4 PERSONALITY PATHOLOGY IN ADOLESCENCE: A REVIEW

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In working with adolescents, clinicians receive minimal guidance from the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV*; American Psychiatric Association [APA], 1994). Aside from the diagnosis of conduct disorder (and its near-neighbor, oppositional defiant disorder), clinicians are on their own in assessing the personality characteristics that contribute to adolescent distress and dysfunction. *DSM–IV* is explicit in its caution to avoid making personality disorder (PD) diagnoses in adolescence. However, this caution is based on the relative lack of data on adolescent personality pathology, not on any research suggesting that adolescent personality pathology does not exist or cannot be diagnosed.

Indeed, a recent series of studies suggests that PDs not only can be diagnosed in adolescence but show considerable continuity over time (Bernstein et al., 1996; Johnson et al., 1999). Of relevance, as well, is a growing body of literature suggesting that adolescent conduct disorder is a highly heterogeneous category (see Moffitt, 1993; Moffitt et al., 1996). For example, some adolescents showing delinquent behavior, including those diagnosed with conduct and oppositional defiant disorders, are callous, remorseless, and psychopathic, whereas others are relatively high-functioning, are able to maintain loving and intimate relationships, and show a very different quality of moral functioning. In this sense, the research literature is beginning to catch up with the clinical literature, in which a distinction has long been made between psychopathic adolescents, who tend to have a poor prognosis, and teenagers for whom oppositional, destructive, or delinquent behavior is an expression of neurotic conflicts, masked depression, and other normative and non-normative adolescent concerns.

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In this chapter, we review the literature pertaining to personality disturbance in adolescence. We first address the stability of personality dispositions in adolescence. We then consider the domains of functioning that constitute personality and the way they develop in adolescence, with an eye to what can go wrong along each of these developmental lines. Next, we examine the empirical literature on adolescent personality disorders and related constructs. We conclude with a description of a program of research aimed at developing an empirically sound, clinically near approach to the classification and diagnosis of adolescent personality.

Throughout, we often employ the term personality pathology rather than personality disorder, because of compelling data suggesting that only some patients who present in clinical practice with clinically significant, enduring, maladaptive patterns of thought, feeling, motivation, or behavior that lead to distress or dysfunction—that is, personality—have severe enough problems to warrant a PD diagnosis (Westen and Arkowitz-Westen, 1998).

Adolescent Personality: Shooting at a Moving Target

Four issues confront any effort to understand, classify, and treat adolescent personality pathology. The first is the question of whether classification is even appropriate for adolescents given the presumed instability of personality in adolescence. A second, related issue is whether adolescence is a time of relative *sturm und drang*—storm and stress—or a period of relative continuity between childhood and adolescence. A third regards the nature of personality itself: What are the domains or elements of personality, and what kinds of change occur in these domains in the teenage years? Fourth, on what basis do we classify observed regularities in personality in adolescence? We address the first two questions in this section, and turn to the others in the remainder of the chapter.

DOES PERSONALITY EXIST IN ADOLESCENCE?

Although some theorists have argued that adolescent personality is inchoate and unstable, a considerable body of research supports the

view that personality shows substantial continuity from at least age three through the adolescent years and beyond (Caspi, 1998). Young children who are shy and inhibited are more likely to be anxious and inhibited in adolescence (Kagan and Snidman, 1991; Gest, 1997). Infants who are insecurely attached at 12 to 24 months of age are more likely than their securely attached peers to have interpersonal difficulties in childhood (Jacobsen and Hofmann, 1997) and to have lower ratings of emotional health, self-esteem, ego resiliency, and peer competence as adolescents (Sroufe, Carlson, and Shulman, 1993). Boys who are aggressive in childhood are more likely to be antisocial or otherwise dysfunctional adults (Caspi, Elder, and Herbener, 1990). Boys who are undercontrolled and impulsive, and girls who are overcontrolled and constricted, are more likely to be depressive in late adolescence and early adulthood (Block and Gjerde, 1991). Childhood axis I symptoms (e.g., conduct disorder, major depression) are highly predictive of later adolescent personality pathology as assessed using axis II criteria (Bernstein et al., 1996). All these studies suggest considerable continuity over time between childhood and adolescent personality, just as Offer et al.'s (1998) data showed continuity into adulthood.

Other relevant data come from research on the Five Factor Model of personality (FFM), which shows that the same dimensions that capture many important aspects of personality in adulthood across several cultures (McCrae and Costa, 1997)—neuroticism (negative affect), extroversion, conscientiousness, agreeableness, and openness to experience—appear to capture important individual differences in adolescents (John et al., 1994). Although most FFM studies of adults have relied exclusively on self-reports, John and colleagues (1994) studied the links between adolescent personality and psychopathology using an FFM measure, personality ratings by mothers, and reports of behavior problems by teachers.

John et al.'s (1994) findings support the view that the FFM can be used in adolescents to predict relevant criterion variables. For example, boys who had committed severe delinquent acts (e.g., shoplifting, vandalism, drug dealing, gang fighting) were substantially lower on Agreeableness and Conscientiousness than nondelinquent boys. Boys with externalizing pathology more generally (e.g., stealing, lying, inattention, impulsivity, hyperactivity, aggression) showed a similar pattern. Internalizing boys were higher on Neuroticism and lower on Conscientiousness than noninternalizing boys. FFM data were also able to predict school performance: Conscientiousness and Openness both predicted

higher teacher ratings for adolescent boys' achievement in reading, writing, spelling, and math.

All told, the view that adolescents lack stable personality characteristics seems inaccurate in the light of available data. This is not to suggest, of course, that personality is fixed or immutable by age 15 (any more than it is immutable by age five). One of the most obvious (and encouraging) aspects of clinical work with adolescents is the malleability of personality at this life stage, within the constraints imposed by temperament (e.g., Plomin et al., 1997), untoward childhood experiences (e.g., Tizard and Hodges, 1978), and current familial circumstances. Every longitudinal study showing that adolescent personality can predict 50 percent of the variance in adult personality (which few can show) is simultaneously showing that 50 percent of the variance is either unstable or not well measured. Research on nonpsychopathic delinquent boys provides a particularly useful example, because many of these boys go on to lead productive lives, whereas others are snared into adult dysfunction (Moffitt et al., 1996). Nevertheless, the data are clear that personality is indeed a force to be reckoned with clinically in adolescence and is likely one of the major targets of clinical intervention.

ADOLESCENT PERSONALITY: CONFLICT OR CONTINUITY?

A second question focuses on the extent to which adolescent personality is qualitatively or quantitatively different from personality in childhood and adulthood. Conflict models, first put forth at the turn of the century by Hall (1904), suggest that conflict and crisis are normal in adolescence and that this distinguishes adolescence from other life stages. Hall viewed adolescence as a time of developmentally appropriate upheaval, marked by turmoil and psychological distress. Identity confusion, conflictual interpersonal relationships, and extreme moodiness were considered normative and not particularly symptomatic of personality disturbance per se. Subsequent psychoanalytic theorists extended the view of adolescence as a period in which identity crises (Erikson, 1968), motivational conflicts (A. Freud, 1958), and regression (Blos, 1968) were not only normative but necessary for adolescent development. Indeed, as we shall describe, many theorists argue that

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adolescents need to go through a period of crisis to separate themselves psychologically from their parents and carve out their own identity.

