz et al. (2004), emphasize the importance of impulsive symptoms in children as a precursor to adolescent Borderline PD. An unstable sense of self and others, and identity disturbance can be seen as referencing a similar experience of self. However, the overall criteria of definitive symptomology agreed upon by professionals within narcissistic, borderline and antisocial PD's in children and adolescents, is not clear.

2.8 Conduct Disorder and Antisocial Personality Disorder Diagnoses

The DSM-IV-TR does not permit the diagnosis of Antisocial PD in children under the age of 18, and says that conduct disorder (CD) must be the first diagnosis. Taylor et al. (2007), compared adolescents who met criteria for CD to those who met adult criteria for Antisocial PD and found that the two are distinct in a number of ways, and that adolescent Antisocial PD is a valid construct. They found that an ADHD diagnosis, depression, and substance abuse were associated with Antisocial PD, across gender. Also, CD does not always develop into adult Antisocial PD. The two were also found to be different in their "co morbid diagnoses, academic performance and peer group problems". Their studies showed similarities between adult Antisocial PDs and adolescent PDs.

A study by Eppright, Kashani, Robinson & Reid (1993) found that Antisocial PD and Conduct Disorder were significantly related, where Conduct Disorder was the co morbid Axis I diagnosis. Furthermore, this study found that Conduct Disorder and Antisocial PD were independent of age between 11 and 18 years, providing substantiation for the notion of Antisocial PD diagnosis in children. Other studies have also supported the notion of Conduct disorder as the most prevalent Axis I diagnosis in adolescents with PD's (Guile, 1996; Greenman et al., 1986). Cohen et al. (2005) endorse that Conduct Disorder when stable, should be thought about as a PD.

Kernberg et al (2000) emphasizes that Antisocial PD children are completely unable to maintain any social relationships and are hallmarked by a lack of anxiety. Also noted is that the DSM III sub types conduct disorder into groups

and that Antisocial PD children will fall into the psychopathy group of “non-socialized aggressive / solitary aggressive”. Kernberg et al (2000) proposes that the DSM-III’s categorisation of Conduct Disorder into socialised and un-socialised individuals is an important distinction between the splitting of the path between children who develop an Antisocial PD diagnosis later on, and those who don’t, the un-socialised group being the latter. They add that the DSM-IV should have acknowledged the difference between socialised aggressive and non-socialized aggressive children. According to Bleiberg (2004), the DSM-IV-TR does not make reference to relationship patterns or coping mechanisms, in the diagnosis of conduct disorder and these are relevant to personality disorder diagnoses. Bleiberg (2001) also reports the necessity for an Antisocial PD diagnosis in children and adolescents.

2.9 The developmental appropriateness of symptoms

It is important to note that a number of the symptoms in this study can be seen as developmentally appropriate in both children and adolescents. Kernberg et al. (2000) addresses this problem directly by emphasising the need to differentiate developmentally appropriate behaviours from pathological diagnoses. It is also noted that as a result of the process of development and the changes it incurs, children are unlikely to meet full diagnostic criteria, but present rather with a number of pathological traits. As with the DSM-IV-TR PD diagnosis, no one symptom is indicative of pathology, but rather a cluster of symptoms or traits are taken together to form a whole diagnostic criteria. According to Kernberg et al. (2000) Borderline pathology is seen as a failure to accomplish developmental achievements, but also, the presence of multiple severe behavioural and neurotic symptoms that persist beyond their developmental threshold and it is this that differentiates normality from pathology.

With regards to developmentally appropriate and pathological narcissism, Kernberg et al. (2000) highlights that developmentally appropriate narcissism still allows a child to soothe his needs for admiration with the attention he receives from parents and is able to respond accordingly to this. The narcissistic child’s needs are not appeased by normal amounts of attention

and are excessive and unreasonable, and nor is he able to respond with any form of appreciation for this or reciprocation for the other (Kernberg-Bardenstien, 2009). Kernberg et al. (2000) also comments that the inability to tolerate failure seen in narcissistic children is not developmentally appropriate and that gradually children learn to forgo winning and manage losing for the interpersonal benefits that can be gleaned from this. Thus, although symptoms alone may be developmentally appropriate at a particular age, the narcissistic child's symptoms such as envy, empathy or exploitation of others, exceed developmentally appropriate boundaries in intensity and duration. Guile (1996) supports this, saying that in preadolescents with Narcissistic PD, development is not stalled but continues along a pathologised pathway. Although this pathology may express itself alongside age related developmentally appropriate symptoms, if these developmental symptoms are predefined clearly, it is possible to diagnose preadolescents with PD's.

2.10 Conclusion of Literature review

From the above literature review it can be seen that a number of disparities exist with regard to the diagnosing of children and adolescents with PDs. This relates to the validity and utility of making a diagnosis in the first place, then to differences in opinion on the symptoms most frequently seen and how these relate to gender and age and what the stability of PD traits are from childhood over a life time. The DSM-IV-TR does not give guidelines with regard to how clinicians should view these issues. This research aims to assess what the most commonly seen symptoms are in Cluster B PDs in children, and if professionals in South Africa believe the DSM-IV-TR is a valid tool in this population.

Finally, there is evidence of some confusion among South African clinicians on the presence of personality pathology in children and adolescents, and the diagnosis of PDs in children and adolescents. It is more widely accepted that there is evidence of personality pathology in this population (Sosnovik 2007). This study will assess the opinions of clinicians on Cluster B personality symptomology in children and adolescents, rather than questioning the

practice of diagnosing in this population group, and is not attempting to develop a new diagnostic tool.

CHAPTER 3

METHODS

3.1 Research Questions:

The following questions were addressed by this research

1) If, in those instances, where South African psychologists and psychiatrists believe personality pathology can be seen in children and adolescents, what is the symptomology profile of Cluster B (excluding Histrionic) Personality pathology in children and adolescents?

2) If present, is there a difference in presentation between childhood and adolescence?

3) Where applicable, do South African clinicians prefer individual personality pathology types or an over all Cluster B type?

4) Should future revision of the DSM-IV-TR include a separate category for the diagnosis of children and adolescents with personality disorders?

3.2 Research Design:

This research was a quantitative, exploratory study, which employed the use of questionnaires to obtain data from psychologists and psychiatrists. As only a small amount of research in this area exists in South Africa, the questionnaire was designed by the researcher from relevant literature, and thus validity has not been established. The format of the questionnaire is a closed question checklist (Haslam & McGarty, 2003). The questionnaire consisted of symptoms taken from

- “A” - Kernberg et al. (2000)’s, adaptation of Achenbach’s Behaviour Checklist;
- “B” - Kernburg et al. (2000) and Bleiberg (2001)’s symptoms as per their writings;

- “C” - symptoms as present in the Adult DSM IV TR criteria;
- “D” - other

These symptoms were then coded, and the researcher was aware of which group of symptoms belong to each of the above sub sections. This was done to prevent participants from overtly acknowledging the DSM IV TR criteria for adults, and to allow an equal opportunity for other symptoms to be noted.

The questionnaire was then divided into:

1) Borderline Symptoms
2) Narcissistic Symptoms
3) Antisocial Symptoms

The respondents were asked to mark relevant blocks with a “tick”, according to whether they believed each of the symptoms were present in children, adolescents, male, female, generally in Cluster B, or not applicable. A column for the participant to note “other” symptoms that they may have felt were relevant was included (see Annexure F)

Due to the nature of this research and professionals’ hesitancy to make a personality disorder diagnosis in children and adolescents, as was evidenced by the Sosnovik (2007) study, it was clearly explained on the questionnaire that this research is assessing what symptoms professionals may be seeing, but is not an assessment of whether a full personality disorder diagnosis is being made. It was also outlined that participants may still complete the questionnaire if they have only seen some of the symptoms, or only felt able to answer one or two of the Borderline / Narcissistic / Antisocial categories.

3.3 Sample

The sample frame of this study was based on professional qualification, and the participants in this study were: Psychiatrists, Child Psychiatrists, Clinical Psychologists, Educational Psychologists and Counselling Psychologists. This

sample was chosen as it is felt that these were the professionals most likely to be working with the children and adolescents that this study is looking at.

The sample was obtained from relevant contact details given to the researcher by her supervisor which consisted of email addresses of professionals at local hospitals. Email addresses were also taken from the databases of the South African Depression and Anxiety Group (SADAG) with the permission of Founder, Ms Zane Wilson, and Ububele – The African Psychotherapy Resource Training Centre, with the permission of the Project Manager Mr Jake Matlhong and CEO, Mr Tony Hamburger, as well as from Shrink Wrap, with the permission of the co founding member, Ms Judith Ancer. Email addresses were also obtained from internet sites, The South African Society of Psychiatrists and listings of Psychologists practising in South Africa.

This research was conducted as an email based questionnaire that was sent to psychologists and psychiatrists throughout South Africa. However, due to the low response rate, and the need to access professionals practicing in Gauteng Hospitals, Medical Ethics permission was obtained. It was decided with the assistance of the researcher's Supervisor to contact Tara Hospital Child and Adolescent Unit, and Tara Child In Patient Unit, Baragwanath Child and Family Unit, Rahima Moosa Psychology and Psychiatry Unit and Charlotte Maxeke Hospital Child and Family Unit and questionnaires were taken to these hospitals.

3.4 Procedure:

Once Ethical Clearance was obtained from the University of the Witwatersrand the email based survey was sent out four times, between 01 June 2009 and 05 October 2009 to the email addresses of respondents on the data base, which consisted of a total of 405 email addresses. The email that was sent out consisted of a note explaining who the researcher was, and the heading of the research being conducted. It also explained that the research was looking only at symptoms and not full personality pathology diagnosis. Potential respondents were then asked to click onto the attached

document should they be interested in completing the questionnaire. On this document was a link to Survey Monkey, an online based survey system that allows researchers to host questionnaires online. This ensures professional lay out, and that records and data are collected efficiently. The researcher paid a quarterly fee for the use of this data collection tool, and this site ran from the 11th May 2009 to 11th November 2009. Potential respondents were informed that if they were unable to open the site link, that they should contact the researcher for an email survey to be sent to them. This occurred on one occasion (Annexure A)

According to Krantz & Dalal (2000), the validity of email based studies has been argued both for and against, with conflicting results. Studies by Keisler and Sproull (1986) and Menta & Sivadas (1995) both showed that email based surveys and mail delivered surveys had equivalent response rates. In this study, the response rate of the email based survey was higher than that of the other methods employed. Email based surveys also allowed studies to reach larger sample groups over larger areas, with a shorter response time (De Vaus, 1985). However, Crawford, Couper & Laimas (2001) and other studies, have found that web based surveys had lower response rates than normal mail delivery response rates. Krantz & Dalal (2000) note that a problem with email based surveys is that they deliver to respondents as Junk email, which hinders participation. For the purposes of this research emails were sent from an Internet Service Provider, Global Sense, which has a local registered email account, and not via an upstream provider which meant mail was not blocked as spam, nor delivered as Junk Mail.

