informa
healthcare

Exposure to teacher bullying in schools: A study of patients with personality disorders

TORIL MONSVOLD, MONS BENDIXEN, ROGER HAGEN, ANNE-SOFIE HELVIK

Monsvold T, Bendixen M, Hagen R, Helvik A-S. Exposure to teacher bullying in schools: A study of patients with personality disorders. Nord J Psychiatry 2011;65:323–329.

Background: The aim of this study was to examine the level and affect of exposure to teacher bullying in primary and secondary schools on patients with personality disorders (PD). *Method:* The study group contained 116 people (18–60 years old); 49 patients diagnosed with PD undergoing psychiatric treatment in 10 different psychiatric outpatient clinics in the Southern and Middle part of Norway, and a control group consisting of 67 people who worked in an institution for somatic/elderly people and an institution for people with drug/alcohol dependency in the Middle part of Norway. All study participants filled out a self-report questionnaire, which included demographic data, one item about whether they have been bullied by one or several teachers, and 28 items regarding subjection to negative acts from teachers based on the Negative Acts Questionnaire -Revised (NAQ-R). *Results:* Patients diagnosed with PD reported significantly more bullying by teachers in both primary school (OR 7.3; 95% CI 1.9–27.7) and secondary school (OR 5.8; 95% CI 1.1–30.5) than healthy controls. Patients with PD also reported a higher prevalence of negative acts from teachers than healthy controls in both primary and secondary schools, such as differential treatment, ridicule, humiliation, and being ignored or neglected at least once weekly. *Conclusion:* Our findings indicate a correlation between bullying from teachers, as reported by PD patients, and the development of PD in adulthood. The problem of teacher bullying deserves more attention with regard to this possible correlation between student victimization and the development of PD.

• *Clinical, Personality disorders, Self-reports, Teacher bullying, Victimization.*

Toril Monsvold, St. Olav's Hospital University, Trondheim, NO-7441 Trondheim, Norway, E-mail: Toril.Monsvold@stolav.no; Accepted 7 December 2010.

Research has indicated an association between bullied in school and the development of psychiatric disorders in adult psychiatric patients (1). Specifically, it has been hypothesized that children who have been systematically exposed to social exclusion or isolation run a higher risk of developing abnormal personality traits (2). Bullying is commonly defined as when a person is repeatedly exposed to unpleasant, hurtful or degrading treatment, and when those negative actions persist over a long period. A central characteristic of bullying is the real or perceived power imbalance between the bully and victim (3, 4). A victim is defined as someone who is systematically exposed to negative acts over time, producing feelings of vulnerability and defencelessness (5). Two main groups of children have been identified as potential victims of bullying: 1) the passive or submissive victim, who usually is quiet, careful, sensitive and has poor self-confidence (i.e. negative self-image) (6, 7), and 2) the provocative victim, who is more prone to retaliate, has low frustration tolerance, is impulsive, hyperactive and is generally considered to be difficult. Because of this behaviour, he or she is often disliked by adults—teachers included (6, 7). Teacher bullying is defined as when a teacher uses his or her power to punish, manipulate or disparage a student beyond what would be considered reasonable disciplinary procedures (8). This definition also includes repeatedly unpleasant and hurtful things said or done by the teacher (4).

Awareness that some teachers in fact bully students began to grow during the 1990s (7). Furthermore, investigations have shown that teachers bully students in both primary and in secondary school (4, 7–15). A pioneering study by Olweus (4) was conducted in 1985 on 2400 Grades 6–9 students enrolled in primary schools in Bergen, Norway. In this 5-month study, 2% of the students were identified as having been bullied by a teacher (4, 7). A similar study of 5472 Grade 4–6 students enrolled in primary schools in Israel, found that 29.1% reported being emotionally maltreated by a staff member, and 22.2% reported being victims of at least one type of physical

DOI: 10.3109/08039488.2010.546881

maltreatment (9). Another Israeli study of 10,410 secondary school students found that 24.9% of the children reported being emotional maltreated by a staff member, 13.0% reported being a victim of at least one type of physical form of maltreatment, and 8.2% reported the occurrence of at least one sexually inappropriate behaviour by a staff member (10). Teacher bullying was defined in this study as emotional, physical and sexual victimization of students (10).

