OBJECTIVES

- To gain an appreciation of the controversy surrounding this topic
- To review ‘normal’ personality development
- To review the relevant research in the area of personality disorders in children and adolescents
- To highlight the implications of early identification
WHY IS THIS AN IMPORTANT DISCUSSION?

- Personality disorders are very common:
  - 14.8% adults >18yrs meet criteria for at least 1 personality disorder
  - 78% hospitalizations for PD are patients btwn age 15 & 44
- Aberrancies of personality occur in adolescents & young adults
  - Adult relationship skills developing, obtaining education, establishing careers, attempting to gain autonomy.
- Engaging in maladaptive behaviours during this stage has significant implications for the future

WHY IS THIS AN IMPORTANT DISCUSSION?

- Individuals with maladaptive personality styles often have co-morbid Axis I diagnoses:
  - substance abuse, anxiety disorder, mood disorder, eating disorder, and suicidal ideation and/or attempts
- ~50% of prisoners have ASPD
  - Associated behaviors (impulsivity, substance abuse) can lead to criminal activity
  - Diagnosis itself requires evidence of conduct disorder with onset < 15 yrs
- Significant social consequences associated with PD:
  - Domestic violence, child abuse & neglect (has implications for personality development), poor work performance, gambling
WHAT IS THE CONTROVERSY?

- DSM IV-TR defines personality disorders as
  “…enduring patterns of inner experience & behavior…
  the pattern is inflexible and pervasive… the pattern is of
  long and stable duration…”
- Clinicians often defer making diagnosis in adults to
  stigma attached to label
  - Difficult to treat
  - Chronic course
  - Sense of hopelessness
- Children and teens are engaged in dynamic
  developmental process
  - Body & personality changing, developing new ways to
    interact with environment on daily basis

WHAT IS THE CONTROVERSY?

- Difficult to comment on “…enduring patterns of inner
  experience…” when one views a child from this
  perspective
  - Some believe that personality has not yet crystallized in
    childhood and adolescent- this line of thinking would mean
    that a personality disorder could not exist

- Diagnosis implies severity and non-malleability.
  - PD label may adversely affect the child's (or
    her family's) self-concept
  - Label may haunt child in future by appearing somewhere in
    their personal record
WHAT IS THE CONTROVERSY?

- Questions to consider:
  - Do personality disorders exist in children and adolescents?
    - If the answer is yes, then resources should be directed at early intervention and treatment of personality pathology
    - Relieve suffering; prevention of future negative consequences
  - Do adult personality disorders originate in early childhood?
    - Again, if the answer is yes then research resources need to be allocated appropriately to study the process of personality development

PERSONALITY DEVELOPMENT

- Personality:
  - Dynamic and organized set of characteristics possessed by a person that uniquely influences their thoughts, motivations, and behaviors in different situations
  - The concept of personality refers to the profile of stable beliefs, moods, and behaviors that differentiate among children (and adults) who live in a particular society
  - Specific personality traits describe individual differences in behavior, emotion and cognition that result from the interaction between temperament and the environment
### PERSONALITY DEVELOPMENT

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Assumed Process</th>
<th>Primary Outcome</th>
<th>Theorist(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment</td>
<td>Emotional bond between infant and primary caregiver</td>
<td>Control of impulse, social habits, security, anger, frustration tolerance, trust in others, capacity for love</td>
<td>Bowlby, Ainsworth</td>
</tr>
<tr>
<td>Temperament</td>
<td>Behavioral style and characteristic way of responding to inherent physiological processes</td>
<td>Ease of arousal, ability to regulate emotions and impulses, energy, reaction to unfamiliar people and events, dominant mood</td>
<td>Thomas &amp; Chess</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>Conflict over sexual and hostile motives</td>
<td>Depression, defenses, phobias,</td>
<td>Freud, Erikson</td>
</tr>
<tr>
<td>Observed Behaviors</td>
<td>Acquired habits</td>
<td>Sociability, aggressive behavior, impulsivity, shyness, obedience</td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>Interpretations of experience, identification</td>
<td>Guilt, shame, anxiety and self confidence</td>
<td>Kohut</td>
</tr>
</tbody>
</table>

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**Influences on Personality Development:**

- **Biological/genetic-**
  - **Temperament**
    - **Easy:** adaptable, positive mood, regular routine
    - **Difficult:** reacts negatively, ++ cries, irregular routine, less adaptable
    - **Slow-to-warm up:** low activity level, negative, low adaptability, low mood intensity