A further problem with web based surveys as delineated by Crawford et al. (2001), is that in paper and pen responses, potential participants have time to peruse the questionnaire before beginning, and thus were able to make informed decisions about whether or not they wanted to complete the questionnaire, and that this did not apply to web based surveys. In the case of this research, participants were able to look at the questionnaire fully before beginning, as well as able to go backward and forward, and modify their answers if they wished to do so. This was also represented by the number of

participants who began the questionnaire and answered the demographics questions (73 participants), but then did not continue once they had looked at the full questionnaire.

Due to the need to access professionals from Johannesburg Hospitals, Medical Ethics was obtained in August 2009 (Medical Ethics Clearance number M090665). The researcher phoned the Heads of Department of all of the hospitals' included in the study, to make an appointment to see them to discuss the obtaining of there permission to conduct the research in their department. The researcher met and obtained permission from each of these department heads. Once an application for Medical Ethics had been made, the researcher then obtained clearance from each of the Hospital CEO's.

Each of the department heads was then sent a copy of the Medical Ethics Clearance form and a date was set for questionnaires to be delivered and collected. The researcher delivered approximately 10 -15 questionnaires to each hospital, depending on the number of potential participants, as discussed with the Department Head. It was arranged that the questionnaires be collected two weeks after delivery, and they were delivered and collected between 8th of September and the 30th of September respectively. All of the questionnaires were left in individual A4 envelopes, and it was requested that they be sealed once completed. However, due to delays of the handing out of questionnaires at one hospital, and a delay in staff collection at another, this was extended by a week at two of the hospitals (Annexure B)

Questionnaires were also handed out at Psychoanalytic reading groups in August 2009. Questionnaires were also sent to the South African Association for Child and Adolescent Psychiatry and Allied Professions Conference in Bloemfontein (SA ACAPAP) which was held from the 6-8th of July 2009. The researcher contacted the conference organisers to ask permission to hand out questionnaires and was given permission to do so by Conference Chairman Dr Richard Nichol. The questionnaire was handed out on the first day of the conference with the brochure that attendees are given, and then announcements were made by speakers to remind individuals to complete

them (see annexure C). Completed questionnaires were then couriered back to the researcher. Questionnaires were delivered to the Wits Department of Psychiatry to be handed out to psychiatrists and psychologists attending meetings and lectures at the department, with the permission of Department Heads, Professor Szabo and Professor Jeenah (Annexure B).

However, no respondents returned questionnaires from the Wits department of Psychiatry, none from the reading group, 5 SA ACAPAP conference, 17 from Gauteng Hospitals and 30 from the online email based survey.

Thus, due to the low number of responses collected, the data will be used descriptively in order to get a full understanding of the responses gained, as inferential statistical analysis of data cannot be made. Thus a description of the results of this study will be done, but the findings are not generalisable, as they cannot be reliably inferred to be representative of the population and Type II errors are likely, as is sampling error (Nadbank, Small sample Guidelines 2008.)

SAS® the Statistical Analysis programme was used once the data had been coded and entered into an excel spread sheet. Frequency counts were used to assess what symptoms were noted by respondents most recurrently, for each Borderline, Narcissistic and Antisocial category, and this was then looked at according to symptoms among children, adolescents and Cluster B. Due to the large number of variables in this study, the assessment of symptoms occurring in males and females as a comparison was excluded, as this would have become a confounding variable as the sample size is not big enough to accommodate these variables (Burns & Grove, 2001).

3.5 Ethical Considerations

This study was conducted once ethical clearance had been given to the researcher by the Human Research Ethics Committee of The University of The Witwatersrand and the Human Research Medical Ethics Committee of The University of The Witwatersrand .

No patient or sensitive populations have participated in this study. Those requested to participate are professionals in the field. Furthermore, although demographic data was requested, no identifying data was recorded on the questionnaires. When questionnaires were returned via email, the researcher protected confidentiality and questionnaires were printed and stored separately from respondents' emails which were permanently deleted on the 30th of November 2009. Questionnaires that were delivered were given out in plain brown envelopes and it was requested that, on collection, they be sealed. Questionnaires delivered to Gauteng Hospitals, (Johannesburg Hospital Child and Family Unit; Rahima Moosa Psychology and Psychiatry Unit; Tara Hospitals' Adolescent Ward, Tara In- and Out-patient Child Wards and Baragwanath Children's Unit) were left in envelopes in a box (placed in a staff common area/office) for potential participants to fill out should they wish to. The questionnaires were collected approximately two weeks after delivery by the researcher. Respondent's questionnaires were kept in a locked cabinet at the researchers' home and were treated with strict ethical consideration for confidentiality. All documentation will be destroyed after the research has been completed.

A letter accompanied the questionnaire in which it was explained that the Researcher is a Masters Psychology student at the University of The Witwatersrand and registered with the Health Professions Council of South Africa (PS S 0102466), and it was an invitation to participate. The letter contained information regarding the nature of this research so that all participants were able to give informed consent. It was explained that they were not obligated to participate and could withdraw from participation in the study at any time. Respondents were told that they have been chosen for this study because of their qualification as psychologists or psychiatrists. It was also stated how participants may access the research findings, should they wish to, once the research has been completed. If participants did want to receive the findings of the research, they were asked to check a box and write their email addresses, at the end of the questionnaire.

No consent form was used in this study for those participants responding to emailed questionnaires or hand delivered questionnaires as it was clearly stated in the cover letter to potential participants that completion and return of the questionnaire to the researcher will be understood by the researcher as informed consent by the respondent. The reason for this is that a large portion of questionnaires were emailed to potential respondents and the printing and faxing back of consent forms may not have been viable for all respondents and may, therefore, have prevented them from participating.

However, as part of this research involves the handing out of questionnaires to staff in Gauteng Hospitals, namely, Johannesburg Hospital Child and Family Unit; Rahima Moosa Psychology and Psychiatry Unit; Tara Hospitals' Adolescent Ward, Tara In- and Out-patient Child Wards and Baragwanath Children's Unit, a consent form was provided with these questionnaires (Annexure E). The reason for this is due to the small number of psychologists and psychiatrists in these units, identification of respondents may have been possible. In these instances, all questionnaires will be held with the highest regard for confidentiality and all data will be kept in a locked cabinet at the researchers' home. Furthermore, no identifying data will be used at any point during the conducting of, or write up of this research. While hospital staff may be more exposed, only the researcher will see the questionnaires and enter them into a database, so no one else will be privy to them.

This study is in no way structured or presented to result in the harm to, or of, any participant; it is voluntary and contains no element of deception. It was also stated that the Researcher is under supervision and would give the supervisors details as well as the researchers contact details.

3.6 Data Analysis

In order to analyse this data and answer the research questions of this study the following procedures were employed. Descriptive statistics were used to allow for an understanding of the sample parameters and parametric assumptions of each of the procedures used were tested. In the main analysis

the research questions were tested using frequency counts, analysis of variance (ANOVA) and covariance (ANCOVA). In the post hoc analysis a Tukeys Range Test was used (Haslam & McGarty, 2007).

CHAPTER 4

RESULTS

This research aimed to consider what symptoms psychiatrists and psychologists believe they are seeing that are consistent with Cluster B personality pathology, specifically, Borderline, Narcissistic and Antisocial. The aims of the present study were to identify a symptomology profile of Cluster B disorders in children and adolescents, how the symptoms noted relate to the Adult DSM-IV-TR symptoms for these disorders, if the presentation of these symptoms differs between children and adolescents, and whether clinicians prefer individual pathology types or an overall cluster B type. Finally, it was assessed whether or not respondents felt future revisions of the DSM-IV-TR should include a separate category for the diagnosis of children and adolescents. Analyses of variance were conducted to test the main hypothesis. Included as Post Hoc analyses, were an assessment of whether a significant relationship existed between child, adolescent and Cluster B disorders as well as an assessment of whether the type of training the participant had influenced their responses

Preliminary Analysis

Descriptive Statistics:

The sample for this study consisted of Psychiatrists (11), Child Psychiatrists (8), Clinical Psychologists (27), Counselling psychologists (2) and Educational psychologists (4).

Table 1: Sample and Sample sizes

Sample	**Sample Size**
Psychiatrist	N = 11
Child Psychiatrist	N = 8
Clinical Psychologist	N = 27
Counselling Psychologist	N = 2
Educational Psychologist	N = 4
Total	**N = 52**

Below is a Pearson's Correlation Coefficient Matrix, which shows the bivariate correlations of all pairs of dependent and independent variables.

With regard to the Borderline, Narcissistic and Antisocial correlations, it can be seen that the Borderline Cluster B symptoms were moderately significantly correlated with the symptoms noted for Borderline Child $r = 0.26$, $p<0.05$ and the Adolescent Borderline Symptoms were significantly correlated with the Borderline Child symptoms $r = 0.61$, $p<0.01$. In the Narcissistic group, the Narcissistic Child and the Narcissistic Adolescent symptoms were significantly correlated $r = 0.46$, $p<0.01$. In the Antisocial group, Antisocial Child was significantly correlated to Antisocial Cluster B symptoms $r = 0.32$, $p<0.01$, and Antisocial Adolescent symptoms were significantly correlated to Antisocial Child symptoms $r = 0.52$, $p< 0.01$. Between the groups, Narcissistic Cluster B symptoms were found to be moderately significantly negatively correlated to Borderline Child symptoms $r = -0.28$, $p<0.05$, Antisocial Child symptoms were found to be significantly negatively correlated with Borderline Adolescent symptoms $r = -0.42$, $p<0.01$, Antisocial Cluster B was significantly negatively correlated to Borderline Adolescent symptoms $r = -0.33$, $p<0.01$ And Antisocial Child was found to be moderately significantly correlated to Narcissistic Child symptoms $r = 0.29$, $p<0.05$. Number of years in Practice was found to be moderately significantly correlated to Borderline Child Symptoms $r = 0.37$, $p<0.05$.

Parametric Assumptions:

The following Parametric assumptions were evaluated:

Before the main analysis was performed the assumptions of the ANOVA were tested. This study meets the assumption of independence because, while it was a sample of convenience, participation in the study was not dependent on any systemic sources of variance. As a result, within the convenience sample, there was independence of observation. The assumption of linearity was met, as this was tested by plotting scatter plots, and all relations were found to be linear. No outliers dramatically affected the distribution of scores. The assumption of homogeneity of variance was also met, as the F test is robust to violations of normality (Ferguson & Takane, 1989).

The Shapiro-Wilk test was used to test normality, which was not met in all cases. The absence of normality in this sample may be due to the fact that the symptoms were largely extracted from nosological classification systems describing Borderline, Narcissistic and Antisocial personality symptoms. In addition to this the diagnosis of personality pathology in children and adolescents has been contested. Given that the present study is exploring practitioners' perceptions it is unlikely that these perceptions would be normally distributed in the population. Further more, personality pathology in children and adolescent can be seen to be a some what contested topic, thus an even distribution of views would be absent. As such, these parametric assumptions were met and parametric statistics were used in the main analysis. (Haslam & McGarty, 2003).