In support of conflict models, research on boys suggests that delinquent behavior is in fact normative for adolescent boys and that those who do not engage in any form of antisocial behavior tend to be inhibited and maladjusted (Moffitt, 1993). Other research finds that adolescents who do not experiment with illegal drugs (both boys and girls) are often as poorly adjusted as those who overindulge. Teenagers at both extremes of drug use (complete abstainers and abusers) can be distinguished from teenagers who experiment with drugs but do not become consumed by them by problematic relationships with their mothers observed as early as the preschool years (Shedler and Block, 1990).

In contrast with conflict or disturbance models of adolescent personality are continuity theories, which suggest that the stormy, moody, conflict-ridden adolescent is the exception rather than the rule (Bandura, 1964; Masterson, 1967; Compas et al., 1995; Offer et al., 1998). Offer and colleagues (1998) reported epidemiologic findings showing that adolescents and adults show similar rates of health and disturbance. Consistent with their findings over many years, Offer and colleagues found that 20 percent were clinically disturbed, 20 percent at risk, and fully 60 percent "normal," without much of the storm and stress emphasized in conflict models. Longitudinal findings from this study showed that adolescents with the most storm and stress, in the clinically disturbed group, tended to remain disturbed in their personality patterns through middle age.

One reason for the discrepancy between conflict and continuity models undoubtedly lies in their different "samples" and methods of observation. Conflict models emerged from the clinic, which arguably provides an unrepresentative sample for generalizing about adolescent personality but has the virtue of allowing tremendous depth of observation. In contrast, continuity models emerged from the laboratory, in work with normative samples. The data from these studies are more generalizable but have relied heavily on self-report methods that likely miss a substantial amount of adolescent conflict. An equally important reason for these divergences in perspective on adolescent personality is the wide divergence among adolescents themselves: Adolescence is a time of enormous individual differences, with many alternative paths that vary according to the individual, culture, and historical period (see Erikson, 1968; Hauser et al., 1991).

Asking whether adolescence is primarily a time of conflict or continuity may thus not be the right question. The answer will depend on which domain of functioning one is studying, how one is studying it, and which adolescents one chooses to describe.

Domains of Personality Functioning: Continuity and Change

To understand what changes in adolescent personality, as well as what can go awry, we now describe three central domains of personality that, taken together, provide a relatively comprehensive formulation of an individual's personality functioning (Westen, 1995, 1998b). According to this model, which was derived from both clinical experience with adolescence and adults and empirical data from a wide range of psychological literatures (e.g., on cognition, coping, defense, affect, affect regulation, object relations, social adjustment), understanding an individual's personality requires asking three questions:

1. What does the person wish for, fear, and value, and to what extent are these motives mutually compatible or conflicting, and conscious or unconscious?
2. What psychological resources—cognitive processes, affective proclivities, and ways of regulating affect and impulses—does the person have at his or her disposal to deal with internal presses and external demands?
3. What is the person's capacity for relatedness to others and experience of the self and others?

In psychoanalytic terms, these domains of functioning comprise the central questions posed by classical models of motivation, conflict, and compromise (question 1); ego psychology (question 2); and object relations, self-psychological, and relational theories (question 3). Although we recognize that these domains of functioning are not, of course, independent, we examine each in turn, focusing on what changes in adolescence and where development can be derailed.

WISHES, FEARS, VALUES, AND CONFLICTS

The first question regards what motivates the person: What does the person wish for, fear, and value, and to what extent are these motives

conscious and mutually compatible? This question encompasses classical Freudian conflicts between wishes and superego prohibitions as well as conflicts between wishes (e.g., wishes to be popular and wishes to achieve, which can often be conflicting for adolescents), between wishes and fears (e.g., wishes to be like an identification figure and simultaneous fears of being like the person), and between fears (e.g., fears of disappointing one's father vs. fears of being ostracized by peers).

From a psychoanalytic point of view, the result of conflicting wishes, fears, and values is typically a compromise formation (Brenner, 1982)—a compromise that satisfies as many motivational "pulls" as possible—as when an adolescent simultaneously satisfies angry, aggressive, defiant, or autonomy-focused wishes in relation to parents along with affiliative wishes toward peers by becoming involved in vandalism. A wide array of empirical data from multiple areas of psychology and cognitive neuroscience now supports the basic psychoanalytic hypotheses that much of mental life is unconscious and that people often resolve conflicts between unconscious or implicit affective-motivational dynamics through compromise solutions (see Westen, 1998b; 1999a, b).

Anna Freud was one of the first to enunciate a theory of motivation and conflict in adolescence. In her now classic paper (1958), she argued for a model of "developmental disturbance" to describe adolescence, suggesting that much of normative adolescent behavior could be understood as what one might call normal pathology. Freud emphasized the importance of the eruption of genital sexual drives that could overwhelm the immature ego of the adolescent and require new ways of experiencing the self and others and regulating impulses and affects. Her understanding of adolescence rested on the premise that adolescent defenses against forbidden wishes lead to new conflicts and ultimately to consolidation of adult character traits. According to Freud, the degree to which adolescents could successfully renegotiate the sublimations and repressions of the latency years and wrestle with oedipal and preoedipal object ties was crucial to subsequent character development. She emphasized reaction formation, withdrawal, regression, and displacement of libidinal impulses from the objects of infancy to new objects as central defenses in adolescence.

Some more recent theorists have argued that Anna Freud's emphasis on displacement of libidinal impulses and fantasies from early objects may overestimate the extent to which adolescent searching for new objects of attachment and identification is motivated primarily by de-

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fense (M. Slavin and Kriegman, 1992; J. Slavin, 1996). For example, Slavin (1996) argued that the adolescent shift away from the family and early attachment figures is motivated in part by a recognition by the adolescent that the people and relationships outside the family "hold possibilities for gratification, resolution of conflict, and revision of one's relationship to reality that were unattainable in the family arena" (p. 39). The view of adolescence as a time of actively pursuing extrafamilial opportunities in hopes of wish gratification and conflict resolution is not, of course, incompatible with a focus on conflict, defense, and displacement. Rather, it is emphasizing the more adaptive aspects of the compromise formations forged by adolescents as they move into the adult world of love and work.

More generally, adolescence is a time of substantial motivational change. Hormonal changes lead to dramatic alterations in the motives that drive adolescent behavior, particularly sexual but aggressive as well. In boys, for instance, circulating testosterone levels increase substantially, which appears to be related to both their newfound sexual interests and the surge of crime and violence associated cross-culturally with the presence of high numbers of teenage males in the population. From a psychosocial perspective, adolescence is also a period in which children are transitioning into adult responsibilities and roles, which most teenagers are likely to approach with both excitement and anxiety. Ways of interacting with adults that were once gratifying may now become sources of conflict. Physical contact with parents takes on new meaning (both for adolescents and their parents), as does submission to the wishes or values of adult identification figures (although this varies, of course, with the cultural context).

Many adolescent girls, for example, experience conflict, confusion, and distress as their fathers become uncomfortable with their emerging sexuality and pull back in ways that feel both painful and inexplicable, leading them to wonder what they have done to lose their fathers' love. Clinically, dynamics of this sort are common in many cases of adolescent anorexia, in which one meaning of the symptom appears to be a desperate effort not to grow up (which often serves functions related to dependent ties to the mother as well). At the same time that teenage girls may be coping with their reactions to their fathers' feelings about their changing bodies, they find themselves drawn to males other than their fathers, which in turn will affect their fathers' experience of loss and ways of responding. In addition, they are often faced with the dawning sense—and their mothers' sense—that they have outdone their

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mothers in physical attractiveness, as men start to notice them more than their mothers, which can be as poignant an experience for mothers as the loss of "daddy's little girl" for fathers. Thus, changes brought about by puberty are likely to lead to new compromise formations in both teenagers and their parents and to familial compromises that reflect the compromise of multiple intrapsychic compromises.