*Three styles of temperament modulated by:*

- **Emotionality:** tendency to be distressed (arousal of sympathetic NS); ability to cope with fear and anger
- **Sociability:** tendency to prefer company of others vs being alone
- **Activity level:** tempo of the child (high energy vs placid)
PERSONALITY DEVELOPMENT

○ Influences on Personality Development:
  • Biological/Genetic-
    ○ Physical attributes of person
    ○ Position in family (ie: first born vs middle child vs youngest)
    ○ Medical illness
    ○ Family history of illness- physical and mental illness
    ○ Intelligence/cognitive capacity
  • Psychosocial-
    ○ Early attachment relations (2 parent family, single parent family, foster family, institutionalized care)
    ○ Parental socialization and Parental childhood experiences
    ○ Identification with parents
    ○ SES
    ○ Culture and religion
    ○ Peer relationships
    ○ Unpredictable experiences (death in family, abuse, relationships with others, divorce)

PERSONALITY DEVELOPMENT

○ Challenges in Personality Development:
  • Emotion Regulation:

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Reason &lt;5 yrs</th>
<th>Reason &gt;5 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear &amp; Anxiety</td>
<td>Unfamiliar Situations</td>
<td>Identification, school failure, peer rejection</td>
</tr>
<tr>
<td>Anger &amp; Resentment</td>
<td>Frustration &amp; punishment</td>
<td>Coercion, rejection, risk failure</td>
</tr>
<tr>
<td>Shame &amp; Guilt</td>
<td>Violation of parental standards</td>
<td>Failure to meet internalized standards</td>
</tr>
</tbody>
</table>
PERSONALITY DEVELOPMENT

Process of Personality Development:

<table>
<thead>
<tr>
<th>Process</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification</td>
<td>Expectation of success or failure, pride vs. shame</td>
</tr>
<tr>
<td>Ordinal Position</td>
<td>Attitude towards legitimate authority</td>
</tr>
<tr>
<td>Social Class</td>
<td>Feelings of entitlement and power vs. feeling of impotence and coercion</td>
</tr>
<tr>
<td>Parental Socializations</td>
<td>Values the child holds for achievement, honesty, tolerance to others, responsibility, loyalty, control of aggression, guilt over failure</td>
</tr>
</tbody>
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DEVELOPMENT OF PERSONALITY PATHOLOGY

Let’s focus on temperament for a moment:

- Biological basis
- Individual differences- ie: differences in emotion processing
- Personality emerges later than temperament AND includes wider range of individual differences

Childhood temperament and adult personality traits have much in common

- Both influenced by heredity & environment
- Traits in both characterized by positive & negative emotions
- Share similar hierarchical structure (Big Five)
DEVELOPMENT OF PERSONALITY
PATHOLOGY

Dimensions vs Categories

- Five factor model of personality traits
  - Higher order traits: Extraversion, Agreeableness, Conscientiousness, Neuroticism, & Openness
  - Each trait dimension has associated lower order traits
- DSM IV = categorical model of personality disorders
- Pathology may best be described as combination of adaptive & maladaptive traits
- Research has been able to link the dimensional five factor model with categorical model
- May be possible to describe normal traits and pathology in terms of one’s standing on the FFM

If this is the case for adults, what about children?

- Evidence for FFM structure of personality beginning in preschool yrs:
  1. Mervielde et al. (2005) & Widiger et al. (2005) provide evidence for a dimensional representation of childhood temperament and personality; found that ‘Big Five’ structure has been found in many factor analytic studies of personality questionnaires, Q sorts from parents/teachers + self reports from teens.
  2. Putnam et al. (2001) developed temperament questionnaires that yield traits similar to the ‘Big Five’ in preschoolers to early adolescence [Surgency (extraversion); Negative Affectivity (neuroticism); Effortful Control (conscientiousness); Affiliativeness (agreeableness)]
  3. Behavioral tasks & observational studies have illustrated traits similar to Big Five in children (Shiner, 1998)
DEVELOPMENT OF PERSONALITY PATHOLOGY

What does all this mean?