Table 2: Shapiro – Wilk Test for Borderline, Narcissistic and Antisocial groups:

Group	***Shapiro-Wilk Test***	***P-value***	**Normality**
Borderline Child	0.887	0.0001	No
Borderline Adolescent	0.957	0.06	Yes
Borderline Cluster B	0.939	0.001	No
Narcissistic Child	0.883	0.001	No
Narcissistic Adolescent	0.893	0.001	No

Narcissistic Cluster B	0.927	0.01	No
Antisocial Child	0.883	0.001	No
Antisocial Adolescent	0.825	0.001	No
Antisocial Cluster B	0.825	0.0001	No

Main Analysis:

The hypotheses of this study were tested below using parametric statistics. For each of the Borderline, Narcissistic and Antisocial groups, all of the symptoms that were endorsed by 50% or more of the participants were included in the write up of results.

- **Research Question 1: In those instances where South African Psychologists and Psychiatrists believe personality pathology can be seen in children and adolescents, what is the symptomology profile of Cluster B personality pathology in children and adolescents:**

Borderline Symptoms:

As table 4 shown below depicts, only half of the respondents felt that Children presented with Borderline symptoms, the most prevalent of which was *Clingy / demanding.* The only other elevated symptoms for this grouping were that of *Impulsive* behaviour and *Fear of abandonment*.

Table 3 Frequency Table : Borderline Children Symptoms:

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Clingy / Demanding	28	53.85%	Kernberg
2	Impulsive*	25	48.08%	DSM
2	Fears abandonment*	25	49.02%	DSM

***Symptoms that were also noted as Cluster B symptoms

A large percentage of the respondents noted that the symptoms: *Anger problems; Deliberately harms self; Feelings of emptiness; Self centeredness; Suicidal behaviour* were seen most commonly in Adolescents (Table 5).

Table 4 Frequency Table: Borderline Adolescent Symptoms

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Anger problems*	39	75%	DSM
1	Deliberately harms self*	39	75%	DSM/ Achenbach
2	Feelings of emptiness*	38	73.08%	DSM
2	Self centeredness*	38	73.08%	Kernberg
2	Suicidal behaviour*	38	73.08%	DSM
3	Argues a lot	37	71.15%	Achenbach
4	Impulsivity*	36	69.23%	DSM
5	Affective instability*	35	67.31	DSM
5	Identity disturbance*	35	67.31%	DSM
5	Alternating idealizing* - devaluing relationships	35	67.31%	DSM
6	Cruelty/Bullying or Meanness to others	34	65.38%	Achenbach
6	Feelings of worthlessness / helplessness	34	65.38%	Kernberg
7	Fears abandonment*	33	63.46%	DSM
8	Physically attacks others	32	61.54%	Achenbach
9	Hysterical traits	29	55.77%	Kernberg
9	Clingy / Demanding	29	55.77%	Kernberg
9	Rapid shifts in ego* functioning	29	55.77%	Other
10	Complains of loneliness	28	53.85%	Achenbach
10	Annihilation anxiety	28	54.90%	Kernberg
11	Withdrawn	27	52.94%	Kernberg

*****Symptoms that were also noted as Cluster B symptoms

As can be seen in table 6, the symptoms most frequently noted by participants as falling generally in the Cluster B diagnosis were those of *Self Centred; Suicidal behaviour; Affective instability; Alternating idealising – devaluing relationships* and as stated above these symptoms, other than the most frequently noted symptom, self centred, which is from Kernbergs'

symptom, are also predominantly from the DSM-IV-TR adult symptoms used for diagnosis.

Table 5 Frequency Table: Borderline Cluster B:

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Self Centred	34	66.67%	Kernberg
1	Suicidal behaviour	34	66.67%	DSM
1	Affective instability	34	65.38%	DSM
2	Alternating idealising – devaluing relationships	33	63.46%	DSM
3	Feelings of emptiness	32	61.54%	DSM
4	Anger Problems	31	59.62%	DSM
5	Identity disturbance	30	57.69%	DSM
5	Rapid shifts in ego function	30	57.69%	Other
6	Impulsivity	28	53.85%	DSM
7	Fears abandonment	27	51.92%	DSM
7	Deliberately harms self	27	52.94%	DSM / Achenbach

With regards to this checklist, it can be seen that DSM-IV-TR symptoms were far more frequently noted than Kernberg and Achenbach symptoms. However, for both the child and Cluster B sections the most frequently noted symptom was from Kernberg's list of symptoms. However, the DSM symptoms outweigh the other checklist responses.

Narcissistic Symptoms

As can be seen from the tables below, respondents preferred noting symptoms in the adolescent grouping, over that of the child group. However, *Disobedient at home / at school* and *vulnerability in self esteem* where the symptoms noted most frequently for children (Table 8).

Table 6 Frequency Table: Narcissistic Children:

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Disobedient at home / at school	21	52.50%	Achenbach
2	Vulnerability in Self esteem*	20	50.00%	Kernberg

Inability to tolerate failure; *Vulnerability in self esteem; Preoccupation with self image; Extreme sensitivity to criticism* and *Sense of entitlement* were the symptoms that the majority of respondents noted for the adolescent group. Unlike in the Borderline group, symptoms that were noted as child / adolescent and in Cluster B were predominantly from Kernberg's list of symptoms.

Table 7 Frequency Table: Narcissistic Adolescents:

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Inability to tolerate failure*	32	80.00%	Kernberg
1	Vulnerability in self esteem*	32	80.00%	Kernberg
1	Preoccupation with self image*	32	80.00%	Kernberg
2	Extreme sensitivity to criticism*	30	75.00%	Kernberg
2	Sense of entitlement*	30	75.00%	DSM
3	Disobedient at home / school	29	72.50%	Achenbach
3	Envious of others / Believes others envy them	29	72.50%	DSM
4	Exploitative*	28	70.00%	DSM
4	Lacks empathy*	28	70.00%	DSM
4	Arrogant behaviour	28	70.00%	DSM
5	Feels unloved	27	67.50%	Kernberg
5	Sadistic or aggressive pleasure in the defeat of others	27	67.50%	Kernberg
5	Excessive demands*	27	67.50%	Kernberg
5	Grandiosity*	27	67.50%	DSM
6	Showing off / Clowning	26	65.00%	Achenbach
6	Need for Admiration*	26	65.00%	DSM
7	Feels he / she has to be perfect	25	64.10%	Achenbach
7	Fantasies of power / beauty / success /	25	64.10%	DSM

	ideal love			
8	Bragging / Boasting	24	60.00%	Achenbach
8	Aloofness	24	60.00%	Kernberg
9	Frequent complaints of boredom	23	57.50%	Kernberg
9	Believes they are unique	23	57.50%	DSM
10	Lack of interest in others	22	55.00%	Kernberg

*****Symptoms that were also noted as Cluster B symptoms

The symptoms most frequently noted by respondents believed to be in the overall Cluster B group (Table 9) were *Vulnerability in self esteem; Lacks empathy and Extreme sensitivity to criticism.* Unlike the Borderline symptoms seen above, the Narcissistic Cluster B symptoms were drawn equally from the DSM-IV-TR and Kernbergs' symptom list, the most frequent, Vulnerability in self esteem, is from Kernberg's list.

Table 8 Frequency Table: Narcissistic Cluster B

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Vulnerability in self esteem	29	72.00%	Kernberg
2	Lacks empathy	24	60.00%	DSM
3	Extreme sensitivity to criticism	23	57.50%	Kernberg
3	Excessive demands	23	57.50%	Kernberg
3	Sense of entitlement	23	57.50%	DSM
4	Need for admiration	22	55.00%	DSM
5	Inability to tolerate failure	21	53.50%	Kernberg
5	Grandiose	21	52.50%	DSM
5	Exploitative	21	52.50%	DSM
6	Preoccupation with self image	20	50.00%	Kernberg

The checklist list for the Narcissistic grouping shows that slightly more of Kernberg's symptoms were noted than of the DSM symptoms.

Antisocial Symptoms:

More symptoms were noted for children in the Antisocial group than in both Borderline and Narcissistic. From table 10 it can be seen that the symptoms most frequently noted were those of *Cruelty to animals; Steals and Impulsive behaviour.*

Table 9 Frequency table: Antisocial Children:

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Cruelty to animals	25	64.10%	Achenbach
1	Steals*	25	64.10%	Achenbach
2	Impulsive*	22	56.41%	DSM
3	Cruelty / Bullying / Meanness to others*	21	53.85	Achenbach
4	Sets fires	20	51.28%	Achenbach
4	Indifference / Dismissive to consequences of behaviour*	20	51.05	Kernberg
4	Deceitful*	20	51.28	DSM

Respondents agreed most, noting symptoms most frequently, for the Antisocial adolescent grouping (Table 11). The most repeatedly noted symptoms were those of *Truancy; Threatens people; Indifference / Dismissive to consequences of behaviour; Steals*; and *Aggressive – gets into fights* however a number of other symptoms were also prevalent.

Table 10 Frequency Table: Antisocial Adolescents:

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Truancy	34	87.18%	Achenbach
2	Threatens people	33	84.62%	Achenbach
2	Indifference / Dismissive to consequences of behaviour*	33	84.62%	Kernberg
3	Steals*	32	82.05%	Achenbach
3	Aggressive – gets into fights*	32	82.05%	DSM
4	Disregard for social norms *	31	79.49%	DSM
4	Lacks remorse*	31	79.49%	DSM

5	Cruelty / Bullying / Meanness to others*	30	76.92%	Achenbach
5	Vandalism	30	76.92%	Achenbach
5	Doesn't experience feelings of guilt	30	76.92%	Kernberg
5	Intentional aggression	30	76.92%	Kernberg
5	Deceitfulness*	30	76.92%	DSM
5	Consistent irresponsibility*	30	76.92%	DSM
6	Non empathic to others*	29	74.36%	Kernberg
6	Superficial charm*	29	74.36%	Kernberg
6	Manipulative*	29	74.36%	Kernberg
6	Disregard for the safety of others	29	74.36%	DSM
7	Cruelty to animals	28	71.79%	Achenbach
7	Ruthlessness	28	71.79%	Kernberg
8	Explosive*	27	67.23%	Kernberg
8	Impulsive*	27	69.23%	DSM
8	Irritability*	27	69.23%	DSM
9	Destroys things belonging to self or others*	26	66.67%	Achenbach
10	Predatory behaviour	25	64.10%	Kernberg
10	Lack of personal investment in peer relationships	25	64.10%	Kernberg
11	Sets fires	24	61.54%	Achenbach

*****Symptoms that were also noted as Cluster B symptoms

Respondent noted the symptoms of *Manipulative; Impulsive* and *Irritability* as occurring most frequently in Cluster B (Table 12). Of these symptoms, the most noted, *Manipulative*, is from Kernbergs' list, the others were from the DSM-IV-TR.