Exposure to peer bullying in childhood is associated with a number of adverse outcomes, ranging from anxiety and depression, poor social integration and increased levels of alienation, to low self-esteem, and even suicidal thoughts and actions (16). In addition, being bullied by peers is correlated with psychotic symptoms and psychotic-like experiences in cross-sectional (17, 18), as well as in prospective studies (19). Moreover, indirect bullying, such as social exclusion, relationship manipulations and rumour spreading, was even more strongly associated with many of these outcomes. Similarly, subjection to teacher bullying is reported to increase the risk of physical, psychiatric and social problems (9–13), including poor self-esteem (4, 9–14) and suicidal tendencies (11, 13, 14). In fact, negative acts from teachers seem to have a particularly adverse impact (9). In particular, because they are largely stressful experiences (4, 7), they may have traumatic effects on the development of a child's psychological health and well-being (12). Similarly to peer bullying, indirect teacher bullying had an even higher impact on the development of depression than direct bullying, which was explained by the less visible nature of indirect teacher bullying, which is thus more difficult to prove (20). The prospective Israeli studies found that children who reported to be victimized by their teachers through ridicule, isolation, verbal discrimination, physical assault and sexual harassment were more likely to develop problems in school, such as aggressive behaviour, fearful reactions, somatic complaints, dependency, regression and even flashbacks of the trauma inflicted by the teacher (9, 10).

It has been proposed that children who develop personality disorders (PD) have behavioural patterns that make them more susceptible to being bullied (2). The first signs of PD usually emerge in childhood and continue through adolescence into adulthood (2, 21). PD-associated behavioural patterns that are apparent by the end of primary school include aggressiveness, inflexible coping strategies and instability that may progress into subsequent disorders, such as depression, drug use and antisocial behaviour (22). PD are expected to have a serious impact on a person's life, both at school, work, and with respect to social interactions and cognitive and emotional function (22). In fact, most patients with PD seek treatment not for their personality difficulties, but for symptomatic suffering (23).

In summary, being bullied by peers or teachers during childhood is consistently associated with a number of social and psychiatric problems. Although it has been suggested that being bullied during childhood may be associated with PD, the possible link between bullying, victimization and PD has, to our knowledge, not been subject to empirical study. As a consequence, the possible mechanisms linking bully victimization to PD are poorly understood. Thus, in this study, we are first to investigate the level of exposure to teacher bullying in primary and secondary school among adult patients diagnosed with PD. Specifically, we aim to examine the following:

1) Do patients with PD report a higher prevalence of being bullied by teachers in primary and secondary school compared with healthy controls?
2) Do patients with PD report being subjected to a greater number of negative acts from teachers in primary and secondary school compared with healthy controls?
3) What is the prevalence of teacher bullying in primary and secondary schools among different groups of patients with PD and among patients with co-morbid psychiatric disorders?

Methods

Subjects

Study participants were asked to report, retrospectively, on their experiences (if any) with bullying by teachers in primary school and/or secondary school.

The study invited 104 patients who were diagnosed with PD, and were receiving psychiatric treatment at psychiatric outpatient clinics in the Southern and Middle part of Norway. Patients diagnosed with psychosis, bipolar disorder, and alcohol or drug abuse were excluded from treatment at these psychiatric outpatient clinics, as well as those under 18 years of age and over 60 years of age. Of those invited, 70 patients (67.3%) replied, and of these, 49 (36 women and 13 men) who were diagnosed with PD as their main diagnosis were included in the study. The mean ($\pm$ standard deviation, s) age of the study group was 35.5 $\pm$ 8.6 years.