- IF ‘normal’ personality traits and ‘abnormal or pathological’ personality can be described in terms of the ‘Big Five’
- AND children and adolescent personality traits can also be described using a dimensional model
- AND child and adolescent traits appear to be similar to adult traits
- THEN there appears there is a direct link between early personality development and the development of pathology
- PLUS early personality difficulties could be understood in terms of ‘extreme’ standing on the FFM, as in adults

DEVELOPMENT OF PERSONALITY PATHOLOGY

Grounding the Big Five in Children & Adolescents:

- Extraversion:
  - Extraverted children- sociable, expressive, high-spirited, lively, energetic, socially potent
  - Introverted children- quiet, inhibited, lethargic
  - Lower order traits: Energy/Activity level & Sociability

- Neuroticism:
  - High- anxious, vulnerable, tense, guilt prone, moody, low frustration/stress tolerance, insecure in relationships
  - Low- laid back, adaptable in novel situations
  - Lower order traits: Fear, Anxiety & Sadness
DEVELOPMENT OF PERSONALITY PATHOLOGY

Grounding the Big Five in Children & Adolescents:

- Conscientiousness:
  - High- responsible, attentive, persistent, orderly, high standards
  - Low- irresponsible, unreliable, careless, distractible, give up easily
  - Lower order traits: attention, self control, achievement motivation, orderliness, responsibility

- Agreeableness:
  - High- considerate, empathic, generous, gentle, kind
  - Low- aggressive, rude, spiteful, stubborn, bossy, manipulative
  - Lower order traits: prosocial tendencies (helpfulness), antagonism, willfulness (bossy, overbearing), modesty, integrity

Openness to Experience:

- High- eager/quick to learn, knowledgeable, perceptive, imaginative, curious, original
- Low- not keen/slow to learn, insensitive, concrete, apathetic
- Lower order traits: intellect & curiosity, however research still underway to identify and verify these traits

Using the Five Factor Model- integrating the higher order (Big Five) and lower order traits- can help us to identify children at increased risk for a personality disorder
Does this mean that personality disorders can appear in childhood & adolescence?

- Potentially...
- Roberts & DelVecchio (2000) conducted a meta-analysis evaluating stability of temperament and personality traits across lifespan:
  - Individual differences show continuity in infancy & toddler yrs with a large increase in stability in preschool yrs
  - Personality moderately stable during childhood & early adolescence
  - Personality increase in stability from late teens through adulthood
  - Strong stability achieved around age 50

Johnson et al. (2000) conducted longitudinal study of 816 youth. Looked at age related change in personality disorder traits when sample was age 14 (1983), age 16 (1985/86), and 22 (1992)

- Similar findings as Roberts & DelVecchio (2000) in that personality disorder symptoms were moderately stable in adolescence and early adulthood
EPIDEMIOLOGY OF PD’S IN CHILDREN & ADOLESCENTS

- Most epidemiological research in PD’s does not include child and adolescent population
- Some researchers have specifically looked at the prevalence of PD’s in this population:
  - Golombek et al. (1986) - 46% of the 13-year-old children they evaluated met criteria for a DSM-III Axis II
  - Bernstein et al. (1993) – longitudinally followed 733 children 9-19yrs; when group had mean age 16.3 (range 11-21), 31.2% met criteria for a moderate personality disorder; 17.2% were at a severe level.

EPIDEMIOLOGY OF PD’S IN CHILDREN & ADOLESCENTS

- Bernstein et al. (1999) - same population, 3% had severe Borderline PD

- Several studies [Levy et al. (1999); Grilo et al. (1999); Becker et al. (2002)] have found prevalence of Borderline PD in inpatient adolescent population ranges from 43-53%
Weston et al. (2003 & 2005) looked at whether adolescents PD’s could be classified into adult clusters (A, B, C):

- Random sample of 296 clinicians
- Developed Q-sort instrument to look at factor structure of personality traits
- Concluded that adolescent personality pathology looks similar to adults

Concluded further that this was not optimal way of diagnosing adolescents:

- 5 non-overlapping PD’s and 1 personality style:
  - Antisocial-psychopathic dx
  - Emotionally dysregulated dx (like BPD)
  - Avoidant-constricted dx
  - Narcissistic Dx
  - Histrionic Dx
  - Self-critical personality style

- Prototypes shown to be predictive of adaptive functioning in adolescents, axis I illness, future PD, eating disorders, and QOL in adulthood
A BRIEF WORD ON PROGNOSIS

- Some studies have found that PD symptoms slowly decline over a lifetime
  - Reflective of normal development (↓ impusivity, ↓ dependence and ↑ social competence)
  - Implies that mild disorders may remit

- Earlier onset PD associated with more severe & chronic course
  - Severely disturbed individuals become increasingly different from peers as time progresses

A BRIEF WORD ON PROGNOSIS

- There is preliminary evidence to suggest early intervention is efficacious in preventing dysfunction later in life, there are several areas in which interventions could be applied:
  - Childhood personality traits shape their experiences including the way they perceive & select their environmental experiences; the way others respond to them; the way they respond to others
  - Personality acts as a predictor of success in developing meaningful interpersonal relationships, academic achievement, occupational achievement
  - The relative success a child achieves also acts to shape personality function
  - The relative success a child achieves is also dependent not only on their temperament and traits but also on the goodness of fit between the child and the environment
PRECURSORS OF PERSONALITY DISORDERS: GENERAL COMMENTS