Table 11 Frequency Table: Antisocial Cluster B:

Rank	***Symptom***	***Frequency***	***Percentage***	**Checklist**
1	Manipulative	29	74.00%	Kernberg
2	Impulsive	24	61.54%	DSM

2	Irritability	24	61.54%	DSM
3	Disregard for social norms	22	56.41%	DSM
3	Consistent irresponsibility	22	56.41%	DSM
4	Cruelty / Bullying / Meanness to others	21	53.85%	Achenbach
4	Destroys things belonging to self or others	21	53.85%	Achenbach
4	Steals	21	53.85%	Achenbach
4	Explosive	21	53.85%	Kernberg
4	Indifference to consequences	21	53.85%	Kernberg
4	Non empathic to others	21	53.85%	Kernberg
4	Superficial charm	21	53.85%	Kernberg
4	Aggressive – gets into fights	21	53.85%	DSM
5	Doesn't experience feelings of guilt	20	51.28%	Kernberg
5	Deceitfulness	20	51.28%	DSM
5	Lacks remorse	20	51.28%	DSM

For the above checklist it can be seen that symptoms from both the DSM and from Kernberg were equally noted. However, the most frequently noted symptoms for both child and adolescent categories were from Achenbach's symptoms.

- **Research Question 2: If present, is there a difference in presentation between children and adolescents?**

In order to explore whether or not children and adolescents significantly differed in the perceived symptomology for Borderline, Narcissisitc and Antisocial groups, the following procedures were applied. Firstly a new data set was created with two variables. The first was the age variable that coded child and adolescent symptoms for each of the Borderline, Narcissistic and Antisocial groups as a 1 and adolescents' symptoms as a 2, while Cluster B symptoms were coded as a 3. As such, on the second variable all the corresponding scores were denoted in a linear fashion. This allowed for a

repeated measures ANOVA to be conducted, where the second variable (Called Bord, Narc & Anti for ease of reference) was the dependent variable, and the age variable was the categorical independent variable. It is important to mention that the repeated measure ANOVA was conducted to test the mean difference for child, adolescent and Cluster B. This procedure enabled for both hypotheses of research questions 2 and 3 to be answered in one parsimonious step.

Analysis of variance suggested that there was an overall significant effect. Post Hoc comparisons were used to test where differences lay. With regard to both of the research questions, two and three, the over all significant effect for each group were: Borderline symptoms were $F_{(2, 153)} = 10.14$ $p < .0001$. Within the Narcissistic group, a significant difference was found $F_{(2,117)} = 10.43$, $p < .0001$. Within the Antisocial group, a significant difference was found $F_{(2,114)} = 8.02$, $p < .0006$. With this considered, question two and three can now be answered.

The tables below (table 13-15) show that a significant difference exists between respondents' notation of symptoms in children and adolescents, where they were significantly more likely to note symptoms for adolescents than they were for children for all of the Borderline, Narcissistic and Antisocial groups.

Table 12: Borderline – difference between children and adolescents

Tukey Grouping	***Mean***	***Sample - N***	**Significance**
Child	9.00	52	Not significant
Adolescent	16.36	52	Significant

Table 13: Narcissistic – differences between children and adolescents

Tukey Grouping	***Mean***	***Sample - N***	**Significance**
Child	8.80	40	Not significant
Adolescent	16.85	40	Significant

Table 14: Antisocial – differences between children and adolescents

Tukey Grouping	***Mean***	***Sample - N***	**Significance**
Child	12.03	39	Not significant
Adolescent	20.74	39	Significant

Thus in terms of the research question, these results have found that participants are more likely to endorse the use of symptoms to acknowledge PD's in adolescents than they are children, and that these symptoms differ significantly.

- **Research question 3: Where applicable, do South African clinicians prefer individual personality pathology types or an over all Cluster B type?**

A repeated measures ANOVA was conducted to test whether there were mean differences between the endorsement of Child, Adolescent and Cluster B symptoms across all three of the Borderline, Narcissistic and Antisocial groups. The Repeated Measures ANOVA was used to compare three sets of scores, as a t-test if designed for only two. The assumption of Sphericity was tested and a non significant Mauchly's Test suggested the Sphericity could be assumed (Meyers, Gamst & Guarino, 2006). A Post Hoc comparison using A Tukey's Range Test was done. This was done to assess the difference in response between the Child, Adolescent and Cluster B groupings for each Borderline, Narcissist and Antisocial grouping. This test allows for the multiple comparisons of means after the use of an ANOVA, to asses which means differ significantly from the other means (SAS©, 1999)

After the repeated measures ANOVA's used in question two had been done, and overall significant effects had been found, Post Hoc comparisons using a Tukeys Range tests could be conducted. The Tukeys Range Test suggested that while Cluster B symptoms did not significantly differ from Child symptoms, there was a significant difference between Cluster B and Adolescent symptoms as well as a significant difference between Child and Adolescent symptoms.

Table 15 Borderline – differences between Child / Adolescent / Cluster B:

Tukey Grouping	***Mean***	***Sample - N***	**Significance**
Child	9.00	52	Not significant
Adolescent	16.37	52	Significant
Cluster B	12.25	52	Not significant

The use of the Tukeys range test showed that the Child and Cluster B symptoms did not differ, but a significant difference was found between the Adolescent and Cluster B symptoms and the Adolescent and Child symptoms.

Table 16 Narcissistic – differences between Child / Adolescent / Cluster B:

Tukey Grouping	***Mean***	***Sample - N***	**Significance**
Child	8.80	40	Not significant
Adolescent	16.85	40	Significant
Cluster B	11.65	40	Not significant

The Tukeys Range test showed that no significant difference was found between Child and Cluster B symptoms, but significant differences were found between the Adolescent and Cluster B symptoms, and the Adolescent and Child symptoms.

Table 17 Antisocial – differences between Child / Adolescent / Cluster B:

Tukey Grouping	***Mean***	***Sample - N***	**Significance**
Child	12.03	39	Not significant
Adolescent	20.74	39	Significant
Cluster B	13.97	39	Not significant

From the above tables it can be seen that a significant difference exists between Adolescent and Child and between Adolescent and Cluster B, but neither Cluster B nor Child are significant for all three groupings. Thus participants more frequently noted symptoms as present in Adolescents, more so than in Cluster B, and least so in children. Thus professionals are agreeing in this study that the symptoms present are seen in adolescents most frequently.

With regard to the research question it can be seen that participants did not prefer an over all Cluster B diagnosis, and found instead that symptoms were more frequently noted in the Adolescent group than in any other.

Post Hoc:

A set of sum variables was created, where all endorsements, for example, of Child Borderline symptoms, were added to form a new “Borderline Child” sum variable. This was then done for both the Adolescent and Cluster B symptoms for each of the Borderline, Narcissistic and Antisocial groups. This allowed for a one way ANOVA test to be conducted to asses if significant differences exist between how participants responded to symptoms according to Child, Adolescent and Cluster B, for each of the categories Borderline, Narcissistic and Antisocial as a result of their training, e.g. Psychiatrist (Adult / child) / Clinical / Educational / Counselling Psychologist .

The results for the Borderline group showed no significant difference between endorsement of symptoms as a function of training for children $F_{(4, 47)} = 1.31$, $p<0.2794$; adolescents $F_{(4,47)} = 0.64$, $p< 0.6342$ nor Cluster B $F_{(4,47)}=1.21$, $p<0.3172$. In the Narcissistic group, no significant differences were found between training and the endorsement of symptoms for child $F_{(3, 36)} = 2.06$, $p<0.1233$, adolescents $F_{(3, 36)} = 0.27$, $p<0.8497$ and this was also true for Cluster B $F_{(3, 36)} = 0.83$, $p<0.4879$. These findings were also true of the Antisocial group where no significant differences were seen in symptoms endorsed for children $F(3,35) = 1.45$, p<02439, adolescents $F(3,35) = 0.29$, $p<0.8319$ and in Cluster B where $F(3,35) = 0.49$, $p<0.6939$.

These results showed no statistical significance. This indicates that irrespective of the type of training participants had, that they responded similarly to the above symptoms.

- **Research Question 4:**

DSM-IV-TR:

In order to answer these questions, frequency counts were used.

1) Should future revision of the DSM-IV-TR include a separate category for the diagnosis of children and adolescents with personality disorders?
2) Should future revisions of the DSM-IV-TR allow for a more malleable frame with regard to symptom duration, as opposed to a set, life long prognosis?
3) Should future revisions of the DSM-IV-TR acknowledge personality pathology, not severe enough for Personality Disorder Diagnosis?
4) Should future revisions of the DSM-IV-TR include criteria that make reference to Attachment Problems in child pathology?

Table 18 – Frequency Counts of DSM-IV-TR Questions

Question Number	*Sample Size*	*Yes*	**No**
Question 1	N = 39	N = 27	N = 12
	Percentage	**67.50 %**	**30.00 %**
Question 2	N = 38	N = 30	N = 8
	Percentage	**75.00 %**	**20.00 %**
Question 3	N = 39	N = 36	N = 3
	Percentage	**90.00%**	**7.50 %**
Question 4	N = 39	N = 34	N = 5
	Percentage	**85.00%**	**12.50 %**

The table above (table 19) shows that a majority of respondents, 27 of 39 respondents (67.50%) felt that future revisions of the DSM-IV-TR should include categories for the diagnosis of children and adolescents with personality pathology. A large percentage of the respondents, 30 of the 38, (75.00%) felt that the revisions of the DSM-IV-TR should include a more malleable time frame with regard to symptom duration. The largest proportion of respondents 36 of the 39 respondents (90.00%) felt that there should be an acknowledgment of personality pathology not severe enough for diagnosis in future revisions of the DSM-IV-TR. Finally, a large portion of respondents 34 of the 39, (85.00%) noted that the criteria for diagnosis should include references to Attachment problems.

Post Hoc Analysis: One way ANOVA tests were conducted to assess whether differences in training between the respondents influenced how they answered the above four DSM-IV-TR questions. It was found that there were no significant differences between type of training and responses to questions, thus training was not a significant variable. Training, refers to the type of professional e.g. Clinical Psychologist / Psychiatrist (Adult / Child).

For question one, which looked at whether future revisions of the DSM-IV-TR should include a separate category for the diagnosis of children and adolescents with personality disorders, a one way ANOVA revealed no significant differences existed between types of training and responses to this question $F_{(1, 38)} = 0.01$, $p = 0.9054$. For question two, which assessed a more malleable time frame with regard to symptom duration the F test also showed no significant differences $F_{(1, 38)} = 0.01$, $p = 0.9339$. This was repeated in question three with regard to personality pathology not severe enough for diagnosis, where the F test showed $F_{(1, 38)} = 0.22$, $p = 0.6417$ and in question four with regard to an acknowledgement of attachment problems no significant differences were found $F_{(1,38)} = 0.18$, $p = 0.6719$.

Comments by respondents:

The questionnaire allowed respondents to comment after they had completed the questionnaire. Two people felt that personality in childhood is still fluid and thus a definite diagnosis should be avoided, whilst two other similar responses to this, said that for this reason, personality difficulties should be noted as emerging traits. Two respondents said symptoms need to be considered as representative of an axis one disorder, or are manifestations of other psychiatric disorders. Three respondents said that when considering the diagnosis of personality disorders in children and adolescents one needs to think about the implications of this, such as stigma, and the negative response professionals have to Personality Disorders, difficulties with Medical Aids and the poor prognosis of this diagnosis and subsequent implications for therapy. Two respondents felt that Borderline traits were very obvious in children and adolescents, and one commented that Attachment Problems in females with Borderline traits is a “major issue”. Other comments included the need to

consider the symptoms of these disorders as developmentally appropriate to some degree, while another respondent said that many children who present with Cluster B disorders are being diagnosed as Conduct Disordered instead, as this is the only diagnosis of this kind available in the DSM-IV-TR.