Individuals in the healthy control group worked either in an institution for elderly people or in an institution for alcohol or drug abuse patients in the middle part of Norway. In total, 100 control participants were invited, 21 did not respond and 12 were excluded because they exceeded the age limit of 60 years. The final control group included in this study consisted of 67 individuals (53 women and 14 men) with a mean age of 43.4 $\pm$ 10.3 years.

Procedures

The project description information was sent to eight psychiatric outpatient clinics, specializing in the treatment

of patients with PD, and two psychiatric clinics for adolescents (Psychiatric Youth Teams and their therapists). The patients who met the inclusion criteria agreed to participate in the study, signed an informed consent form permitting their data to be stored anonymously for research purposes and were included in the present study by their therapists. In the present study, diagnoses were based on the ICD-10 diagnostic system (21) and a questionnaire filled in by the therapists.

Diagnoses followed the standardized system used by the psychiatric outpatients clinics (24, 25), and were assessed by a Mini International Neuropsychiatric Interview (MINI) (26) and the Structured Clinical Interview for DSM-IV (SCID-II) (27), psychosocial functioning: Global Assessment of Functioning Scale (GAF) (28), the Symptom Distress Symptom Check List-90-Revised (SCL-90-R) (29) and interpersonal problems: Circumplex of Interpersonal Problems (CIP) (30). The control group participants were invited through their employers and were not matched. In this study, control group participants are referred to as healthy controls. Data was collected in 2003/2004. The project was approved by the Regional Ethic Committee for Research (REK), Norway.

Measurements

Following Olweus' suggestions (4) on how to identify victims of bullying, the subjects in this study were asked two introductory questions about their exposure to teacher bullying in primary school (grades 1–10) and in secondary school (grades 11–13). The response categories were "not bullied by any teacher", "bullied by one teacher" and "bullied by several teachers". Neither a description of bullying acts nor a definition of bullying was provided to the respondents. Hence, study participant responses were based solely on subjective self-nomination.

The Negative Acts Questionnaire—Revised (NAQ-R), a self-reporting questionnaire, was developed to measure bullying in the work place (3). In this study, the standard NAQ-R was adapted to fit the educational system and to assess 28 concrete, negative acts from teachers (i.e. bullying acts). Each statement had five response categories: "never", "now and then", "monthly", "weekly" and "daily". Identical questions concerning teacher bullying were asked for both primary and secondary school.

The original NAQ-R has been used in national and international research studies (3, 31, 32), and evaluated to be satisfactorily reliable and valid (3, 32), with high internal consistency (Cronbach's alpha values in the 0.87–0.93 range) (3). In the present study, using an NAQ-R adapted for the school setting, assessment of teacher bullying resulted in a Cronbach's alpha value of 0.97 for primary school and 0.95 for secondary school.

Study participant responses had to meet two criteria to be defined as exposure to teacher bullying: 1) they answered "yes" to the introductory question, "bullied by teachers", and 2) reported "weekly" or "daily" for at least one of the 28 negative acts (32).

Statistical analysis

Data was recorded in SPSS 14.0. Differences in sample characteristics were identified by Pearson's chi-square statistics.

General questions about bullying by teacher(s) and weekly or daily subjection to negative acts from teachers, were dichotomized to "bullied by teacher" (1) and "not bullied by teacher" (0), for both primary school and secondary school, and were first presented with proportions. Data were further analysed using Pearson's chi-square, Fisher's Exact test and odds ratio.

Results

Bivariate analyses were carried out to compare patients with PD with the healthy controls.

Gender distribution was about the same between the two subsamples (Table 1). However, patients with PD had statistically significantly less education than the healthy controls ($P = 0.006$). Furthermore, a large percentage, 42/49 (85.7%), of the PD patients were unemployed. Clinically, a majority of the PD study participants were diagnosed with ICD-10 as having Avoidance PD (32.7%) and Emotional instability (Borderline) PD (26.5%).