- In general children are at increased risk of developing a personality disorder in adulthood when:
  - ↑ levels of family conflict
  - ↑ # comorbid Axis I illness’ (especially anxiety, childhood disruptive behavior disorder, substance abuse)
  - Any form of abuse increases risk of PD by up to 4x

PRECURSORS OF PERSONALITY DISORDERS: CLUSTER A DISORDERS

- Attachment Style:
  - Avoidant attachment w/ dismissive style + low anxiety and high avoidance
- Childhood Experiences:
  - Verbal abuse
  - Neglect
- Parental Behavior:
  - Harsh punishment or aversive parenting behavior
  - Low parental affection
- Axis I Disorders in Childhood:
  - Anxiety disorders found to substantially increase risk of cluster A disorder
  - Disruptive behavioral disorders increase risk as well
PRECURSORS OF PERSONALITY DISORDERS: CLUSTER B DISORDERS

- **Attachment Style**
  - Anxious attachment with high anxiety, low avoidance and aggression

- **Childhood Experience**
  - Physical, Verbal (narcissistic, borderline) and Sexual Abuse, Neglect
  - Physical abuse in particular associated with elevated risk of ASPD
  - Verbal/Emotional abuse can lead to internalization of abusive statements that inevitably alters the way a child interacts with others and develops relationships.

- **Parental Behavior**
  - High overall levels of problematic parenting
  - Low affection and nurturing

- **Axis I Disorders in Childhood**
  - ASPD requires existence of conduct disorder
  - Childhood depressive disorder elevates risk of PD
  - Disruptive behavior disorder increases risk of cluster B PD by up to 4x
  - Adolescent MDD significantly increase risk of ASPD & Histrionic PD
PRECURSORS OF PERSONALITY DISORDERS: CLUSTER B DISORDERS-
BORDERLINE PD

- DSM IV allows Borderline Personality Disorder to be diagnosed in adolescents:
  - Traits have been present for at least one year
  - Pervasive, persistent, not likely limited to developmental stage or part of an axis I disorder

PRECURSORS OF PERSONALITY DISORDERS: CLUSTER B DISORDERS-
NARCISSISTIC PD

- Specific hypothesized risk factors for Narcissistic PD include:
  - Narcissistic parents
  - Being adopted
  - Overindulged
  - Abuse
  - Parental divorce or death
  - Parental warmth, monitoring and psychological control are also associated with Narcissistic PD
PRECURSORS OF PERSONALITY DISORDERS: CLUSTER B DISORDERS - ANTISOCIAL PD

- Important due to potential social impact and it’s difficult to treat
- Specific risk factors include:
  - Callousness
  - Unemotional behavior
  - Marijuana use
- Only 1/3 of youth with conduct disorder progress to ASPD
  - 80-90% of adults with ASPD meet criteria for conduct disorder during adolescence

PRECURSORS OF PERSONALITY DISORDERS: CLUSTER C DISORDERS

- Attachment
  - Anxious attachment
  - Preoccupied attachment style with high anxiety and low avoidance
- Childhood Experiences
  - Physical abuse and neglect (dependent pd)
  - Verbal abuse (OCPD)
- Parental Behavior
  - High overall levels of problematic parenting associated with increase risk development of any PD
  - No specific parenting style associated with Cluster C PD
PRECURSORS OF PERSONALITY DISORDERS: CLUSTER C DISORDERS

- **Axis I Disorders**
  - Childhood anxiety and depressive disorders (increases odds of cluster C disorder 6-8x)
- **Specific childhood associations in adults with Avoidant PD:**
  - Less athletic
  - Fewer extracurricular activities
  - Fewer hobbies
  - Fewer leadership roles
  - Less popular

TAKE HOME POINTS

- Personality development is a dynamic and complex process that involves the interaction between one’s genetic make up and one’s social environment

- Personality can be understood in terms of temperament and traits; it likely has a hierarchical structure that is composed of higher order traits (the Big Five) and several lower order traits; there is evidence to support that childhood, adolescent, and adult personality structure is similar
TAKE HOME POINTS

- Personality starts to stabilize in early childhood
- Personality disorders have precursors in childhood
- Personality disorders are likely diagnosable in childhood
- Early identification and diagnosis provides us with the opportunity to intervene, via pharmacologic or psychosocial means, to enhance and/or instill:
  - Coping skills, resiliency, sense of self worth
  - Family relationships
  - Academic achievement

OBJECTIVES REVISITED

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