CHAPTER 5

DISCUSSION:

This research follows that of two other foundation studies conducted in South Africa, which found a prevalence of personality pathology being diagnosed in the adolescent inpatient units of various Johannesburg Hospitals (Card, 2009; Sosnovik, 2008). While these studies focused on the prevalence of personality pathology in Adolescents, this study is focusing on what symptoms professionals are seeing in children and adolescents. The results of this study will now be discussed. The top ten most frequently noted symptoms for each of the Borderline, Narcissistic and Antisocial groups as outlined are those that are from the DSM-IV-TR list of adult symptoms, these are then compared to the symptoms noted in relevant literature. The difference seen between children and adolescents and the developmental progression of symptoms through childhood and into adolescence is then explored. The notation of individual symptoms over a Cluster B diagnosis is discussed, and finally, so too are the perceptions of respondents with regard to the applicability of the DSM-IV-TR.

5.1 The symptomology profile of Cluster B disorders

Borderline Symptoms:

The symptomology profile of Borderline pathology in children and adolescents according to the respondents of this study were, in children: Clingy / Demanding (53.85%), Impulsive (48.08%) and Fears abandonment (48.02%). A much larger number of respondents noted Borderline symptoms in adolescents, where the ten most frequently noted symptoms were Anger Problems (75%), Deliberately harms self (75%), Feelings of emptiness (73.08%), Self centeredness (73.08%), Suicidal behaviour (73.08%), Argues a lot (71.15%), Impulsivity (69.23%), Affective instability (67.31%), Identity disturbance (67.31%) and Alternating idealizing - devaluing relationships (67.31%).

Of the above symptoms two of the symptoms noted for children, Impulsivity, and Fears abandonment correlate with the adult DSM-IV-TR diagnosis. Of the adolescent symptoms, Anger Problems, Deliberately harms self, Feelings of Emptiness, Suicidal behaviour, Impulsivity, Affective Instability, Identity disturbance and Alternating idealizing – Devaluing relationships were all DSM-IV-TR adult symptoms for diagnosis. Thus all but three of the symptoms most frequently recorded by respondents correlated with those of the DSM-IV-TR criteria for diagnosis. The DSM-IV-TR symptoms were far more frequently noted in the Borderline cluster, compared to the use of the DSM-IV-TR symptoms for the Narcissistic and Antisocial clusters (APA, 2000). The higher rating of *Clingy / demanding* as a symptom also needs to be considered as being noted more frequently than other symptoms because to some degree it is developmentally inappropriate in older children, but may be appropriate in a child of two or three years of age.

Greenman et al (1986) also found that children (aged 6 – 12 years) with a Borderline diagnosis exhibited Demanding / Dependent behaviour as a significant symptom. However, the other significant symptoms of the Greenman et al (1986) study that were not found in this study were Irritable / Hostile; Manipulative and Dissociative Episodes. The study by Sharp and Romero (2007) agreed with the findings of this study, that Fears Abandonment; Impulsivity; Anger Problems; Identity disturbance and Idealisation - Devaluation of relationships are present in children and adolescents. Bleiberg (1990) includes Need to control others; Binge eating; Drug abuse; Promiscuous sex and Preoccupation with immediacy of experience, as Borderline child and adolescent traits.

A larger number of respondents (N=52) answered the Borderline symptoms for both child and adolescent than that of Narcissistic (N= 40) and Antisocial (N = 39). From a review of the literature, it appears that more literature exists on Borderline pathology in children and adolescents, and this is supported by South African (Sosnovik, 2008; Card, 2009) and international research in this area, which showed a Borderline personality disorder diagnosis in

adolescents as more prevalent than any other PD (Grilo, McGlashin, Quinlan, Walker, Greenfield & Edell, 1998).

A number of the above symptoms are from the DSM-IV-TR, which suggests that professionals are relying on the DSM-IV-TR for symptom diagnosis for Adolescents presenting with Borderline symptoms. Symptoms that were also noted as Cluster B symptoms were predominantly those taken from the DSM-IV-TR. The large number of frequently noted symptoms that are from the DSM-IV-TR may also reflect respondent use of this as a diagnostic tool more frequently than in other disorders in this study. This correlates with the Sosnovik (2008) and Card (2009) findings, that professionals are most frequently noting Borderline pathology in South African Adolescents. It could perhaps be said that practitioners may have only felt able to answer the Borderline symptoms and not Narcissistic or Antisocial, as the Borderline children and adolescents are presenting to practitioners more frequently and thus they feel more capable of noting these symptoms. However, this may have been due to the lay out of the questionnaire, where Borderline symptoms were first and thus respondents only answered this one due to time constraints.

Narcissistic Symptoms:

The symptomology profile of Narcissistic PD in children, in this study was: Disobedient at home / at school (52.50%) and Vulnerability in Self esteem (50.00%). The ten most prevalent adolescent symptoms were: Inability to tolerate failure (80.00%), Vulnerability in self esteem (80.00%), Preoccupation with self image (80.00%), Extreme sensitivity to criticism (75.00%), Sense of entitlement (75.00%), Disobedient at home / school (72.50%), Envious of others / Believes others envy them (72.50%), Exploitative (70.00%), Lacks empathy (70.00%) and Arrogant behaviour (70.00%).

Of the above symptoms, those correlating with the DSM-IV-TR symptoms for diagnosis of Narcissistic PD were: Sense of Entitlement, Envious of others / believes others envy them, Exploitative, Lacks empathy, and Arrogant behaviour in the adolescent group. The higher ranking symptoms were taken

from Kernberg's list of symptoms. Of all the symptoms noted by respondents, Kernberg's symptoms were most frequently employed for the Narcissistic cluster (APA, 2000).

A study by Guile (1996) concurred with the findings of this study, that these adolescents show a preoccupation with self image, Arrogant behaviour, Lack empathy, show feelings of envy, are exploitative and show a sense of entitlement. Bleiberg (1990) highlights vulnerability as a symptom noted in his study as well as omnipotent and grandiose behaviour and the tendency to project or split off parts of the self that might threaten their self esteem.

Antisocial symptoms:

The symptomology profile of Antisocial PD in this study, for children were: Cruelty to animals (64.10%), Steals (64.10%), Impulsive (56.41%), Cruelty / Bullying / Meanness to others (53.85%), Sets fires (51.28%), Indifference / Dismissive to consequences of behaviour (51.05%) and Deceitful (51.28%). The profile of the ten most frequently noted symptoms in adolescents were: Truancy (87.18%),Threatens People (84.62%), Indifference / Dismissive to consequences of behaviour (84.62%), Steals (82.05%), Aggressive – gets into fights (82.05%), Disregard for social norms (79.49%), Lacks remorse (79.49%), Cruelty / Bullying / Meanness to others (76.92%), Vandalism (76.92%) and Doesn't experience feelings of guilt (76.92%). However, it must be noted that a number of other symptoms were also frequently noted in this grouping.

Of the above symptoms for children, only the symptoms Impulsive and Deceitful were from the adult DSM-IV-TR diagnostic symptoms for Antisocial PD. Most of the symptoms for this group were from Achenbach's checklist. Of the adolescent group, the symptoms that were from the DSM-IV-TR were Aggressive – gets into fights, Disregard for social norms, and Lacks remorse. The other symptoms were predominantly from Achenbach's checklist.

Kernberg et al., (2000)'s adaptation of Achenbach's Behaviour Checklist has four symptoms from the children's group and five from the adolescent group

that were the most frequently noted symptoms by respondents, that correlate with the DSM-IV-TR diagnosis for Conduct Disorder. This may explain why so many of these symptoms were noted, and also why there were a larger number of Antisocial child symptoms in terms of frequency, than in either the Borderline or Narcissistic groups. A respondent to this study commented that children that present with Cluster B disorders are not being diagnosed as such because Conduct Disorder is the only personality type diagnosis available to children in the DSM-IV-TR. This may also validate the large number of child symptoms noted by respondents. A study by Bernstein et al., (1996) found that Childhood Conduct Disorder was not solely indicative of later Antisocial PD, but a range of personality problems later in life, and that Conduct Disorder is the label given to a array of masked emotional difficulties that express themselves in any number of ways in later life, and that Conduct Disorder can be seen as a "general risk factor for later personality disorder" (pg. 911).

A number of studies have addressed the issue around the diagnosis of Conduct Disorder in childhood, and the later diagnosis of Antisocial PD in children and adolescents, and the need to differentiate the two. The DSM-IV-TR does not allow for the diagnosis of Antisocial personality disorder in children and adolescents, but says that Conduct Disorder must be the initial diagnosis, despite the recognition that severe behavioural problems should have been seen in adolescence (APA, 2000). However, studies have shown that Antisocial Personality Disorder is a valid construct in children and adolescents (Taylor et al. 2007; Bleiberg, 2004; Kernberg, 2000; Grilo et al., 1998).

Kernberg et al. (2000) notes the weight of diagnosing this type of personality disorder in children and adolescents and the long term implications it may have. However, a study by Paris (2003) found that over a life span, that most patients with Antisocial PD diagnoses recovered, at least to some degree as they grew older. This study found that 75% of respondents felt that future revisions of the DSM-IV-TR should employ a PD diagnosis that allows for a more malleable time frame as opposed to the set lifelong prognosis given with

this diagnosis at present, therefore endorsing the belief that PD diagnoses and symptoms may fluctuate over the course of the life span.

Two respondents to this study commented that symptoms need to be considered as representative of an Axis I disorder or as manifestations of other psychiatric disorders. The findings of Kasen, Cohen, Skodol, Johnson & Brook (1999) found that a core characteristic may link Axis I and Axis II diagnosis and that childhood Axis I disorders can be seen to be a stumbling block, increasing the likelihood of personality problems both as co morbid diagnoses and later on in life. According to Guile's (1996) assessment of narcissism in preadolescents, longitudinal studies have shown that PD's can be recognized independent of Axis I disorders, and that symptoms can be both co morbid and distinguishable from Axis I disorders. He notes that the two most common co morbid Axis I disorders in adolescent PD's are Conduct Disorder and Mood Disorders. This is supported by the Sosnovik (2008) South African study which found a significant association between Conduct Disorder and the presence of personality pathology in adolescent case files, where Conduct Disorder was one of the five most frequently noted co morbid Axis I disorders.

5.2 Difference in presentation between childhood and adolescence

This research aimed to assess if a difference could be seen in presentation between children and adolescents. For each of the three Borderline, Narcissistic and Antisocial groups, significant differences were seen, whereby the respondents' were significantly more likely to note symptoms for adolescents than for children. This reflects both international and South African literature, stating that clinicians feel more able to assess the presence of personality pathology in adolescents than in children. Larger amounts of data exist on the presence of adolescent personality pathology than for children, and this is in accordance with the DSM-IV-TR (2000) (Kernberg et al, 2000; Sosnovik, 2008). However, this is not to say that the above mentioned readings themselves do not believe that personality pathology is seen in children, but rather that there is more hesitancy in professionals to give this

diagnosis in childhood, than there is in adolescence, while still noting that personality pathology originates in early childhood.