Table 1. Socio-demographics of the study sample and personality disorders (PD) diagnosis in patients with PD.

	PD		Healthy controls		Pearson's χ^2		
	n	%	*n*	%	$\chi 2$	df	*P*
Total sample	49	40.2	67	59.8			
Gender					0.503	1	ns
Women	36	73.5	53	79.1			
Men	13	26.5	14	20.9			
Highest education					10.250	2	0.006
Primary school	11	22.4	4	6.0			
Secondary school	26	53.1	31	46.3			
University	12	24.5	32	47.8			
Living					2.862	1	ns
Lives alone	18	36.7	15	22.4			
Lives with family/other	31	63.3	52	77.6			
Employment							
Employed	7	14.3	67	100.0			
Unemployed	42	85.7					
Specific and not otherwise specified PD in ICD-10*							
Paranoid PD	4	8.2					
Emotionally unstable (borderline) PD	13	26.5					
Obsessive–compulsive PD	5	10.2					
Avoidant PD	16	32.7					
Dependent PD	4	8.2					
Not otherwise specified PD/other	7	14.1					

*PD diagnoses that did not appear in the clinical sample were: schizoid PD, dissocial PD, dramatized PD, other specific PD; ns, not significant.

As shown in Table 2, both PD patients and healthy controls were exposed to teacher bullying weekly or daily in both primary and secondary school. However, PD patients reported statistically significantly more weekly or daily teacher bullying, both in primary school, $\chi^2 = 10.72$, $P < 0.01$ (OR = 7.3; 95% CI 1.9–27.7), and in secondary school, $\chi^2 = 5.26$, $P < 0.05$ (OR = 5.8; 95% CI 1.1–30.5), than the healthy controls.

As shown in Table 3, PD patients participating in this study were more likely to have been exposed to weekly or daily negative acts from teachers in primary school than healthy controls. The following negative acts were most frequently reported by PD patients to have occurred weekly or daily in both primary and secondary school: being treated differently from other students, being ridiculed or humiliated in connection with their education, and being ignored or neglected by their teachers. In secondary school, PD patients reported that they were ridiculed or humiliated in connection to their education "weekly or more often", whereas none of the healthy control subjects experienced these negative acts ($P = 0.006$, with Fisher's Exact test).

As shown in Table 4, 40/49 (81.6%) of the PD patients were also diagnosed with co-morbid psychiatric disorders such as anxiety or depression, affective disorders with anxiety and depression, or other psychiatric disorders, such as eating disorders, behavioural disorders or post-traumatic stress disorder (PTSD). Patients diagnosed with both PD and co-morbid affective disorders with anxiety and depression reported the highest frequency of teacher bullying in both primary 6/47 (12.8%) and secondary school, 2/37 (5.4%). In contrast, *none* of the PD patients diagnosed with co-morbid anxiety disorders reported teacher bullying in primary or secondary school. In addition, of the PD patients *without* co-morbid psychiatric disorders, none (0/9) reported teacher bullying in primary school, and only one of those that attended secondary school (1/6) experienced teacher bullying.

Discussion

In this study, significantly more PD patients reported that they were subjected to frequent ("weekly or more") teacher bullying in both primary and secondary school than healthy controls. In addition, a larger proportion of the PD patients lacked higher education. Furthermore, the odds of having been exposed to negative acts from teachers, such as being treated differently from other students, being ridiculed, humiliated, ignored or neglected, were significantly higher for PD patients than healthy controls. Notably, PD patients diagnosed with co-morbid psychiatric disorders reported being bullied by a teacher in primary and secondary school more frequently than PD patients without co-morbid psychiatric disorders.