ADAPTIVE RESOURCES

The first domain of personality thus addresses questions of motivation. The second domain, regarding adaptive functioning, can be defined in terms of the cognitive, affective, behavioral, and self-regulatory resources the adolescent has at his or her disposal to meet internal and external demands.

In the cognitive domain, adolescents differ substantially in their intellectual skills, the extent to which they think in relatively global or detailed ways, and the accuracy and intactness of their thought processes. Affectively, adolescents vary in the intensity and lability of their affect states, their tendency to experience various affect states (e.g., whether they are shame-prone), their consciousness of their emotional experience, and the processes they use to regulate their emotions (i.e., their conscious coping strategies and unconscious defensive processes). They also vary in their capacity to regulate their impulses, whether motivated by moral concerns or simply by recognition of potential dangers inherent in acting in certain circumstances.

Research on cognitive development in adolescents shows substantial changes of relevance to the understanding of adolescent personality pathology. Many of these seem to reflect, at least in part, maturation of the frontal lobes. One important development is the capacity for abstract thinking, which Piaget emphasized in his concept of formal operations (Inhelder and Piaget, 1958) and which allows teenagers to think more complexly about themselves and others. A second development is increased working memory capacity (Case, 1998), which allows them to integrate more information consciously while making decisions. Speed of information processing also increases until about age 15 (Kail, 1991), which permits teenagers to match wits with their parents in ways they previously could not. Last, adolescence is a period of continued development of metacognition—the capacity to think about one's own thinking processes (Metcalfe and Shimamura, 1994). Impairment in

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any of these functions—or simply underdevelopment in comparison with age peers—can likely have a substantial impact on school and social performance and ultimately on self-esteem and interpersonal functioning.

Affective processes change substantially through the adolescent years as well. One major change is a greater lability of affect—a central feature of conflict theories of adolescence that has received empirical support. Some of the most important findings come from "beeper studies" in which investigators page subjects at random intervals over a period such as a week and ask them to report what they are feeling and how intensely they are feeling it (Csikszentmihalyi and Larson, 1984). Longitudinal studies using beepers as well as other methods find that adolescents are, on average, more variable and intense in their emotions than children are and that they show decreases in hostility and negative emotionality (and increases in diligence, self-control, and congeniality) as they move into early adulthood (McGue, Bacon, and Lykken, 1993).

When development proceeds relatively smoothly, adolescents show an increasing capacity for experiencing ambivalent emotions—for recognizing that they can feel different emotions toward the same object at the same time (e.g., Harter and Buddin, 1987). Object relations theories have emphasized the development of the capacity for ambivalence that emerges at the end of the preoedipal period, around age five. However, empirical research suggests a much more elongated timetable, as children move from the capacity to experience similar-valenced emotions (e.g., anxiety and guilt) simultaneously, to a fuller capacity (in adolescence and beyond) to recognize that they can love and hate the same person at the same time and thus not end relationships in a moment of rage (Westen, 1989, 1990a).

Another central feature of adolescent development is the increasing capacity to regulate moods and emotions consciously (coping) and unconsciously (defense) and to regulate the impulses that often emerge alongside feelings. Empirically, stable individual differences in coping and defense are observable in adolescents and are associated with differences in severity and type of psychopathology. With respect to conscious coping, adolescents whose coping style is more active— whether characterized by a tendency to take a problem-solving approach to stressful situations, to reframe negative events cognitively, or to elicit social support—are less likely to manifest depressive symptomatology. In contrast, those who use avoidance as a primary coping

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strategy tend to be more vulnerable to depression (Herman-Stahl, Stemmler, and Peterson, 1995).

With respect to defensive processes, Feldman, Araujo, and Steiner (1996) demonstrated differences in defensive styles between adolescents with internalizing and externalizing pathologies and nonclinical comparison subjects. In their study, girls with internalizing disorders tended to use immature defenses such as projection, denial, regression, somatization, and repression. Incarcerated adolescent boys with histories of externalizing disorders were less likely to use mature defenses such as suppression, humor, affiliation, sublimation, and anticipation.[1]

EXPERIENCE OF SELF, OTHERS, AND RELATIONSHIPS

The third question is both intrapsychic and interpersonal: What is the adolescent's experience of the self and others and his or her capacity to relate to others in mutually fulfilling and intimate ways? This domain encompasses a range of interrelated but distinct variables. How complexly does the patient tend to view the self and others? Does he or she expect relationships with others to be enriching or dangerous, and to what extent does this vary by type of relationship (e.g., with peers or adults, with males or females) and under different circumstances (e.g., school, athletic situations, romantic encounters)? To what extent does the adolescent view others as tools to be used for gratification or self-soothing, or as independent others with their own needs and subjectivities with whom one can develop deep intimacy, commitment, and interdependence? How well does he or she understand what makes people tick—that is, how accurately can the adolescent make inferences about why people do what they do and tell coherent narratives about interpersonal events? How positively or negatively does he or she view the self, and under what conditions does that experience vary? How much does the adolescent experience himself or herself as an integrated person with continuity in experience of self over time and a sense of agency for his or her own actions, thoughts, and feelings? How does the adolescent regulate aggression in interpersonal affairs and handle

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[1]Although these findings are highly suggestive, they rely on a self-report measure of defense. Future research would profitably make use of Q-sort methods that can assess defense in ways that may be closer to their clinical meanings (e.g., Vaillant, 1992; Westen et al., 1997).

conflicts between personal needs and those of others? Last, what are the dominant interpersonal themes, or relational patterns, that recur in his or her fantasy, representations, and interpersonal experience?[2]

These questions address the nature of the adolescent's object relations—that is, the person's characteristic ways of experiencing the self, others, and relationships and the ways he or she behaves interpersonally. Perhaps the most influential theory of adolescent development of relevance to object relations is Blos's (1967) argument that adolescence is a second individuation period, in which the child continues the work of the initial individuation from the mother in infancy. From this point of view, adolescents have to redefine their representations of self in relation to their parents as they move into the broader world and separate and individuate from them in a more thoroughgoing way.[3]

Further, as Erikson (1963, 1968) argued, adolescents in many cultures face the enormous task of trying to reconcile their various identifications with their parents and others in the construction of an identity that feels distinctively their own. Identity, for Erikson, refers to a stable sense of knowing who one is and what one's values and ideals are. Identity confusion occurs when the person fails to develop a coherent and enduring sense of self and has difficulty committing to roles, values, people, or occupational choices.

Empirically, in the technologically developed West, some people establish an identity after a period of soul-searching, whereas others commit early without exploration, foreclosing identity development. Still others remain perpetually confused or put off identity consolidation for many years while trying on various roles throughout their 20s (Marcia, 1993). Some research suggests that identity formation in adolescence has an enduring impact on personality later in life, as Erikson proposed. Girls who have difficulty forming an identity in late adolescence are more likely than their peers to experience marital disruption at midlife; boys with late-adolescent identity problems are more likely to remain single and be unsatisfied with their lives in middle age (Kahn

[2]In many respects, this third set of variables is simply a more fine-grained examination of variables addressed in the first two questions as applied to the interpersonal domain, but distinguishing them seems clinically useful, as this domain is so central to personality and psychopathology.

