

Assessment and Treatment of Identity Pathology During Adolescence

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Abstract

Personality disorders can be seen as patterns of maladaptive personality traits that have their onset during childhood or adolescence and that have an impact on the individual throughout the life span. Identity disturbance is seen as the central construct for detecting severe personality pathology—and, most notably, borderline personality disorder—in adults and adolescents. Therefore, in the revision of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, the construct of “identity” has been integrated as a core diagnostic criterion for personality disorders.

One of the most central tasks of normal adolescent development is the consolidation of identity. Crises in the development of identity usually resolve into a normal and consolidated identity with flexible and adaptive functioning. By contrast, identity diffusion is viewed as a lack of integration of the concept of the self and significant others; it is also seen as the basis for subsequent personality pathology, including that of borderline personality disorder, which leads to a broad spectrum of maladaptive and dysfunctional behaviors.

To measure identity pathology and its improvement with treatment, we developed a self-report questionnaire entitled Assessment of Identity Development in Adolescence to establish a reliable, valid, and time-efficient inventory to represent a dimensional concept of healthy and impaired personality development. The reliability of this self-report questionnaire is excellent, and the total score differentiated significantly between controls and patients with personality disorders.

Adolescent Identity Treatment is a treatment model that focuses on identity pathology as the core characteristic of personality disorders. This model integrates specific techniques for the treatment of adolescent personality pathology on the background of object-relation theories and modified elements of Transference-Focused Psychotherapy. Moreover, psychoeducation, behavior-oriented home plans, and family work support the therapeutic process of the adolescent.

Keywords: adolescence; Adolescent Identity Treatment (AIT); Assessment of Identity Development in Adolescence (AIDA), identity; identity diffusion; personality disorder

Introduction

In the revised *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), the definition of personality disorder and its diagnoses have not been changed from those presented in the DSM-IV-TR. However, an alternative model for the diagnosis of personality disorders has been placed in Section III of the DSM-5, and the construct of “identity” has been integrated as a central diagnostic criterion for personality disorders (1). The focus of this article is on the relevance of identity problems to understand personality pathology during adolescence; we will also demonstrate how identity disturbance in adolescents can be assessed and treated.

Identity Disturbance During Adolescent Development

The consolidation of a stable identity is one of the core developmental tasks of adolescence. According to Erikson’s definition (2), *identity* is a fundamental organizing principal that develops constantly throughout life and that provides a sense of continuity within the self and in interaction with others (“self-sameness”); it is also a frame through which to differentiate the self from others (“uniqueness”) and to function autonomously. A well-integrated identity with flexible and adaptive functioning plays a role in self-esteem, in the realistic appraisal of the self and others, and in the development of insight into the effect that one has on others. Identity is a basis of self-reflective

functioning that provides predictability and continuity of functioning within a person, across situations, and across time (3).

Erikson (2) was the first to formulate concepts of identity crises and identity diffusion as characteristics of normal and pathological personality development. An identity crisis occurs as a result of a lack of confirmation by others of the adolescent's changing identity. During such a period, there is a lack of correspondence between the view of the adolescent by his or her immediate environment and the adolescent's changing self-experience (4). Identity crises are normal elements of adolescent development (5). During identity crises, the continuity of the self remains across situations and across time, despite experimentations with different roles. Such crises usually resolve into a normal and consolidated identity with flexible and adaptive functioning (3).

In contrast, identity diffusion is seen as the core of personality pathology. It implies that there has been a lack of integration of the concepts of the self and significant others (6,7), and it leads to a broad spectrum of maladaptive and dysfunctional behaviors:

- The leading symptoms are chronic emptiness, superficiality, poor anxiety tolerance, and a lack of impulse control (8).
- The normal capacity for self-definition is lost, so emotional breakdowns occur at times of physical intimacy, occupational choice, or competition (1).
- The lack of a stable self-definition leads to a threatening sense of danger of fusion or of loss of identity in intimate relationships. Thus, one of the interpersonal consequences of identity diffusion is the incapacity for intimacy in relationships; this is one of the four core criteria presented in the alternative model given in the DSM-5 (9).
- Under the influence of a peak affective state, there is a serious loss of the normal capacity for self-reflection and mentalization (10). The person is not able to assess the affective state from the perspective of an integrated sense of self.