Results from this study support previous findings that suggest that teacher bullying represents a problem in both primary and secondary schools (4, 7–14, 29), and that teacher bullying is more prevalent in primary schools (9, 10). The reduction of teacher bullying in secondary school has been proposed to be related to children's development; in secondary school, children are older and better able to protect themselves from teachers, both verbally and physically, and are thus less likely to feel victimized by their teachers (9, 10). The most frequently reported negative acts by the PD patients participating in this study, both in primary and secondary school, were being treated differently from other students, being humiliated or ridiculed in the classroom, and being ignored and/or neglected by their teachers.

The results of this study indicate that patients with PD seem to have had more adverse experiences during their school years than healthy controls. The literature suggests that PD patients who seek treatment often present with

Table 2. Reported exposure to weekly/daily general teacher bullying in primary and secondary school.

	PD*		Healthy controls†		Pearson's	Fisher's Ex. Sig.	
	n	%	*n*	%	χ^2	*P*	OR (95% CI)
Primary school (*n*‡ = 114)							
Yes	12	25.5	3	4.5			
No	35	74.5	64	95.5			
Total	47§	100.0	67	100.0	10.72	<0.01	7.3 (1.9–27.7)
Secondary school (*n*‡ = 99)							
Yes	6	16.2	2	3.2			
No	31	83.8	60	96.8			
Total‡	37§	100.0	62	100.0	5.26	<0.05	5.8 (1.1–30.5)

PD, personality disorders.
*Total 11/49 patients with PD reported not attending secondary school.
†Total 5/67 healthy controls reported not attending secondary school.
‡Total sample who answered the question of teacher bullying weekly/daily in primary and secondary school.
§Incomplete information about teacher bullying experiences from 2/49 patients with PD for primary school and 1/38 for secondary school.

Table 3. The most prevalent negative acts from teachers that patients with personality disorders (PD) experienced most frequently in primary and secondary school, compared with the healthy controls.

	PD*, weekly/daily		Healthy controls†, weekly/daily		Fisher's, Ex. Sig.	
Negative acts experienced from teachers	*n*	%	*n*	%	*P*	OR (95% CI)
Primary school‡						
Treated differently from other students	11	40.7	3	7.5	0.002	8.5 (2.1–34.6)
Being ridiculed or humiliated	10	35.7	3	7.9	0.010	6.5 (1.6–26.5)
Being ignored/neglected	9	33.3	2	5.1	0.005	9.3 (1.8–47.3)
Unacceptable verbal treatment	9	33.3	1	2.6	0.001	19 (2.2–161.6)
Secondary school§						
Being ridiculed or humiliated	5	25.0	0	0.0	0.006	Infinity
Treated differently from other students	5	25.0	2	6.1	ns	5.2 (0.9–29.8)
Opinions neglected	4	21.1	1	3.0	ns	8.5 (0.9–83.1)
Being ignored/neglected	4	20.0	1	3.0	ns	8 (0.8–77.6)

*Patients with PD who answered the questions about experienced negative acts from teachers weekly/daily out of the total sample of 49 with primary school and 38 with secondary school.
†Healthy controls who answered the questions about experienced negative acts from teachers weekly/daily out of the total sample of 67 with primary school and 62 with secondary school.
‡In primary school, 27–31 of 49 patients with PD, and 38–40 of 67 healthy controls, answered the questions about negative acts from teachers.
§In secondary school, 18–20 of 38 patients with PD, and 31–33 of 62 healthy controls, answered the questions about negative acts from teachers.
ns, not significant.

wide-ranging problems associated with education, work, economics, living and family (2, 23). Our findings that a larger proportion of PD patients lack higher education are supported by other studies in the literature. For example, it has been reported that PD patients seldom complete education beyond the compulsory school years and have more problems maintaining permanent job positions (2, 23). Furthermore, one study has reported that teacher bullying can have a negative effect on the ability of students to progress academically (33).

Table 4. Prevalence of reported teacher bullying among patients with PD co-morbid with psychiatric disorders in primary and secondary school.