[3]Empirical research on self-representations and object representations has shown that therapeutic progress for adolescents with severe psychopathology involves significant shifts in both the structure and content of their object relations (Blatt et al., 1996).

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et al., 1985). Healthy identity formation in early adolescence also predicts more successful attainment of intimacy in young adulthood and greater overall life satisfaction in later adulthood (Stein and Newcomb, 1999).

From a clinical perspective, more recent research has distinguished four distinct forms of identity disturbance—role absorption (a tendency to define oneself in terms of a single role or label (e.g., "adult child of alcoholics"), a subjective sense of painful incoherence, a more objective inconsistency (e.g., a tendency for feelings and actions to be grossly discrepant), and a lack of commitment to roles, values, and significant others (Wilkinson-Ryan and Westen, 2000)—all of which distinguish patients with borderline PD from other patients. To what extent these forms of identity disturbance vary in adolescents and differ from normal processes of adolescent identity formation is as yet unknown.

The differing paths to identity described here reflect not only the individual's idiosyncratic experiences but the cultural and historic contexts. Many traditional cultures have initiation rites in adolescence—rites that initiate the child into adulthood and impose a more socially bestowed identity. A period of identity confusion occurs primarily in technologically more advanced societies or in cultures undergoing rapid changes, as in much of the contemporary world.

Researchers are increasingly recognizing and documenting the importance of the cultural and historical contexts in the development of identity, self, and self in relation to others (Westen, 1985; Lopez and Hernandez, 1986; Westermeyer, 1987; Markus and Kitayama, 1991; Feldman, Mont-Reynaud, and Rosenthal, 1992; Roland, 1996). For example, in contrast to contemporary Western conceptions of selfhood that emphasize ever increasing independence (both models in the culture and psychological models that describe and reflect those models), identity in many Asian cultures more strongly reflects a sense of interdependence and connection to cultural and familial roots (Bradshaw, 1990; Markus and Kitayama, 1991; Roland, 1996).[4] Studies of ethnic identity

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[4]Interestingly, in the West, female identity development and self-esteem seem closer in some respects to the pattern seen in Asian and technologically less developed societies. Using a longitudinal design, Block and Robins (1993) found that subjects likely to show increases or decreases in self-esteem from adolescence to adulthood could be predicted from adolescent personality characteristics. Girls who showed increases in self-esteem from adolescence to adulthood had interpersonal qualities such as warmth and the ability to nurture in adolescence, whereas, for boys, the best predictors of increases were self-focused characteristics (e.g., the capacity to control personal anxiety). Thorne and Michaelieu (1996) found a similar pattern in their

development in multicultural societies point to the conflicts inherent in enculturation and their impact on identity development. Adolescents whose ethnic identity seems to be relatively unexamined or in flux tend to have lower levels of self-esteem, self-confidence, and sense of purpose in life than those who have wrestled with the conflict between the "two cultures" within which they live (Martinez and Dukes, 1997).

Another major area of change in adolescence of relevance to object-relational development is the development of social cognition (see Livesley and Bromley, 1973; Westen, 1989, 1991; Flavell and Miller, 1998). Preschoolers and early-school-age children, who tend to think rather concretely about themselves and others, focus on relatively observable behaviors and qualities, such as whether they are a boy or girl, what games they like to play, and so forth (Blatt et al., 1979; Damon and Hart, 1988). Around age eight, however, children (at least in the industrialized West, where these developmental changes are much more uniform and robust) begin to define themselves based not only on these readily perceptible attributes but on aspects of their personalities, such as their likes and dislikes, the way they interact with and are perceived by others, and the ways they tend to feel and think.

In adolescence, representations of the self become much more subtle (Harter and Monsour, 1992; Harter, 1998), as does the capacity to make complex and accurate inferences about why people do what they do (Westen et al., 1991). For example, a 17-year-old interviewed for a research project on the development of children's representations of self and others described herself as follows: "I seem really shy on the outside, but *inside* I'm really involved when I'm with people, thinking a lot about what they are saying and doing. And with people I'm comfortable with, I probably don't seem shy at all." Also of considerable relevance to the increasing complexity or subtlety of adolescent social cognition is the expanding capacity for taking others' perspectives—for example, making explicit inferences about others' representations of the self (Selman, 1980).

Adolescents differ from younger children not only in their representations of others but in their capacity to invest in others in mature,

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longitudinal study of gender and self-esteem. For females, wanting to help female friends during childhood was related to high and increasing levels of self-esteem from age 14 to 23 years. For boys, in contrast, memories of successfully asserting oneself were significant predictors (Thorne and Michaelieu, 1996).

mutually satisfying, and intimate ways (Westen, 1990a, b; Westen et al., 1991). For example, research on the development of children's experience of friendship largely documents three shifts that occur from the preschool years through adolescence (see, e.g., Damon, 1977). The first is a shift from defining friendship in terms of its more surface features (e.g., "we often play together") to a greater focus on caring for each other, sharing thoughts and feelings, and comforting each other. The second is a shift from a self-centered orientation of the friend as satisfying the child's own wants and needs to a mutually satisfying relation. The third is a shift in the way children describe friendships, from a focus on momentary or transitory acts to a sense of relationships as enduring over time and surviving conflicts. For example, Damon (1977) reported the following interview with an eight-year-old—an interview that illustrates the latency-age child's tit-for-tat quality of emotional investment in relationships:

Interviewer: "Why is Shelly your best friend?"
Child: "Because she helps when I'm getting beat up, she cheers me up when I'm sad, and she shares."
Interviewer: "Do you share with Shelly?"
Child: "Yes, I share so she'll share" [p. 159].

Research using projective techniques has documented a similar shift. For example, studies have documented a steady increase in the number of human figures seen in Rorschach responses throughout childhood and adolescence—an indicator associated with better object relations in adults (see Blatt and Lerner, 1983). Similar findings have emerged using Thematic Apperception Test (TAT) (Bogen, 1982). The narratives children produce, both in response to TAT cards and to the instruction to describe salient interpersonal events (e.g., interactions with their mother or best friend), similarly demonstrate a normative shift from a need-gratifying approach to relationships in childhood to increasingly mutual and intimate ways of relating (Westen et al., 1991). Interestingly, this shift seems to be delayed considerably, if not blocked entirely, in adolescents and adults with severe personality disorders (Westen, Lohr, et al., 1990; Westen, Ludolph, Lerner, et al., 1990; Westen, Ludolph, Silk, et al., 1990; Porcerelli, Cogan, and Hibbard, 1998).

Personality Pathology in Adolescence: Empirical Research

Having outlined the major domains of personality and personality development in adolescence, we now examine the empirical data on adolescent personality pathology. We begin by considering studies of PDs in adolescence, and then examine other empirical literatures relevant to adolescent personality pathology, including work on adolescent ego development and attachment.