Assessment of Identity Development

The Self-Report Questionnaire Assessment of Identity Development in Adolescence (AIDA)

Because identity development is regarded as the key feature in emerging personality disorders during adolescence, we developed the self-report questionnaire Assessment of Identity Development in Adolescence (AIDA) (11) to differentiate between healthy identity integration, identity crisis, and identity diffusion. This instrument has proved to be a reliable, valid, and time-efficient inventory

that represents a dimensional concept of healthy and impaired personality development. It can also be used as a screening instrument to evaluate the outcomes of specific treatments for identity disturbance, such as Adolescent Identity Treatment (AIT). AIDA has been translated into 15 different languages, with each translation focusing on thorough cultural adaptation (12).

AIDA is a 58-item self-report questionnaire for adolescents and young adults that assesses identity development in the two dimensions of continuity and coherence.

Continuity/Discontinuity and Coherence/Incoherence

Characteristics that help us to differentiate identity diffusion from normal identity are found along the continuums of continuity/discontinuity and coherence/incoherence (8).

Continuity is the basic emotional experience of the self as existing fully in the moment and across time, which is also known as the "I." It is characterized by the experience of a subjective self-sameness within a moment and across time and that exists in the past, the present, and the future (i.e., ego stability). This is associated with identity-stabilizing goals, talents, roles, and relationships within an accessible emotional context.

Coherence is the narrative experience of the self that is articulated in the awareness of the social context; this is also known as the "Me," and it is defined as being identical with oneself. It is characterized by the individual being consistent and genuine rather than suggestible or superficial. It requires good access to cognitive awareness, which is particularly evident in the presence of well-integrated and differentiated mental representations, which allow for the maintenance of the self in the context of others (i.e., ego strength).

For an individual with a normal identity, coherence and continuity are both present, so the experiences of "I" and "Me" are integrated and do not feel distinct or distant. This state is associated with the capacity for in-depth interpersonal relationships, with good self-differentiation and other differentiation, with mutuality and reciprocity, and with the maintenance of self within the social context.

AIDA has shown good reliability, with an alpha of .94 for the total scale of identity integration versus identity diffusion as well as alphas of .86 and .92 for the two primary scales discontinuity and incoherence, respectively. The total score differentiated significantly between controls and patients with personality disorders, with effect sizes of more than two standard deviations (13).

Treatment of Identity Pathology During Adolescence

Adolescent Identity Treatment

In 2000, Paulina Kernberg and coworkers illustrated a model for understanding identity pathology in children and adolescents (3). Their primary concern was differentiating those adolescents with normal identity crises from those with identity diffusion. In 2005, a clinical supervision study group co-led by Paulina Kernberg and Pamela Foelsch began to develop a treatment approach to facilitate the integration of identity with consideration for the developmental tasks and capacities of adolescents; the results were later developed by our group into AIT (14).

AIT is a therapeutic approach to the treatment of personality disorders in adolescents that includes both psychodynamic and integrative perspectives. AIT specifically focuses on identity; it integrates modified elements of Transference-Focused Psychotherapy (15) with psychoeducation, behavior-oriented home plans, and work with parents to support the therapeutic process of the adolescent. In contrast with typical psychoanalytic treatments, AIT has characteristics that include the use of a treatment contract, emphasis on affects in the here and now, the preferred technique of clarification (and less interpretation), the combination with behavioral and psycho-educational elements like a home plan, and the inclusion of parents, school, peer-groups, and siblings.

The Theory Behind the Model: Object Relations Theory

In modern object relations theory, there is a basic assumption that early experiences with caregivers, particularly those within intense affect states, lead to the development of internalized mental representations of the self and a mental representation of the other (7,16). Under conditions of peak affect activation—whether they are of an extremely positive and pleasurable nature or an extremely negative and painful one—specific internalizations take place and are framed by the dyadic nature of the interaction between the baby and the care-taking person. This leads to the development of specific affective memory structures with powerful motivational implications. Kernberg (7,15,17) stated that dyadic structures constituted by a representation of the self, interacting with a representation of a significant other, under the dominance of a peak affect state explain adult pathology that is based on early developmental experiences. These basic dyadic units are heuristic devices that facilitate the recognition of shifts in affective experience of the self and others in therapeutic “here and now” moments.