	Not bullied		Bullied	
PD co-morbid with psychiatric disorders	*n*	%	*n*	%
The clinical sample with primary school (*n** = 47)				
PD/NOS	9	19.1	0	0.0
PD co-morbid with anxiety	5	10.7	0	0.0
PD co-morbid with depression	8	17.0	2	4.2
PD co-morbid with affective disorders, anxiety, depression	7	14.9	6	12.8
PD co-morbid with other psychiatric disorders	6	12.8	4	8.5
Total	35	74.5	12	25.5
The clinical sample with secondary school (*n*† = 37)				
PD/NOS	6	16.2	1	2.7
PD co-morbid with anxiety	4	10.8	0	0.0
PD co-morbid with depression	9	24.3	1	2.7
PD co-morbid with affective disorders, anxiety, depression	7	18.9	2	5.4
PD co-morbid with other psychiatric disorders	5	13.6	2	5.4
Total	31	83.8	6	16.2

*2/49 missing information about teacher bullying in primary school (one patient with PD and depression and one patient with PD and affective disorders).
†1/38 missing information about teacher bullying in secondary school (one patient with affective disorders).

Interestingly, in this study, nearly all PD patients who reported teacher bullying had co-morbid psychiatric disorders. A comparison of the prevalence of teacher bullying among PD patients with co-morbid problems shows that PD patients with a mix of co-morbid anxiety and depression disorders reported the highest prevalence of teacher bullying both in primary and secondary school. This data suggests that the experience of being bullied by a teacher could put additional strain on persons susceptible to developing personality disorder pathologies.

It is well known that a small proportion of children identified as victims of bullying seem to have more provocative rather than submissive personalities (6). Because persons with PD can often have trouble regulating their emotions, even as early as primary school (22), they could be more prone to teacher bullying. It is possible that the causal process correlating PD with teacher bullying is similar to the so-called "child effect", in that disruptive behaviour and emotional instability in children (who later are diagnosed with PD) provokes negative teacher reactions that could be reported as bullying later in life. However, because of the retrospective nature of this study, we did not have the opportunity to explore these underlying mechanisms.

Limitations and future directions

The most serious limitations of the use of a retrospective study design are with respect to the interpretation of causality.

It is possible that bullying is an important risk factor in the development of PD. However, strong inferences cannot be drawn, because we did not control for any other adverse childhood experiences, such as peer bullying and punitive or neglective parenting, which could also be associated with the development of PD. In addition, patients undergoing treatment for PD may have easier access to instances of negative encounters in their memory compared with healthy controls, resulting in recall bias (34). This recall bias could therefore have caused the observed group differences in reported bullying. Also, in the search for a coherent narrative to explain their difficult situations, PD patients could have reported teacher bullying more than their healthy controls. Finally, this study did not assess when the bullying took place, or to what extent respondents were bullied. This lack of grading may have produced less than ideal measurements of bullying for studying victimization–PD associations.

Despite these limitations, this study has several strengths. First, we have no reason to believe that the PD diagnoses are invalid, as the psychiatric outpatient clinics who participated in this study use structured diagnostic interviews. Second, this study is, to our knowledge, the first to examine PD patients' self-reported teacher bullying and negative acts from teachers in schools. PD seems to be associated with childhood traumatic experience(s) (24), and being exposed to negative acts from teachers in school may be one of these (35). The present study indicates that teacher bullying is much more prevalent among patients with PD than in healthy controls, and that being bullied by teachers might have adverse consequences of various kind as now shown in a number of studies. Future studies using prospective data and controlling for the possibility of third variables, such as exposure to peer bullying and to adverse parenting, should be able to address some of the limitations in this study on how teacher bullying affects the development of personality disorder pathology.