Examination of *Table 2* however, reveals that Borderline adolescent symptoms were significantly correlated with the Borderline Child symptoms, the Narcissistic Child and the Narcissistic Adolescent symptoms were significantly correlated and Antisocial Adolescent symptoms were significantly correlated to Antisocial Child symptoms. This may indicate that the symptoms that are seen in childhood are likely to persist on into adolescence. If we consider these symptoms as part of a developmental trajectory then it can be seen that these symptoms in childhood place children on a pathological developmental pathway, disabling them from managing the stresses of childhood and adolescence effectively (Guile, 1996; Kasen et al., 1999; Bernstein et al, 1996; Meekings & O'Brien, 2004; Lyddon & Sherry, 2001). A longitudinal study by Kasen et al. (1999) identified that Childhood pathology, increases the risk of PD development in later life, and that the roots of adult PD are seen in childhood because of the harmful feedback cycle that is formed as these children interact with the social world, persisting their pathology into adolescence and adulthood.

These finding were supported by those of Bernstein et al. (1996), where the antecedents of adolescent personality pathology were identified in the form of childhood behavioural difficulties. Thus the notion that childhood personality pathology is relatively stable through adolescence and into adulthood is supported by a number of studies (Shriner, 2005; Guile & Greenfield, 2004; Zelkowitz, et al. 2004). However, a study conducted by Paris (2003) found that Borderline and Antisocial PD's show waxing and waning effects in adulthood, with some level of improvement. Sharp and Romero (2007) drew on the findings of Marton, Connolly, Kutcher & Korenblum (1993) (in Sharp & Romero, 2007) which found that 44% of the children diagnosed with personality pathology were found to be clear of this diagnosis at a three year follow up and 85% of adolescent in patients were free of a Borderline PD diagnosis at a three year follow up (Miejer, Goeadhart & Treffers, (2000) in Sharp & Romero, (2003). Thus, these studies can be seen to support the

need for the early identification of these traits and the necessity of intervention in childhood and adolescence.

5.3 The use of an overall Cluster B type

As has been discussed above, respondents to this questionnaire were more likely to note symptoms for adolescents than for children. With regard to the frequency that respondents noted Cluster B symptoms, significant differences were found, where respondents noted symptoms most in adolescence, then in Cluster B, and least so in children. Thus participants in this study did not endorse the use of the overall Cluster B symptoms as frequently as they did for adolescence. This is not in accordance with research done on this topic in South Africa which found that clinicians in adolescent in patient units prefer to note “Cluster B Traits” on the Axis II diagnosis (Card, 2009; Sosnovik, 2008), and that this reflected the uncertainty about making a full PD diagnosis in early adolescence (Card, 2009).

In this study, (Table 2) Borderline Child symptoms were found to be moderately significantly correlated to Borderline Cluster B symptoms, where Borderline Adolescent symptoms were not. Antisocial Child symptoms were also found to be significantly correlated to Antisocial Cluster B symptoms while Antisocial Adolescent symptoms were not related to Cluster B symptoms. This may indicate that the presence of these symptoms noted in Cluster B that are being seen in children may be more indicative of serious pathology in childhood, than the symptoms seen in adolescents, which may be somewhat developmentally appropriate.

However, it could also be said that if clinicians are more likely to diagnose PD’s in adolescents as was found in the Card (2009) and Sosnovik (2008) studies, professionals making these diagnoses may have a clearer understanding of how PD’s present in adolescents than they do of this presentation in children. This links to the findings of the South African studies which found a high prevalence of Axis II notations of “Emerging Cluster B disorder traits / Cluster B traits” (Card, 2009; Sosnovik, 2008). The Sosnovik (2008) study showed that in South Africa adolescent case files, Borderline

pathology (39.19%) and Antisocial pathology (20.27%) are most frequently noted while Narcissistic pathology is only (2.70%).

5.4 Applicability of the DSM-IV-TR

The current study questioned the applicability of the DSM-IV-TR and its use in diagnosing children and adolescents with PDs. With regard to the DSM-IV-TR and the inclusion of a separate category for the diagnosis for children and adolescents, 67.50% of respondents said yes. A number of studies have found that adolescent PD symptoms resemble those of the adult diagnosis, while questioning its utility (Westen, 2003; Durrett & Westen, 2005; Greenman et al., 1985; Kernberg et al., 2000; Bleiberg, 2001). Levy et al., (1999) point out the need for adolescent diagnostic criteria to be in place so that adjustments for normal developmental measure can be applied.

This is mirrored by South African research in which professionals voiced, that the DSM does have some applicability to children and adolescents, but that this needs to be made more applicable to the child and adolescent populations (Sosnovik, 2008; Sosnovik, 2007). With regard to this research then it can be seen that these professionals agree that some adjustment needs to be a made to diagnostic criteria for children and adolescents. This question could have been split into two questions, as a difference in response to this question, according to child and adolescent categories may have been found.

One of the concerns about giving a PD diagnosis in children and adolescents is that it implies a life long and chronic disorder, as the DSM-IV-TR describes it. Kernberg (2000) picks up on it as one of the reasons why clinicians will not diagnose this disorder in children or adolescents as this diagnosis on a child's records can cause discrimination. Taylor et al. (2007) note that with regard to antisocial PD pathology, that such a diagnosis would prevent individuals from receiving appropriate rehabilitation. Thus, authors agree that the negative impact that giving a diagnosis that is long term and unmalleable is a hindrance to diagnosing children and adolescents. Three respondents in this study commented on the need to consider the implications of this diagnosis

on a child's future, such as stigma, the negative response some professionals have to working with PD patients and the implications of this for therapy, as well as difficulties with Medical Aid that adult PD patients are currently experiencing. 75.00% of respondents in this study felt that the future revisions on the DSM should have a more malleable frame with regard symptom duration as opposed to the set life long prognosis. As mentioned above, although some studies have advocated the relative stability of PD over a lifetime, others, have found personality disorder symptoms show less stability (Paris, 2003). It appears that more longitudinal research may need to be done on the stability of a PD diagnosis from childhood into late adulthood.

Sosnovik (2008) and Card (2009) both found that professionals were more likely to note "Traits Present" than they were to note that a full PD diagnosis was made. In this study 90.00% of respondents felt that future revisions of the DSM should acknowledge PD not severe enough for full diagnosis and this may further represent the hesitancy of professionals to make a full diagnosis, and instead by making an Axis II diagnosis of traits present they are leaving the door open for this to change in the future. Two respondents to this study commented that personality in childhood is still fluid and thus a definite diagnosis should be avoided and noted instead as emerging traits.

With regard to respondents' perceptions of the need for the DSM to make reference to Attachment issues, 85.00% said yes that this is something that should be taken into consideration. One of the comments made was that attachment problems in female patients with Borderline traits is a "major issue". An early environment of neglect and deprivation, and disrupted attachments namely disorganised and avoidant attachment, inappropriate parental behaviour and abuse is one which fosters the development of a PD (Harman, 2004; Ludolph et al., 1990; Sourfe, 2005; Nakash-Eisikovits et al., 2000). The study by Sosnovik (2008) revealed a significant correlation between the presence of personality pathology and Attachment difficulties in the South African adolescent case files.

According to Skodol (2009) the DSM-IV-TR is being assessed, and future revisions are looking at the “Definition and the Diagnostic criteria for PD diagnosis, Levels of Severity of Personality Psychopathology, Personality across the Life Span” as well as reviews of each of the 10 PD categories. Furthermore, traits will be adopted for use on their clinical utility, and will form a 4 point scale of applicability. Also, a model is being constructed with core personality traits, indicative of severe personality pathology, and then a set of peripheral traits indicating more mild relational problems, to allow for a scale of personality severity, thus allowing for the presence of PD traits not severe enough for diagnosis. If these changes are incorporate into the DSM-V a number of the problems noted above will be mediated.

The checklists used in this study showed that the DSM-IV-TR symptoms were endorsed most frequently by participants for the Borderline PD group above that of any other, as was discussed above. A larger number of Narcissistic symptoms were taken from Kernberg’s list of symptoms, and for the Antisocial symptoms and equal number were taken from the DSM-IV-TR symptoms and from Kernberg’s symptoms. A study by Guile (1996) compared the DSM-IV, Kernberg and Bleiberg’s symptoms for Narcissism and found that the three groups agreed on all DSM-IV criteria except that of the presence of Envy. Guile (1996) highlights that although concordance between these diagnostic systems is seen, additional criteria for future diagnostic systems are also important, such as Hypersensitivity to Defeat and Hypersensitivity to criticism. The comparison of these three diagnostic systems allowed for a clearer outline of the presentation of Narcissistic PD in preadolescents.

5.5 Correlations seen between the Borderline, Narcissistic and Antisocial groups

In table 2, also noted were significant correlations between, Narcissistic Cluster B and Borderline child symptoms, as well as between Borderline adolescent, Antisocial child and Antisocial Cluster B. A moderately significant correlation was also seen between Narcissistic child and Antisocial child. This can be explained by the findings of Shedler & Westen (2004), who draw attention to the fact that not only do personality disorders present co morbidly,

but also that the symptoms noted for one PD diagnosis can also correlate with the diagnosis of other disorders. However, the DSM-IV-TR has not included these symptoms in order to keep Axis II diagnostic categories separate. Thus, although it is not acknowledged by the DSM symptoms, in clinical practice, professionals are seeing symptoms believed to be indicative of pathology, that may not fit neatly into one diagnostic category, but may rather be a sign of personality pathology as a whole, and that the DSM does not accommodate for problems such as this.

Furthermore, these authors found very little distinction between the Borderline and Histrionic diagnosis, and also found overlapping symptoms between the Narcissistic and Antisocial diagnoses (Shedler & Westen, 2004). This indicates that traits are present in these diagnoses that overlap the four separate PD categories, in the Cluster B group. But, that this is not acknowledged by the DSM-IV-TR which separates and minimises the flexibility of diagnostic criteria. If co morbidity on Axis II and overlap in traits is seen in adults, it is possible that this is also the case for this diagnosis in children and adolescents, and would explain the significant relation seen between symptoms of different Cluster B disorders in this study.

The notion that future revisions of the DSM needs to acknowledge levels of PD severity, so as to include patients who meet some but not all of the diagnostic criteria (Widiger & Louw, 2007), links to the finding of this study, where 90% of respondents felt that future revisions of the DSM should acknowledge personality pathology not severe enough for full diagnosis. This may correlate with the significance found in this study across the Borderline, Narcissistic and Antisocial groups, as personality pathology in children may not yet be entrenched, where patients may present with an array of Cluster B symptoms, as opposed to meeting the full criteria for one diagnosis, as has been found in adults.

This speaks to the findings of the Sosnovik (2008) and Card (2009) studies where professionals were more frequently noting a Cluster B diagnosis, than a specific PD diagnosis in adolescents. Card (2009) points out that the noting

of Cluster B, or “traits present”, is the acknowledgment by professionals of the developmental processes that may still be in play in this age group, which could prevent them from making a full PD diagnosis as personality is still likely to be fluid and susceptible to change.