PERSONALITY DISORDERS IN ADOLESCENCE

Until recently, a summary of the research literature on adolescent PDs would have been very brief. With the exception of research on conduct disorder, which is of obvious relevance to adolescent personality pathology, the first sustained empirical research on adolescent PDs appeared in the early 1990s, on borderline PD (Ludolph et al., 1990; Westen, Ludolph, Silk, et al., 1990). The major findings of these studies are as follows. First, borderline PD is in fact diagnosable in adolescence, with only minor modifications of adult diagnostic criteria or interviews. Second, the phenomenology and etiology of borderline PD are highly similar in adults and in adolescents beginning at around age 14, whereas borderline disorders of childhood do not resemble either their adult or adolescent counterparts and appear to be a different disorder (on borderline disorders of childhood, see Greenman et al., 1986). Third, borderline adolescents and adults share a high rate of sexual trauma in childhood, as well as a greater likelihood of a childhood history of disrupted attachments (e.g., extended separations from the primary caregiver). Fourth, borderline adolescents and adults show similar object-relational disturbances (notably, relative to normal and depressed comparison subjects, a tendency to activate malevolent representations under conditions of interpersonal stress, a relative incapacity to understand causality in the social realm, a difficulty telling coherent and interpersonal narratives, and a tendency to have a need-gratifying orientation to relationships), although various aspects of object relations appear to mature even in borderline patients between adolescence and adulthood. Fifth, borderline adolescents and adults share a similar quality of depression, characterized by diffuse negative affectivity, affective

lability, a sense of evilness or inner badness, and a tendency to be triggered by perceived abandonment or aloneness.

More recently, a number of research groups have begun systematically studying adolescent PDs using adult criteria. Grilo et al. (1998) compared the frequency of *DSM–III–R* (APA, 1987) axis II disorders assessed by the Personality Disorders Examination (PDE; Loranger et al., 1987) using adult criteria in a large ($N = 255$) series of adolescent (age 12–17) and adult (age 18–37) inpatients. With two exceptions (dependent and passive–aggressive PD), similar rates of PDs emerged in the two samples.

Bernstein, Cohen, and colleagues (Bernstein et al., 1993; Bernstein et al., 1996; Johnson et al., 1999; Kasen et al., 1999) have undertaken the largest study of PDs in adolescents yet conducted ($N = 641$), following up a community sample of adolescents and young adults years after they were initially studied. This project has yielded important data on the nature, prevalence, antecedents, comorbidity, and continuity into adulthood of adolescent PDs (Kasen et al., 1999).[5] Instead of presenting findings on discrete disorders (which were presumably highly overlapping in this, as in most adult samples), the investigators have largely analyzed their data using the three axis II clusters identified in *DSM–IV*: cluster A (odd/eccentric, including paranoid, schizoid, and schizotypal), cluster B (dramatic/erratic, including borderline, histrionic, and narcissistic, but excluding antisocial because of inadequate data related specifically to antisocial PD rather than conduct disorder), and cluster C (anxious, including dependent, avoidant, obsessive-compulsive, and passive–aggressive). Because of the absence of structured interviews for adolescent PDs other than borderline, and because this research was not initially designed as a study of PDs, the investigators drew upon items from many components of their extensive interview and self-report protocol that tapped most of the axis II criteria, and

[5]These findings should be understood in the context of the methodology used in these studies. The three most important advantages of the research design are its use of a normative "catchment" sample, its use of multiple observers (self-report and interviews with both the children and their parents), and the longitudinal design. The three biggest drawbacks are the exclusive reliance on self-reports and interviews conducted by lay interviewers, the use of an idiosyncratic method for assessing PDs with relatively unknown validity and reliability, and the lack of reliable data for making diagnoses beyond the level of broad axis II clusters (rather than the level of individual disorders, for which internal consistency of the items tended to hover around .40 to .50 as assessed by coefficient alpha, and diagnostic overlap was likely very high).

relied on both patient and parent reports to make diagnoses. Categorical diagnoses were made based on extreme scores relative to others in the sample (elevation of two standard deviations) rather than *DSM–III–R* or *DSM–IV* cutoffs.

The major findings of the studies emerging from this longitudinal projected reported thus far are as follows. First, consistent with earlier studies of borderline PD, PDs do seem diagnosable in adolescence. Roughly 15 percent of adolescent subjects met study criteria for presence of a PD before adulthood, and axis II diagnosis was predictive of increased odds of receiving an axis I or axis II diagnosis in young adulthood, even holding constant child and adolescent axis I conditions. Thus, axis II diagnosis in adolescence provides "value added" beyond axis I diagnosis. Fewer than half of patients diagnosed in late childhood or early to mid adolescence with a PD retained a PD diagnosis two years later, although subjects diagnosed initially with a PD were at substantially elevated risk for having a PD diagnosis upon reassessment.

Second, childhood behavioral and emotional problems were predictive of adolescent PDs. Children with conduct problems, and those with a pattern of "immaturity" (distractibility, low persistence at tasks, low achievement motivation, and noncompliance with adult demands), were likely to develop a broad range of PDs in adolescence across all three clusters. Children with depressive and anxious symptoms in childhood were more likely to develop specifically cluster B disorders in adolescence.

Third, a young adult follow-up assessment found that axis II pathology can be useful in predicting later psychopathology on both axes, even holding constant the presence of the same disorder in childhood. Presence of child and adolescent axis I and axis II disorders both increased the odds of receiving multiple axis I and axis II diagnoses in young adulthood. Although the presence of any axis I or axis II diagnosis increased the risk of odds of having many different axis I and axis II conditions in adulthood, some child and adolescent diagnoses showed relative specificity in predicting adult disorders. For example, cluster A disorders in adolescence were somewhat more predictive of later anxiety disorders than other PDs diagnosed in adolescence, whereas cluster B disorders tended to predict later substance use diagnosis.

As in other research (Lewinsohn et al., 1997), one of the most important findings is the relation between presence of multiple comorbid conditions in childhood and the likelihood of axis II diagnoses in

adulthood. Across clusters, subjects with only one axis I condition tended to have relatively little personality pathology. Each additional disorder diagnosed in childhood typically doubled the percentage of patients with axis II conditions in adulthood. In general, these findings suggest that the distinction between axis I and axis II may be problematic in adolescents (as it is with adults), with "comorbidity" essentially a sign of the presence of a PD.

PATHWAYS OF ADOLESCENT EGO DEVELOPMENT

Research on adolescent PDs is in its infancy, but a large body of research on related topics is relevant to the understanding of adolescent personality pathology. Programmatic research by Hauser and colleagues on ego development has provided one window into adolescent personality development and pathology. As conceptualized by Loevinger, ego development is a broad construct that includes impulse control, moral development, style of interpersonal relating, and cognitive complexity (Loevinger, Wessler, and Redmore, 1970; Hauser, 1993; Best, Hauser, and Allen, 1997).

Using a longitudinal design, Hauser and colleagues have followed up two samples for more than 20 years, one a sample of adolescents hospitalized for severe characterological disturbances and the other a sample of adolescents from a nearby school (Hauser, 1991). Using these samples, they have identified six pathways of ego development that capture a continuum of health and pathology.

The first path is one of "profound arrests in development," characterized by the adolescents' tendency to see the world in black and white, to view themselves with minimal complexity, and to frame moral questions in terms of what they can "get away with." Adolescents on the second pathway do not stand out as either problematic or exceptional. These "steady conformists" are largely guided by group norms. They have friends and follow societal rules but seem somehow stunted in their preoccupation with acceptance and blending in with others.

Four other pathways are characterized by shifts in ego development over time during adolescence. Adolescents who follow the path of "early progression" begin with a concrete worldview and a focus on immediate gratification but shift toward recognition and acceptance of group expectations and norms. In other words, they move from the

first to the second pathway. Those who are on a pathway of "advanced progression" move from a more conformist stance to recognizing and valuing complexity, individual differences, and internal moral standards and principles. Hauser and colleagues (1991) described this progression as one in which "conscience and integrity are now the watchwords, rather than acceptance and belonging" (p. 46). Adolescents who followed a pathway of "dramatic progression" shifted from experiencing the world in black-and-white terms and a tendency to externalize personal difficulties to recognizing the complexity of others, relationships, and individual differences. Those who follow this pathway develop a greater appreciation for the complexity of feelings, understanding of motives for behavior, self-respect, and overall conceptual complexity. Finally, teenagers on the sixth developmental pathway, "accelerated development," are, from the start, unusually mature adolescents who "frequently evoke delighted and, at times, perplexed reactions from adults . . . they comprehend complex personal relationships and can articulate subtle aspects of their inner lives" (p. 48). These are adolescents who are able to tolerate and even value ambiguity and paradox.