Acknowledgements—We wish to thank the patients and staff at the outpatients clinics at the Norwegian Network of Psychotherapeutic Day Hospitals, the Psychiatric Youth Teams (PUT) in Nord-Trøndelag and Sør-Trøndelag, the healthy people and staff at the institution for elderly people and at the institution for people with drugs and alcohol abuse.

We also wish to thank Professor Ståle Einarsen, UiB, Bergen, Terje Aursand, Lade Treatment Center, MD Ph.D./associate Professor Gunnar Morken and chef psychiatrist Erling Bakken and colleagues, St. Olav's Hospital University, Department of Østmarka; and Forskningsutvalget ved St. Olav's Hospital University for financial support.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

1. Fosse GK. Mental health of psychiatric outpatients bullied in childhood. Thesis for the degree of doctor medicinae. NTNU, Trondheim, November 2006.
2. Malt UF, Rettersdøl N, Dahl AA. Lærebok i psykiatri. Gyldendal Norsk Forlag AS; 2005.
3. Einarsen S, Hoel H. The Negative Acts Questionnaire: Development, validation and revision of a measure of bullying at work. Paper presented at the 10th European Congress on Work and Organisational Psychology, Prague, May 2001.
4. Olweus D. Mobbing av elever fra lærere. Bergen: Alma Mater Forlag A/S; 1996.
5. Einarsen S, Raknes BI, Matthiesen SB, Hellesøy OH. Mobbing og harde personkonflikter. Helsefarlig samspill på arbeidsplassen. Oslo: Sigma Forlag A.S; 1995.
6. Olweus D, Solberg C. Mobbing blant barn og unge. Informasjon og Veiledning til foreldre. Oslo: Pedagogisk Forum; 1997.
7. Smith PK, Morita Y, Junger-Tas J, Olweus D, Catalano R, Slee P. The nature of school bullying. A cross-national perspective. London: Routledge; 1999.
8. Twemlow SW, Fonagy P. The prevalence of teachers who bully students in schools with differing levels of behavioural problems. Am. J. Psychiatry 2005;162:2387–9.
9. Benbenisty R, Zeira A, Astor AR, Khouri-Kassabri M. Maltreatment of primary school students by educational staff in Israel. Child Abuse Negl 2002;26:1291–309.
10. Benbenisty R, Zeira A, Astor AR., Children's reports of emotional, physical and sexual maltreatment by educational staff in Israel. Child Abuse Negl 2002;26:763–82.
11. Delfabbro P, Winefield T, Trainor S, Dollard M, Anderson S, Metzer J, et al. Peer and teacher bullying/victimization of South Australian secondary school students: Prevalence and psychosocial profiles. Br J Educ Psychol 2006;76:71–90.
12. Shumba A. The nature, extent and effects of emotional abuse on primary school pupils by teachers in Zimbabwe. Child Abuse Negl 2002;26:783–91.
13. Twemlow SW, Fonagy P, Sacco FC, Brethour JR Jr. Teachers who bully students: A hidden trauma. Int J Soc Psychiatry 2006;52: 187–98.
14. Chapell M, Casey D, De la Cruz C, Ferrell J, Forman J, Lipkin R, et al. Bullying in college by students and teachers. Adolescence 2004;39:53–64.
15. Hepburn A. Power lines: Derrida, discursive psychology and management of accucations of teacher bullying. Br J Soc Psychol 2000; 39:605–28.
16. Vatn, AS, Bjertness, EP, Lien, L. Mobbing og helseplager hos barn og ungdom. Tidsskr Nor Laegeforen 2008;127:1941–4.
17. Campbell, MLC, Morrison AP. The relationship between bullying, psychotic-like experiences and appraisals in 14–16-year olds. Behav Res Ther 2007;45:1579–91.
18. Kelleher I, Harley M, Arseneault CF, Cannon M. Associations between childhood trauma, bullying and psychotic symptoms among a school-based adolescent sample. Br J Psychiatry 2008;193:378–82.
19. Schreier A, Wolke D, Thomas K, Horwood J, Hollis C, Gunnell D, et al. Prospective study of peer victimization in childhood and psychotic symptoms in a nonclinical population at age 12 years. Arch Gen Psychiatry 2009;66:527–36.
20. Wal van der MF, Wit de, CAM, Hirasing RA. Psychosocial health among young victims and offenders of direct and indirect bullying. Pediatrics 2003;111:1312–17.
21. World Health Organization ICD-10. Psykiske lidelser og atferdsforstyrrelser.Kliniske beskrivelser og diagnostiske retningslinjer. Oslo: Gyldendal Norsk Forlag A/S; 2000.
22. Kernberg PF, Weiner AS, Bardenstein KK. Personality disorders in children and adolescents. New York: Basic Books; 2000.
23. Norèn K, Lindgren A, Hällström T, Thormählen B, Vinnars B, Wennberg et al. Psychological distress and functional impairment in patients with personality disorders. Nord J Psychiatr 2007;61: 260–70.
24. Karterud S, Urnes Ø, Pedersen G. Personlighetsforstyrrelser. Forståelse, evaluering, kombinert gruppebehandling. Oslo: Pax Forlag A/S; 2001.