The belief that personality is not yet crystallised has been discussed as a reason as to why professionals would not make this diagnosis in children and adolescents (Kernberg et al. 2000) and the findings of the overlap in symptomology in this research may be evidence of this. However, the findings of the Card (2009) and Sosnovik (2008) studies show that South African professionals are indicating in the case files of adolescents by noting Cluster B or “traits present / Emerging PD” (Card, 2009) that a personality pathology is embryonic, and this can be seen as a time in which the need for intervention is urgent. Thus, this broad notation, over that of a full PD diagnosis may indicate a compromise in professionals, between not wanting to make a full PD diagnosis in order to compensate for developmental processes still at work, yet, it indicates the need for intervention and points to the finding that PD diagnoses are not always clear cut in clinical practice.

The Post Hoc analysis conducted on whether the participants’ type of training (e.g. Clinical / Counselling / Educational Psychologist / Psychiatrist / Child Psychiatrist) influenced how participants responded to symptoms reflected the findings of international literature, that professionals are diagnosing PD’s similarly across training boundaries, and that no significant differences were evidenced (Westen, Arkowitz-Westen, 1998). This was also a finding of Russ et al., (2008) whose research showed that findings were unrelated to the types of training of professionals making the Narcissistic PD diagnosis.

Also seen in table 2 is the correlation between Practice and the Borderline child diagnosis. However, as far as the researcher can gather there is a dearth of literature available looking at how the number of years a professional has been in practice influences their endorsement of Personality Disorder symptoms. Thus, this is an area in need of further research.

CHAPTER 6:

CONCLUSION

The findings of this study evidence that a number of professionals feel that personality pathology can be seen in children and adolescents. This study did not asses whether these professionals are making a full PD diagnosis, but looked instead at what symptoms / traits they believe are evidence of personality pathology in children and adolescents. The results of this study show a hesitation among some South African professionals to look at this diagnosis in children, and found that respondents were more likely to note symptoms as present in adolescents than they were in children. Furthermore, respondents were also more likely to endorse individual symptoms than they were to endorse symptoms as overall Cluster B Traits.

More respondents answered the Borderline category, than both the Narcissistic or Antisocial categories and this may be evidence of a prevalence of the diagnosis of Borderline PD occurring in this age demographic more frequently than any other diagnosis. This finding correlates with studies already conducted in South Africa. In accordance with this, a higher number of the symptoms most frequently noted by respondents were from the DSM-IV-TR, which may also indicate its more frequent use in diagnosing Borderline patients than either Narcissistic or Antisocial categories. For the Narcissistic and Antisocial categories, Kernberg and Achenbach's symptoms respectively were more frequently used than the DSM-IV-TR symptoms.

In accordance with participants endorsement of a separate category for the diagnosis of children and adolescents, it can be seen that although the adult PD symptoms do have some relevance to PD diagnosis in children and adolescents, they cannot be applied entirely, and do need to draw from developmentally appropriate considerations as those put forward by Kernberg and Achenbach. This corroborates with research as discussed above, about the utility and applicability of the DSM-IV-TR, that although it can be used, criteria for the diagnosis of children and adolescents needs to be formulated.

6.1 Limitations of this study

Future research should try to access the sample to a greater extent in order to obtain a higher return rate as access to a larger portion of the sample population will allow results to be more accurately generalised to the population. Low response rates have affected this study, preventing the use of statistical tests and analyses that require a larger sample size. Also, the measurement instrument used in this study should have been used in a pilot study so that professionals could contribute to the symptoms that they feel are irrelevant and add those they felt were not present, before the survey was sent out. The fact that this questionnaire was constructed by the researcher is also a limitation to this study such as the double barrelled symptoms and questions should also be removed. Respondents may have also found the questionnaire lengthy.

6.2 Future Research:

Future research should consider gaining access to more hospitals, including those outside of the Gauteng Area, both Government and Private, and more conventions and meetings where the professionals that this research targets would be attending. It was also recommended to the researcher by a participant that Psychiatric Nurses be included in future research as it is believed they too have the appropriate professional experience and would add a valuable source of data. Further research of this kind should look at whether or not differences exist between gender and the symptomology profile of children and adolescents as well as how the number of years a professional has been in practice influences their use of the personality disorder diagnosis in this age demographic and in adults as well. Although this data was collected as part of this research, due to the limited scope and small sample size it could not be assessed in full. This research forms part of foundational research in this area in South Africa (Sosnovik, 2008; Card, 2009) and indicates that ongoing research and more collaboration is needed between professionals in this area to asses those symptoms that may be deemed developmentally appropriate.

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Annexure A

Email Based Questionnaires:

To Whom It May Concern

My name is Bronwynn Snelgar. I am a Clinical Psychology Masters Student at the University of The Witwatersrand and I am registered with the HPCSA as a student psychologist (PS S 0102466), and I have ethical clearance to conduct this study.

I am conducting my research on the opinions of South African psychologists' and psychiatrists' regarding Cluster B personality pathology symptomology in children and adolescents. This study follows research conducted that found a prevalence of personality pathology in the South African clinical adolescent population. This research hopes to identify what South African clinicians believe are the symptoms most frequently seen among children and adolescents with Cluster B personality pathology. There are no risks to you as this is only an assessment of opinion and your opinion will be kept anonymous. In instances where questionnaires are returned via email, the researcher will protect confidentiality and questionnaires will be printed and stored separately from respondents' emails which will be permanently deleted, to decrease any likelihood of questionnaires being linked to email addresses. This questionnaire is an online based survey, which also prevents questionnaires from being linked to respondents.

I would like to invite you to partake in this study by completing the attached questionnaire; your participation will be treated as confidential. Participation in this research is optional and you may withdraw at any time. This questionnaire is an internet based survey, and therefore you would need to complete this survey at one time and will not be able to complete it in part and then return to it later. If you have any problems accessing the survey please contact the researcher, and an email format questionnaire can be sent to you which you, and then you may complete it over a period of time. This questionnaire should take approximately 15 minutes to complete.

No consent form has been included with this questionnaire as it will be understood that with the completion and return of the questionnaire to the researcher, consent has been given by the potential participant, to the researcher to partake in this study.

This research project is to be submitted in partial fulfilment of the requirements for the degree of Masters of Arts in Clinical Psychology at the University of the Witwatersrand. A copy of this research report will be housed at the university after completion. Although you will not benefit directly from participating in this questionnaire, should you wish to receive a summary of the findings of this research once it is completed, please email the researcher requesting this.

My supervisor for this study is Ms Renate Gericke, a lecturer in the Wits Psychology Department. Her contact details are: (011) 717–4555 or email: renate.gericke@wits.ac.za

Instructions:

Please mark the appropriate column with a tick if you believe that the symptom is seen in "children / adolescent / male / female patients". Please mark as many columns as you feel are relevant per symptom. Please mark the "Cluster B" column with a tick if you believe that the symptom appears in a general Cluster B diagnosis rather than the specific disorder.

It is requested that you attempt to answer all the questions on the questionnaire as it is in the best interests of this research. However, you do have the right to not respond to questions that you do not wish to. You are under no obligation to partake in this study should you not want to.

Please follow this link to complete the questionnaire:

https://www.surveymonkey.com/s.aspx?sm=ZFR412mkkDprfvpAqvZVxg_3d_3d

Thank you for your time

Bronwynn Snelgar
Home: 011 463 1127
Cell: 082 341 8884
Email: brons@globalsense.co.za

Annexure B
Hand Delivered Questionnaire's – Hospital Staff

To Whom It May Concern

My name is Bronwynn Snelgar. I am a Clinical Psychology Masters Student at the University of The Witwatersrand and I am registered with the HPCSA as a student psychologist (PS S 0102466), and I have ethical clearance to conduct this study.

I am conducting my research on the opinions of South African psychologists' and psychiatrists' regarding Cluster B personality pathology symptomology in children and adolescents. This study follows research conducted that found a prevalence of personality pathology in the South African clinical adolescent population. This research hopes to identify what South African clinicians believe are the symptoms most frequently seen among children and adolescents with Cluster B personality pathology. There are no risks to you as this is only an assessment of opinion. Questionnaires will be delivered to the hospital in envelopes that you are required to seal once you have completed the questionnaire, and all completed questionnaires will be held with the utmost regard for confidentiality.

I would like to invite you to partake in this study by completing the attached questionnaire; your participation will be treated as confidential. Participation in this research is optional and you may withdraw at any time. If you are not able to complete the questionnaire now, please complete the questionnaire within two weeks of receipt and then email/phone the researcher to collect the questionnaire, or arrange a date for collection. Should you wish to complete this questionnaire via email instead, please contact the researcher and one will be sent to you.

A consent form has been included in this study, as due to the small numbers of psychologists and psychiatrists in Gauteng Hospitals, identification of participant responses may be possible, although identifying demographic data is not asked. All questionnaires will be held with the highest regard for confidentiality and all data will be kept in a locked cabinet at the researchers' home. Furthermore, no identifying data will be used at any point during the conducting or write up of this research. Although hospital staff could be more exposed to identification, only the researcher will see the questionnaires and enter them into the database and so no one else would be privy to them.

This research project is to be submitted in partial fulfilment of the requirements for the degree of Masters of Arts in Clinical Psychology at the University of the Witwatersrand. A copy of this research report will be housed at the university after completion. Although you will not benefit directly from participating in this questionnaire, should you wish to receive a summary of the findings of this research once it is completed, please make note of this in an email to the researcher.

My supervisor for this study is Ms Renate Gericke, a lecturer in the Wits Psychology Department. Her contact details are: (011) 717–4555 or email: renate.gericke@wits.ac.za

Instructions:

Please mark the appropriate column with a *tick* if you believe that the symptom is seen in *children* / *adolescent* / *male* / *female*. Please mark as many columns as you feel are relevant per symptom. Please mark the "Cluster B" column with a *tick* if you believe that the symptom appears in Cluster B disorders in general. This survey aims to assess what symptoms professionals may be seeing in both of these age groups and according to gender, and is not an assessment of whether a full personality disorder diagnosis is being made. If you have only seen some of the symptoms, or only feel able to answer one or two of the Borderline / Narcissistic / Antisocial categories, your input would still be appreciated.

It is requested that you attempt to answer all the questions on the questionnaire as it is in the best interests of this research. However, you do have the right to not respond to questions that you do not wish to. You are under no obligation to partake in this study should you not want to.

Thank you for your time

Bronwynn Snelgar
Home: 011 463 1127
Cell: 082 341 8884
Email: brons@globalsense.co.za

Annexure C

SA ACAPAP conference questionnaires

To Whom It May Concern

My name is Bronwynn Snelgar. I am a Clinical Psychology Masters Student at the University of The Witwatersrand and I am registered with the HPCSA as a student psychologist (PS S 0102466), and I have ethical clearance to conduct this study.

I am conducting my research on the opinions of South African psychologists' and psychiatrists' regarding Cluster B personality pathology symptomology in children and adolescents. This study follows research conducted that found a prevalence of personality pathology in the South African clinical adolescent population. This research hopes to identify what South African clinicians believe are the symptoms most frequently seen among children and adolescents with Cluster B personality pathology. There are no risks to you as this is only an assessment of opinion and your opinion will be kept anonymous.