Empirically, these pathways through adolescence seem related to patterns of family interaction (Hauser et al., 1984; Hauser, Powers, and Noam, 1991). Adolescents at higher levels of ego development are more likely to be empathic and curious and to problem-solve during family interactions. Those at lower levels of ego development tend to be more devaluing and withholding with their families, particularly their parents. Reciprocally, parents' tendency to accept, explain, and empathize with their teenagers is associated with higher levels of adolescent ego development. Conversely, parents high in "cognitively inhibiting" behaviors such as withholding, distracting, or devaluing tended to have adolescents at lower levels of ego development. More recently, Hauser and colleagues, following up their subjects as they have moved into early adulthood and now into midlife, have been studying their patterns of adult attachment and the attachment patterns of their own children (Allen, Hauser, and Borman-Spurrell, 1996).

ATTACHMENT IN ADOLESCENCE

Another area of research of tremendous relevance to adolescent personality and personality pathology is research on adolescent patterns of attachment. Bowlby, an ethologist and psychoanalyst, developed a

model integrating the psychoanalytic understanding of object relations with evolutionary concepts of adaptations emphasizing the innate tendency of infants of many species to form emotionally intense, dependent bonds with their caregivers (1969, 1973, 1980). Bowlby proposed that children form mental representations of relationships based on their interactions with, and adaptation to, the caregiving environment, which provide them with varying degrees of attachment security. Described as internal working models, these cognitive/affective representations reflect both the objective and subjectively experienced features of early attachment relationships. These working models help organize affect and social experience, and shape not only current but future interpersonal relationships (Sroufe, Fox, and Pancake, 1983).

Attachment theory, like other object relations and psychoanalytic theories, proposes that early parent–child relationships serve as prototypes for later intimate relationships and play a role in the intergenerational transmission of family patterns (S. Freud, 1915; Fairbairn, 1952; Framo, 1992). Hence, an insecure working model of attachment serves as a potential risk factor for difficulties in various relationships across the life span (Ainsworth, 1969; Main, Kaplan, and Cassidy, 1985). An increasing body of evidence supports Bowlby's conceptualization of attachment styles (and their underlying internal working models) as relatively stable across the life span (Main and Cassidy, 1988; Wartner et al., 1994; Allen et al., 1998) and transmitted across generations (Crowell and Feldman, 1991; Fonagy, Steele, and Steele, 1991; Cohn et al., 1992; Ward and Carlson, 1995; Cowan et al., 1996).

Although research on attachment has traditionally focused on infants and young children, more recent studies have moved beyond infancy and childhood to include consideration of attachment patterns and internal working models in adolescents and adults (Main et al., 1985; Kobak and Sceery, 1988; Rice, 1990; Allen et al., 1996). The development of the Adult Attachment Interview (George, Kaplan, and Main, 1996) has made assessment of these working models possible. Instead of providing self-reports about their childhood experiences, interviewees describe their relationships with childhood and other attachment figures, and for each relationship provide a series of narrative descriptions of events that exemplify the relationship. Researchers then code these narratives for the language subjects use to convey their experience and the degree to which their narratives seem believable, coherent, and integrated. Based on these ratings, subjects receive a classification

of secure/autonomous, insecure dismissing, insecure preoccupied, or insecure unresolved with respect to loss or trauma.

Adolescents and adults classified as having secure models of attachment maintain a balanced view of early relationships and speak in open and nondefensive ways about their attachment experiences. Insecure adolescents and adults tend either to deny the importance of early attachment experiences (dismissive) or to remain enmeshed in their past or present relationships with their parents (preoccupied). A fourth classification, unresolved about loss or trauma, corresponds to the infant classification of disorganized attachment and is often assigned to those who have experienced the loss of an attachment figure and whose quality of narrative seems to shift to less coherence when talking about that person.

This unresolved classification is of particular relevance to personality pathology, because it was designed to capture individuals whose attachment strategies and attempts to construct coherent working models were overwhelmed (disorganized) in the process of experiencing major loss or trauma and who have not been able to reorganize in a coherent way (Main and Hesse, 1990). Main and Hesse (1990) hypothesized that this attachment category would be associated with more severe psychopathology in adolescents, and, empirically, adolescents classified as disorganized during infancy have shown the most marked indices of psychopathology on a structured psychopathology interview, the K–SADS (Carlson, 1998).

Insecure attachment (including dismissing, preoccupied, and unresolved patterns) has been implicated as a risk factor in the development of childhood psychopathology (Lewis et al., 1984; Rubin and Lollis, 1988; Renken et al., 1989; Sroufe and Egeland, 1989). More recent research has linked attachment status and adolescent psychopathology (Kobak and Sceery, 1988; Rice, 1990; Allen et al., 1996; Rosenstein and Horowitz, 1996; Allen et al., 1998). For example, Rosenstein and Horowitz (1996) found that dismissing adolescents are at elevated risk for conduct, substance use, narcissistic, and antisocial personality disorders. Conversely, preoccupied adolescents are more likely to have affective, obsessive-compulsive, histrionic, borderline, or schizotypal personality disorders. Other research has linked the preoccupied classification in adolescents to higher levels of internalizing pathology (Allen et al., 1998), suicidal behavior (Adam, Sheldon-Keller, and West, 1995), anxiety, and personal distress, as well as lower levels of ego resilience (Kobak and Sceery, 1988).

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Whether adolescent attachment status is a risk factor for personality pathology or simply a synonym for many aspects of object-relational disturbance in adolescence may be a matter of semantics. What is becoming increasingly clear, however, is that attachment patterns and internal working models with their roots in early attachment relationships appear to be highly relevant to the later development of personality disturbances in adolescence and adulthood.

Toward a System for Classifying Personality Pathology in Adolescence

The recent studies of adolescent personality disorders have moved the field a quantum leap forward regarding the question of whether PDs can be diagnosed in adolescence, and have begun to address important issues such as their prevalence and antecedents. Stepping back however, a major question is whether the categories and criteria developed in *DSM–IV* for adults (or the broad clusters A, B, and C, on which most data are available) represent an optimal way of classifying adolescent personality.

Indeed, although the diagnostic system for adults is based on a great deal of good clinical horse sense as well as empirical efforts to refine the categories and criteria empirically, several caveats should be carefully considered before importing it into the field of adolescent psychopathology (see Widiger and Frances, 1985; Livesley and Jackson, 1992; Livesley, 1995; Westen and Shedler, 1999a, b). These include (a) a tendency for disorders to be highly overlapping (because they were selected by committee rather than by statistical aggregation procedures that group patients or variables on the basis of their natural similarity), (b) failure to capture much of the personality pathology that, empirically, clinicians treat, particularly in the less severe range, (c) a widely perceived lack of clinical utility, and (d) problems of measurement (e.g., the weak validity coefficients of most interviews and self-reports, and their inability to distinguish what appear clinically to be distinct disorders, such as schizotypal and borderline, which show high rates of comorbidity in virtually all studies). A further caveat is that personality pathology may be less differentiated or may have different markers at age 14 or 15 than in adulthood, and hence may require different categories or criteria.