25. Karterud S, Arefjord N, Andersen NA, Pedersen G. Substance use disorders among personality disordered patients admitted for day hospital treatment. Implications for service developments. Nord J Psychiatr 2009;63:57–63.
26. Sheehan DV, Lecrubier Y. Mini International Neuropsychiatric Interview (M.I.N.I.). Tampa, FL/Paris: University of South Florida Institute for Research in Psychiatry/INSERM-Hospital de la Salpetriere; 1994.
27. First M. Structured Clinical Interview for DSM-IV (version 2.0). New York: New York State Psychiatric Institute; 1994.
28. American Psychiatric Association. Global Assessment of Functioning (GAF) Scale. Diagnostic and statistical manual of mental disorders, 4th edition. Washington, DC: American Psychiatric Association; 1994.
29. Derogatis LR. SCL-90-R. Manual: Administration, scoring & procedures. Baltimore, MD: Clinical Psychometric Research; 1983.
30. Pedersen G. Norsk revidert versjon av Inventory of Interpersonal Problems—Circumplex (IIP). J Norw Psychol Assoc 2002;39:25–34.
31. Mikkelsen EG, Einarsen S. Bullying in Danish work-life: Prevalence and health correlates. Eur J Work Organiz Psychol 2001;10: 393–413.
32. Nielsen B, Einarsen S. Kartlegging av mobbing i arbeidslivet: Negative Acts Questionnaire. Tidsskr Nor Psykologforen 2007;4: 151–53.
33. Dake JA, Price JH, Telljohann SK. The nature and extent of bullying at school. J Sch Health 2003;73:173–80.
34. Paris J. Treatment of borderline personality disorder. A guide to evidence based practice. New York: Guilford Press; 2008.
35. Torgersen S. Personlighet og personlighetsforstyrrelser. Oslo: Universitetsforlaget AS; 1995.

Toril Monsvold, R.N., R.P.N., M.Sc. in Health Science, Department of Public Health and General Practice, Faculty of Medicine, Norwegian University of Science and Technology (NTNU), Trondheim, Norway, and St. Olav's Hospital University, Trondheim, Norway.
Mons Bendixen, Ph.D./Associate professor, Department of Psychology, Norwegian University of Science and Technology (NTNU), Trondheim, Norway.
Roger Hagen, Ph.D./Associate professor, Department of Psychology, Norwegian University of Science and Technology (NTNU), Trondheim, Norway.
Anne Sofie Helvik, D.Phil./Associate professor, Department of Public Health and General Practice, Faculty of Medicine, Norwegian University of Science and Technology, Trondheim, Norway; Innlandet Hospital Trust, Division Tynset, Tynset, Norway; and St. Olav's Hospital University, Trondheim, Norway.