An Empirically Derived Classification of Adolescent Personality Disorders

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Objective: This study describes an empirically derived approach to diagnosing adolescent personality pathology that is clinically relevant and empirically grounded. **Method:** A random national sample of psychiatrists and clinical psychologists (N = 950) described a randomly selected adolescent patient (aged 13–18 years, stratified by age and gender) in their care using the Shedler-Westen Assessment Procedure-II-A for Adolescents (SWAP-II-A) and several additional questionnaires. **Results:** We applied a form of factor analysis to identify naturally occurring personality groupings within the patient sample. The analysis yielded 10 clinically coherent adolescent personality descriptions organized into 3 higher-order clusters (internalizing, externalizing, and borderline-dysregulated). We also obtained a higher-order personality strengths factor. These factors and clusters strongly resembled but were not identical to factors similarly identified in adult patients. In a second, independent sample from an intensive day treatment facility, 2 clinicians (the patients' treating clinician and the medical director) independently completed the SWAP-II-A, the Child Behavior Checklist (CBCL), and a measure of adaptive functioning. Two additional clinicians, blinded to the data from the first 2 clinicians, independently rated patients' ward behavior using a validated measure of interpersonal behavior. Clinicians diagnosed the personality syndromes with high agreement and minimal comorbidity among diagnoses, and SWAP-II-A descriptions strongly correlated in expected ways with the CBCL, adaptive functioning, and ward ratings. **Conclusion:** The results support the importance of personality diagnosis in adolescents and provide an approach to diagnosing adolescent personality that is empirically based and clinically useful. J. Am. Acad. Child Adolesc. Psychiatry, 2014;53(5):528–549. **Key Words:** adolescent personality disorders, internalizing, externalizing, emotional dysregulation, adolescent personality pathology

Personality diagnosis in adolescence has long been controversial. Concerns include questions about the stability of personality in adolescents, differentiating normative adolescent characteristics from adult psychopathology, and the stigma of personality diagnoses.[1-4] Beginning with research conducted 2 decades ago showing that borderline personality disorder (BPD) can be reliably identified in adolescent samples,[5] several independent research teams using different methodologies have identified patterns of personality pathology in adolescent samples in both cross-sectional[6,7] and longitudinal[4,8-10] investigations.

Personality refers to stable patterns of affect, cognition, and behavior that emerge under specific conditions over time.[11,12] Although adolescence is a period of flux and development, a growing body of research highlights the persistence of personality characteristics from childhood and adolescence into adulthood.[8,9,13,14] Longitudinal research by Cohen *et al.* has documented that *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV)* personality disorder (PD) diagnoses in adolescence predict a range of outcomes in the 20s and 30s in a large normative sample, including emergence of axis I disorders not predicted by presence of the same disorders in adolescence (e.g., mood, anxiety, and substance use disorders). Other studies have documented not only the ability of adolescent personality diagnoses to predict current and future functioning, but also similarities between adolescent and adult variants of the same disorders.[5,15-18] Thus, despite the admonition in the *DSM-IV TR* and the tempered admonition in the *DSM-5* against personality diagnosis in

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adolescence, overwhelming evidence since the initial publication of the *DSM-IV* nearly 2 decades ago has demonstrated that such diagnoses can be made reliably by at least age 13 or 14 years and can predict important outcomes.

How best to classify personality pathology in adolescents, however, and whether adult PD diagnoses and criteria are optimal for adolescents, remain open questions, primarily for 2 reasons. First, the disorders in the *DSM-5* were identified using adult samples. Given the developmental differences between adolescents and adults, the applicability of precisely the same syndromes and criteria would seem unlikely. Second, although the classification of PDs in adults has been revised using empirical methods since its initial presentation in the *DSM-III*, it was never generated empirically and has proven to be fraught with difficulties over the last 30 years. These include excessive rates of artifactual co-occurrence of disorders or "comorbidity"; low cross-observer agreement in diagnosing personality except in narrowly defined reliability studies in which 2 observers observe the same interview or conduct the same interview within a few weeks of each other; the consistent finding that dimensional diagnosis is far more predictive of relevant criterion variables than categorical diagnosis; and the tendency of patients to receive uninformative "not otherwise specified" (NOS) diagnoses in both research and practice.[19-21]

The present studies were undertaken to develop and validate a taxonomy of adolescent personality pathology. Study 1 comprises a large sample (N = 950), highly representative of adolescents in clinical practice, in which treating clinicians provided the data from which to derive diagnoses empirically. Study 2 comprises a smaller study of the validity of those diagnoses, particularly cross-observer validity, in which 2 clinicians independently rated the SWAP-II-A and Child Behavior Checklist (CBCL),[22] and 2 other licensed clinicians independently completed ratings of patients' behavior on the unit using a well-validated instrument.

METHOD

Study 1

Participants. As part of a larger institutional review board–approved study on adolescent personality pathology,[23] we contacted a national sample of psychiatrists and psychologists with at least 5 years' experience post-residency (MDs) or post-licensure (PhDs) selected from the membership registers of the American Psychiatric and American Psychological Associations, including clinicians targeted in prior solicitations to create a practice research network. We selected clinicians whose membership records indicated an interest in or practice with children or adolescents, and supplemented this where necessary with a general sample of clinicians who did not indicate any particular interest or preference, given that many clinicians who treat adults also treat adolescents; the 2 subsamples of clinicians and patients did not differ in any significant ways. More than one-third of clinicians agreed to participate in the study by the time that we completed recruitment of the sample, with psychologists represented at roughly twice the rate as psychiatrists. Participating clinicians received a consulting fee of $200 to complete a battery of measures. Clinicians received a packet containing a cover letter, a consent form, a postage-paid return envelope, and the study measures. Each clinician contributed data on only 1 patient, to minimize rater-dependent variance.

Procedures. To obtain a broad range of personality pathology, from relatively minimal to substantial, we asked clinicians to describe "an adolescent patient you are currently treating or evaluating who has enduring patterns of thought, feeling, motivation, or behavior—that is, personality problems—that cause distress or dysfunction," and emphasized that patients need not have a *DSM-IV* PD diagnosis. We also instructed clinicians to disregard the caveats in the *DSM-IV-TR* regarding the application of axis II diagnoses to adolescents, and to simply to select a patient with any degree or form of personality pathology.

We obtained a stratified random sample, stratifying by age (13–18 years) and sex. The only exclusion criteria were chronic psychosis and mental retardation. In addition, we asked clinicians to select a patient whose personality they believed that they knew, using as a guideline $\geq$6 clinical contact hours but $\leqq$2 years (to minimize confounds imposed by personality change with treatment). To minimize selection biases, we directed clinicians to consult their calendars to select the last patient whom they saw during the previous week who met the study criteria, regardless of setting (e.g., private practice, residential facility).

Measures. The core battery of measures required approximately 2 hours to complete. We describe here only the measures used in this report.

Clinical Data Form for Adolescents (CDF-A). The CDF-A is the adolescent version of the Clinical Data Form,[24] a clinician-report form developed over several years that assesses a range of variables related to demographics, diagnosis, adaptive functioning, developmental and family history, and etiology.[25] Clinicians first provide demographic data on themselves and the patient. They then rate the patient's adaptive functioning using a number of indices, such as ratings of school performance and peer relations, as well

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