In this final section, we describe a programmatic effort to develop a clinically grounded, empirically based classification of personality disturbance in adolescence. Rather than assuming existing categories and criteria, it derives a classification system empirically, reliably quantifying and aggregating clinical observation of large samples of patients using a Q-sort instrument called the Shedler–Westen Assessment Procedure–200 for Adolescents (SWAP–200–A; Westen and Shedler, 2000b; Westen, Shedler, Glass, et al., 2000c). The SWAP–200–A is an adaptation for adolescents of the SWAP–200, which was designed to assess and classify adult personality pathology (Westen and Shedler, 1999a, b). Data from several samples with the adult version of the instrument demonstrate that it can be used to develop nonoverlapping diagnostic categories and criteria and can predict (a) clinician PD diagnoses made both categorically and dimensionally, (b) objective indicators of personality dysfunction such as suicide attempts, (c) overall level of adaptation assessed by measures such as the Global Assessment of Functioning Scale from the *DSM–IV*, and (d) various developmental and genetic history variables. A study just completed suggests that the adolescent version of the instrument has similar psychometric properties.

A Q-sort (in the context of personality assessment) is a set of personality-descriptive statements. Each statement may describe a given person well, somewhat, or not at all. The statements are printed on separate index cards, and an observer with a thorough knowledge of the subject sorts (rank-orders) the statements into categories, from those that are inapplicable or not descriptive to those that are highly descriptive. (For a thorough description of Q-sort methodology and its applications to personality and psychopathology, see Block, 1978.)

The SWAP–200–A is a Q-sort procedure for use by experienced clinical observers. After either interacting with and observing the patient over multiple clinical hours, or administering the Clinical Diagnostic Interview (Westen et al., 1997), a loosely structured two- to three-hour interview that resembles a thorough psychiatric interview (e.g., MacKinnon and Michels, 1971), clinicians sort 200 statements into eight categories. The first category, which is assigned a value of 0 for data-analytic purposes, includes statements the clinician judges irrelevant or inapplicable; the last category, which is assigned a value of 7, includes statements that are highly descriptive. Intermediate categories include statements that apply to varying degrees. The SWAP–200–A thus provides a numeric score ranging from 0 to 7 for each of

200 items. The items provide a standard vocabulary for clinicians to express their observations and inferences.[6]

The items comprising the SWAP–200–A are written in a manner close to the data (e.g., "Tends to run away from home," "Has an exaggerated sense of self-importance"), and items that require inference about internal processes are stated in simple language without jargon (e.g., "Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors" rather than "Uses externalization as a defense"). Thus, the instrument can be used by clinicians regardless of their theoretical orientation. Empirically, clinicians' theoretical orientation seems to have little impact on cluster- or factor-analytic solutions that emerge using the adult version of the instrument (see Shedler and Westen, 1998; Westen and Shedler, 1999c).

Creation of the item sets for the SWAP–200 and its adolescent adaptation was an iterative process that took many years. Items came from a mixture of sources, including diagnostic criteria from several editions of the *DSM*; clinical and empirical literature on PDs; input from hundreds of clinicians who used the instrument over several iterations; research on normal personality traits; research on child and adolescent development and psychopathology; and the authors' own clinical experience with adolescents and adults. To hone the item set, we used the standard item-refinement procedures employed by personality psychologists, such as soliciting feedback from hundreds of clinicians who used the item set to describe their patients, eliminating items with minimal variance or high redundancy with other others, and so forth.

Here we briefly describe a study, just completed, that represents a first attempt at using this method to develop a taxonomy of adolescent personality pathology. Like our previous studies with adult samples, the study relied on experienced clinicians as informants, using a practice research network method that allows us to do taxonomic work with large samples. Participants were 294 psychologists and psychiatrists randomly selected from the registers of the American Academy of Child and Adolescent Psychiatry and the American Psychological Association. Each clinician used the SWAP–200–A[7] to describe a randomly

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[6]The distribution of Q-sort items into categories is fixed; that is, the clinician is obligated to assign a specified number of items to each category. The use of a fixed distribution has important psychometric advantages that have been discussed in detail elsewhere (Block, 1978).

[7]In this study, clinicians used a semiconstrained rating scale version of the instrument, in which they were given general guidelines on the number of items to be given

selected adolescent patient in his or her practice (operationalized as "the last patient you saw last week before completing this form who meets study criteria"). Patients met inclusion criteria if they were between the ages of 14 and 18 (inclusive) and were being treated for "enduring maladaptive patterns of thought, feeling, motivation, or behavior—that is personality."

Patients were relatively evenly split by age and gender, with demographics largely similar to those of the general U.S. population. Clinician-respondents tended to be highly experienced and diverse in both theoretical orientation and work settings (e.g., private practice, clinic, school, residential treatment setting). They knew the patients well, having met with them an average of 20 sessions before completing the forms.

To identify naturally occurring clusters or groupings among patients, we used Q-factor analysis. The technique is designed to identify clusters of patients who share common psychological features, and are distinct from other clusters of patients. This technique has been used successfully in studies of normal personality (e.g., Block, 1971; Robins et al., 1996; Caspi, 1998) and recently in the study of adult patients with PDs. Q-analysis is essentially inverted factor analysis, in which the rows and columns of data are reversed, so that people (cases), rather than variables, are factored and hence aggregated. Thus, Q-analysis identifies groups of patients who share important psychological features—distinct from patients in other groups. The groups, called Q-factors, represent empirically derived diagnostic categories. Whereas factor analysis isolates a small number of items that measure a shared trait, Q-analysis makes use of all 200 items in clustering cases, and thus takes account of the configuration of personality characteristics across a very broad range of items encompassing characteristic patterns of thought, feeling, motivation, and behavior.

The Q-factor analysis yielded six orthogonal (nonoverlapping) clinically and theoretically meaningful clusters of Q-factors, which accounted for 46 percent of the variance. Because the first Q-factor (high-functioning) was very large (accounting for 15 percent of the variance by itself), we applied a second Q-factor analysis to patients who fell

a rating of 5, 6, or 7, but did not actually perform a sort. We used this method in this study to maximize response rate (because the sorting procedure takes considerably longer) and to ascertain the extent to which the distribution selected over several iterations for adults is appropriate for an adolescent sample.

into this category, which yielded two coherent subtypes. Thus, the final procedure yielded two high-functioning Q-factors (hereafter referred to as personality styles) and five personality disorders. Although each Q-factor is defined by the entire configuration of the 200 items included in the Q-sort, we describe, for the sake of brevity, only the most diagnostic criteria for each disorder.

The *self-critical dysphoric style* was characterized by SWAP–200–A statements indicating (in descending order of diagnosticity) a tendency to be shy or reserved; to be self-critical; to feel ashamed or embarrassed; to feel guilty; to be anxious; to blame self or feel responsible for bad things that happen; and to be perfectionistic. At the same time, this prototype includes a number of positive qualities, such as conscientiousness, empathy, and presence of moral standards the child strives to achieve.