I would like to invite you to partake in this study by completing the attached questionnaire; Participation in this research is optional and you may withdraw at any time. If you are not able to complete the questionnaire now, please contact the researcher and an email based survey will be sent to you.

No consent form has been included with this questionnaire as it will be understood that with the completion and return of the questionnaire to the researcher, consent has been given by the potential participant, to the researcher to partake in this study.

This research project is to be submitted in partial fulfilment of the requirements for the degree of Masters of Arts in Clinical Psychology at the University of the Witwatersrand. A copy of this research report will be housed at the university after completion. Although you will not benefit directly from participating in this questionnaire, should you wish to receive a summary of the findings of this research once it is completed, please make note of this one the last page of the questionnaire.

My supervisor for this study is Ms Renate Gericke, a lecturer in the Wits Psychology Department. Her contact details are: (011) 717–4555 or email: renate.gericke@wits.ac.za

Instructions:

Please mark the appropriate column with a *tick* if you believe that the symptom is seen in *children* / *adolescent* / *male* / *female*. Please mark as many columns as you feel are relevant per symptom. Please mark the "Cluster B" column with a *tick* if you believe that the symptom appears in Cluster B disorders in general.

This survey aims to assess what symptoms professionals may be seeing in both of these age groups and according to gender, and is not an assessment of whether a full personality disorder diagnosis is being made. If you have only seen some of the symptoms, or only feel able to answer one or two of the Borderline / Narcissistic / Antisocial categories, your input would still be appreciated.

It is requested that you attempt to answer all the questions on the questionnaire as it is in the best interests of this research. However, you do have the right to not respond to questions that you do not wish to. You are under no obligation to partake in this study should you not want to.

Please complete the questionnaire at any time before 13.00hrs on Wednesday the 8th of July and hand it in at the Registration Desk.

Thank you for your time

Bronwynn Snelgar
Home: 011 463 1127
Cell: 082 341 8884
Email: brons@globalsense.co.za

Annexure D

Hand Delivered Questionnaires (non hospital staff):

To Whom It May Concern

My name is Bronwynn Snelgar. I am a Clinical Psychology Masters Student at the University of The Witwatersrand and I am registered with the HPCSA as a student psychologist (PS S 0102466), and I have ethical clearance to conduct this study.

I am conducting my research on the opinions of South African psychologists' and psychiatrists' regarding Cluster B personality pathology symptomology in children and adolescents. This study follows research conducted that found a prevalence of personality pathology in the South African clinical adolescent population. This research hopes to identify what South African clinicians believe are the symptoms most frequently seen among children and adolescents with Cluster B personality pathology. There are no risks to you as this is only an assessment of opinion. Questionnaires will be delivered in envelopes that you are required to seal once you have completed the questionnaire, and all completed questionnaires will be held with the utmost regard for confidentiality.

I would like to invite you to partake in this study by completing the attached questionnaire; your participation will be treated as confidential. Participation in this research is optional and you may withdraw at any time. If you are not able to complete the questionnaire now, please complete the questionnaire within two weeks of receipt and then email/phone the researcher to collect the questionnaire. Should you wish to complete this questionnaire via email instead, please contact the researcher and one will be sent to you.

No consent form has been included with this questionnaire as it will be understood that with the completion and return of the questionnaire to the researcher, consent has been given by the potential participant, to the researcher to partake in this study.

This research project is to be submitted in partial fulfilment of the requirements for the degree of Masters of Arts in Clinical Psychology at the University of the Witwatersrand. A copy of this research report will be housed at the university after completion. Although you will not benefit directly from participating in this

questionnaire, should you wish to receive a summary of the findings of this research once it is completed, please make note of this in an email to the researcher.

My supervisor for this study is Ms Renate Gericke, a lecturer in the Wits Psychology Department. Her contact details are: (011) 717–4555 or email: renate.gericke@wits.ac.za

Instructions:

Please mark the appropriate column with a *tick* if you believe that the symptom is seen in *children* / *adolescent* / *male* / *female*. Please mark as many columns as you feel are relevant per symptom. Please mark the "Cluster B" column with a *tick* if you believe that the symptom appears in Cluster B disorders in general. This survey aims to assess what symptoms professionals may be seeing in both of these age groups and according to gender, and is not an assessment of whether a full personality disorder diagnosis is being made. If you have only seen some of the symptoms, or only feel able to answer one or two of the Borderline / Narcissistic / Antisocial categories, your input would still be appreciated.

It is requested that you attempt to answer all the questions on the questionnaire as it is in the best interests of this research. However, you do have the right to not respond to questions that you do not wish to. You are under no obligation to partake in this study should you not want to.

Thank you for your time

Bronwynn Snelgar
Home: 011 463 1127
Cell: 082 341 8884
Email: brons@globalsense.co.za

Annexure E

Participant Consent Form:

This consent form confirms that I have read and understood the scope of this study.
Additionally, it confirms that I have understood the terms of this study.

I _____ (respondent's name) consent to:

Participation in this study, entitled, "*Psychologists and Psychiatrists Opinions of Cluster B Personality Symptomology in Children and Adolescents"*

I understand that:

Filling out of the attached questionnaire is voluntary.
That I can withdraw from the study at any time.
That I may refrain from answering any questions I do not wish to answer.
That no risks or benefits are anticipated, for participation in this study.

Signature of Respondent_____

Signature of Researcher_____

Annexure F

Cluster B Personality Symptomology
in Children and Adolescents:

Participant Demographics

Please mark the appropriate box with an **"x":**

A) Professional Training:	
1) Clinical Psychologist	
2) Psychiatrist	
3) Child Psychiatrist	
4) Counselling Psychologist	
5) Educational Psychologist	

B) Area of Practice:	
1) Private	
2) Hospital	
3) NGO / NPO	

C) Number of years in practice:	
a) 1 – 5 years	
b) 5 – 10 year	
c) 10 – 15 years	
d) 15 years +	

D) Number of years clinical experience working with children:	
a) None	
b) 1 – 5 years	
c) 5 -10 years	
d) 10 – 15 years	
e) 15 years +	

Instructions:

Please mark the appropriate column with a *tick* if you believe that the symptom is seen in *children / adolescent / male / female*. You may mark as many columns as you feel are relevant per symptom. Please mark the "Cluster B" column with a *tick* if you believe that the symptom appears in Cluster B disorders in general. If you have only seen some of the symptoms, or only feel able to answer one or two of the Borderline / Narcissistic / Antisocial categories, your input would still be appreciated.

Symptom Please mark with an "X" in as many columns as you feels are relevant per symptom:	**Male**	**Female**	**Child** (0 – 11 years)	**Adolescent** (12 - 19 years)	**Cluster B**	**Not Applicable**
Borderline Symptoms						
Argues a lot						
Cruelty / Bullying or Meanness to others						
Deliberately harms self						
Destroys his/her own things						
Complains of loneliness						
Physically attacks others						
Screams a lot						
Obsessions						
Phobias						
Compulsions						
Hysterical traits						
Annihilation anxiety						
Oddities of motor functioning						
Withdrawn						
Clingy / Demanding						
Hyperactive						
Hallucinations						
Self centeredness						
Feelings of worthlessness / Helplessness						
Rapid shifts in ego functioning						
Alternating idealizing – devaluing relationships						
Identity disturbance						
Impulsivity						

Borderline Symptoms Cont.						
Symptom Please mark with an "X" in as many columns as you feels are relevant per symptom:	**Male**	**Female**	**Child** (0 – 11 years)	**Adolescent** (12 - 19 years)	**Cluster B**	**Not Applicable**
Fears abandonment						
Suicidal behaviour						
Affective instability						
Feelings of emptiness						
Anger problems						
Paranoid ideation						
Severe dissociative symptoms						
Other: (please fill in)						

Symptom Please mark with an "X" in as many columns as you feels are relevant per symptom:	**Male**	**Female**	**Child** (0 – 11 years)	**Adolescent** (12 - 19 years)	**Cluster B**	**Not Applicable**
<u>Narcissistic Symptoms</u>						
Bragging / Boasting						
Disobedient at home / school						
Feels she / he has to be perfect						
Showing off / Clowning						
Vulnerability in self esteem						
Inability to tolerate failure						
Extreme sensitivity to criticism						
Aloofness						
Lack of interest in others						
Feels unloved						
Gaze aversion						
Selective deafness						
Frequent complaints of boredom						
Sadistic or aggressive pleasure in the defeat of others						
Preoccupation with self image						
Excessive demands						
Separation Anxiety						
Grandiosity						
Believes they are unique						

Narcissistic Symptoms Cont.						
Symptom Please mark with an "X" in as many columns as you feels are relevant per symptom:	**Male**	**Female**	**Child** (0 – 11 years)	**Adolescent** (12 - 19 years)	**Cluster B**	**Not Applicable**
Fantasies of power / beauty / success/ ideal love / brilliance						
Exploitative						
Lacks empathy						
Envious of others / Believes others envy them						
Arrogant behaviour						
Need for admiration						
Sense of entitlement						
Other: (please fill in)						

Symptom Please mark with an "X" in as many columns as you feels are relevant per symptom:	**Male**	**Female**	**Child** (0 – 11 years)	**Adolescent** (12 - 19 years)	**Cluster B**	**Not Applicable**
<u>Antisocial Symptoms</u>						
Cruelty to animals						
Cruelty / Bullying or Meanness to others						
Destroys things belonging to self or others						
Sets fires						
Steals						
Threatens people						
Truancy						
Vandalism						
Explosive						
Parents experience fear of child						
Ruthlessness						
Doesn't experience feelings of guilt						
Intentional aggression						
Predatory behaviour						
Indifference / Dismissive to consequences of behaviour						
Calm affect						
Non empathetic to others						
Superficial charm						

Antisocial Symptoms Cont.						
Symptom Please mark with an "X" in as many columns as you feels are relevant per symptom:	**Male**	**Female**	**Child** (0 – 11 years)	**Adolescent** (12 - 19 years)	**Cluster B**	**Not Applicable**
Lack of personal investment in peer relationships						
Rapid flow of speech						
Manipulative						
Disregard for social norms						
Deceitfulness						
Impulsivity						
Irritability						
Aggressive – gets into fights						
Disregard for others safety						
Consistent irresponsibility						
Lacks remorse						
Other: (Please fill in)						

- Do you believe that a future revision of the DSM IV TR should include a separate category for the diagnosis of children and adolescents with personality disorders?

  Yes / No

Future revisions should:	Yes	No
1) Allow for a more malleable frame with regard to symptom duration, as opposed to a set, life long prognosis?		
3) Acknowledgment of personality pathology, not severe enough for PD diagnosis?		
4) Include criteria that make reference to Attachment Problems?		
5) Other:		
6)		
7)		

If yes please mark with an "X":

Comments:

Should you wish to receive a summary of the findings of this research once it has been completed please tick the box and write your email address below ☐

Thank you for taking the time to complete this survey

Kind Regards

Bronwynn Snelgar