The *oppositional dysphoric personality style* Q-factor included items reflecting (in descending order of importance) a tendency to feel unhappy; to have emotions that spiral out of control; to get into power struggles with adults; to feel inadequate, inferior, or a failure; to be rebellious or defiant; to be angry or hostile; to feel bored; and to express aggression in passive and indirect ways. These personality items coexist with a tendency to appreciate and respond to humor; to be articulate; to elicit liking in others; to find meaning and fulfillment in guiding, mentoring, or nurturing others; and to have moral and ethical standards the teenager strives to achieve. These are high-functioning acting-out teenagers, often with "masked depression" that appears as anger and rebellion, whose social functioning is well above average but whose school performance is below expectations.

The remaining Q-factors represent personality configurations that closely match the adult construct of personality disorder. The *antisocial-psychopathic personality disorder* Q-factor was characterized by items indicating a tendency to get into power struggles with adults; to be rebellious or defiant toward authority figures; to express intense and inappropriate anger; to be oppositional, contrary, or quick to disagree; to act impulsively, without regard for consequences; to be angry or hostile; to blame others for own failures or shortcomings; to react to criticism with rage or humiliation; to be unreliable and irresponsible; to draw pleasure or self-esteem from being, or being seen as, "bad" or "tough"; to have emotions that spiral out of control; to seek thrills, novelty, and adventure; to break things or become physically assaultive when angry; to feel misunderstood, mistreated, or victimized; and to

be unconcerned with the consequences of his or her actions. This Q-factor closely resembles the construct of psychopathy (Cleckley, 1941; Hare, Hart, and Harpur, 1991). Patients who strongly matched this prototype tended to have histories of physical abuse, as well as first- and second-degree relatives with histories of alcohol abuse, illicit substance abuse, and criminality.

The *emotionally dysregulated personality disorder* Q-factor closely matches a similar empirically derived Q-factor found now in three adult samples, which has features of the current diagnosis of borderline PD. The statements that best characterize this disorder include a tendency for emotions to spiral out of control; to feel inadequate; to become irrational when strong emotions are stirred up; to feel unhappy, depressed, or despondent; to fear rejection or abandonment; to be unable to sooth or comfort self when distressed; to feel helpless and powerless; to feel life has no meaning; to react to criticism with rage or humiliation; to appear to want to "punish" self by creating situations that lead to unhappiness or actively avoiding opportunities for pleasure or gratification; to be self-critical; to "catastrophize," seeing problems as disastrous, unsolvable, and so forth; and to struggle with genuine wishes to kill himself or herself.

The *schizoid personality disorder* Q-factor was best characterized by items indicating a tendency to be passive and unassertive; to appear inhibited about pursuing goals or successes; to have difficulty acknowledging or expressing anger; to be shy or reserved; to have difficulty expressing anger; to be unreliable and irresponsible; to express aggression in passive and indirect ways; to have a limited or constricted range of emotions; to feel bored; to lack social skills; to be verbally inarticulate; to feel listless, fatigued, or lacking in energy; to be inattentive or easily distracted; and to feel like an outcast.

The *narcissistic personality disorder* Q-factor, which appears to reflect a blend of obsessional and narcissistic features, included items indicating a tendency to expect self to be perfect; to think in abstract and intellectualized terms; to be competitive; to be critical of others; to be controlling; to feel privileged and entitled; to be articulate; to be arrogant, haughty, or dismissive; to seek power or influence over peers; to see self as logical and rational, uninfluenced by emotion; to be self-righteous or moralistic; to treat others primarily as an audience to witness own importance, brilliance, beauty, and so forth; to be self-critical (to set unrealistically high standards for self and to be intolerant

of own human defects); and to believe that he or she can only be appreciated by, or should only associate with, people who are high status, superior, or otherwise "special."

Finally, the *histrionic personality disorder* Q-factor was most strongly defined by items reflecting a tendency to fantasize about finding ideal, perfect love; to become attached quickly or intensely; to express emotion in exaggerated and theatrical ways; to seek to be the center of attention; to be suggestible; to be overly sexually seductive or provocative; to be overly needy or dependent; to have unstable and chaotic interpersonal relationships; to choose sexual or romantic partners who seem inappropriate in terms of age, status, and so forth; and to use his or her physical attractiveness to an excessive degree to gain attention or notice. The prototype closely matches Zetzel's (1968) concept of the "bad hysteric" and Kernberg's (1975) concept of hysterical personality style organized at a borderline level.

Several aspects of this empirically derived system for classifying PDs are of note. First, many of the prototypes resemble current axis II categories, capturing the "gist" of the core constructs even if many of the criteria are different. Second, unlike axis II, this classification system can be used to describe patients with a range of personality pathology, from relative health to severe disturbance. Third, whereas Q-analysis reproduced many diagnoses resembling those in the current taxonomy, it selected criteria in such a way that the disorders are, empirically, more cleanly distinguishable and nonoverlapping.

One of the advantages of this system is that it can be used to make both categorical and dimensional diagnoses. The empirically derived Q-factors (e.g., histrionic) serve as diagnostic templates, against which a given patient's SWAP–200–A description is compared to assess degree of match. The correlation between a patient's SWAP–200 profile and each of the seven diagnostic templates yields a series of PD scores, which can be graphed to create a PD profile that resembles a Minnesota Multiphasic Personality Inventory (MMPI) profile. These raw PD scores are dimensional. To work with categorical diagnoses, one simply sets a diagnostic threshold for the PD scores. When a score is above threshold, a categorical diagnosis is given. When it is above a somewhat lower threshold, the patient is described as having features of the disorder.

In everyday clinical practice, this prototype matching process could be approximated using a much simpler method, in which Q-factor descriptions (the first 10–20 items, arranged in descending order of

importance) can serve as diagnostic templates or prototypes (Westen and Shedler, in press). The clinician then simply rates the degree of match between a patient's personality and each diagnostic template, using a 5-point rating scale: 1 = no match, 2 = slight match (patient has minor features of the disorder), 3 = moderate match (patient has features of the disorder), 4 = strong match (patient has the disorder; categorical diagnosis warranted), 5 = very strong match (patient exemplifies the disorder; prototypical case). Rather than counting symptoms, as in the current axis II system, the clinician would simply compare the patient's personality to the overall configuration or gestalt of each prototype to make a diagnosis. This procedure would likely take no more than a minute or two for clinicians familiar with the diagnostic prototypes, and would yield diagnoses similar to those currently used by clinicians (e.g., narcissistic PD with histrionic features), because clinicians would rate the patient on each prototype, but scores greater than or equal to 4 would constitute categorical diagnosis, and scores of 3 would constitute "features."

We believe this way of approaching classification of adolescent personality pathology has advantages over the present system, because it is (a) more clinically grounded, based on the observations made by clinicians in everyday practice, (b) more grounded in the clinical observation of adolescents in particular, and (c) empirically derived, using precisely the kinds of statistical procedures that have been designed to detect patients' similarities and differences that are not manifestly observable to the naked eye. Nevertheless, the data reported here are just a first pass, using a version of the adolescent SWAP–200–A that will be refined based on comments and data from the more than 300 clinicians who have now used the instrument. We are currently beginning a larger, National Institutes of Mental Health–sponsored study using the next iteration of the SWAP–200–A with a sample of 1,200 adolescents evenly divided among three age groups (13–14, 15–16, 17–18 years). We hope this will allow us not only to refine this classification system but to examine the developmental psychopathology of personality pathology, exploring the age at which personality clusters resembling those found in adults begin to emerge.

Conclusion

The study of adolescent personality pathology is in its infancy. Promising developments from a number of quarters suggest, however,

that the infant may be developing rapidly, and may be beginning to individuate from adult classification systems while maintaining "identifications" that prove empirically sound and clinically useful.

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