The Kernberg model (15,17) assumes that positive and negative affective memories are built up separately during the early internalization of these intense caregiving experiences. Later on, they are actively split or dissociated from each other in an effort to maintain an ideal domain of experience of the relationship between the self and others and to escape from the frightening experiences of negative affect states. Negative affect states tend to be projected and to evolve into the fear of “bad” external objects, whereas positive affect states evolve into the memory of a relationship with “ideal” objects. It is proposed that this early split experience protects the idealized experiences from contamination with the bad ones until a higher degree of pain tolerance and a more realistic assessment of external reality, particularly under painful conditions, can evolve.

Basic Principles of Adolescent Identity Treatment

The basis of AIT is to clear blockages of normal development—specifically of identity—to produce improvements in behavioral, affective, and social functioning. The normal development of the integration of positive and negative aspects of self and others can become blocked as a result of constitutional factors, environmental factors, or their combined interaction. The psychotherapeutic interventions of AIT target both constitutional and environmental contributions to help clear the developmental blockages in adolescents who suffer from identity diffusion.

Clearing Blockages

During normal adolescent development, situations that evoke an identity crisis create temporary confusion regarding the individual’s identity. This confusion generally resolves naturally as the adolescent integrates the contradictory images of the self that were evoked from the discontinuities between the self and others’ views of the self. These occur most noticeably in the context of major life choices (e.g., intimacy, career choice, competition, psychosocial). However, it is the everyday situations that the adolescent encounters that evoke the daily decisions that help to define the self through actions. Most of these occur with little awareness or conflict. For example, adolescents make decisions about what they will wear, who they will spend time with, where they will go, and what they will do. Together, these actions define who the adolescents are, how they wish to appear to others, and how others actually see them. The working-through process occurs relatively smoothly and as part of the normal discourse with friends, trusted adults, and family members. In adolescents with identity diffusion, the normal ability to resolve the

contradictory self-images evoked during an identity crisis is blocked by the maintenance of various defenses, particularly the split of the positive and negative representations of the self and of the representations of others.

AIT focuses on clearing these blockages through the use of the therapeutic relationship as well as interpretive work (i.e., using the techniques of clarification, confrontation, and, ultimately, interpretation) so that normal development can occur at an age-appropriate level.

Contract Setting

The purpose of setting a treatment contract is to provide a clear frame within which deviations can be observed, clarified, confronted, and ultimately interpreted. Although most aspects of the individual contract will remain between the therapist and the adolescent (e.g. regular attendance at therapy sessions, no drugs before sessions, report self-cutting), there are some modifications that need the inclusion of the parents to facilitate support for the treatment and the individual contract (e.g., remind the child to go to therapy, help the child to control drug abuse). There is also a need for increased direct environmental interventions by those who work with adolescents (e.g., pediatricians, teachers, social workers). Finally, it is very important to develop and implement the “Home Plan”, which represents the family contract as it applies to rules at home.

Home Plan

The Home Plan is based on the integration of psychodynamic and family systems theory, and it involves primarily cognitive-behavioral techniques. The plan incorporates aspects that the adolescents and their parents have identified as problematic, and it is organized and prioritized by the therapist. Prioritization follows the standard AIT hierarchy, with self-harm being at the top of the list. The therapist must judiciously choose which norms to support and include in the Home Plan; he or she will need to decide which of these will be targeted for change. Although the primary emphasis is on controlling the adolescent’s self-destructive behavior and engendering a sense of respect for the self and others, ineffective patterns of communication by the parents are also addressed. Parents can also include expectations for their own behavior in the home plan, such as “no nagging” (i.e., ask only once and then leave it to the adolescent to respond). The Home Plan serves the function of organizing the overt behavioral interactions between the adolescent and his or her family. It provides rewards and consequences for behavior; it offers an opportunity to clarify

distortions in the perception of reality (particularly the discrepancies between the adolescent and the parents); and it encourages self-reflection and personal responsibility for the actions and the contributions to interactions of each party while remaining flexible. Furthermore, the Home Plan provides a “helping ego” for the family by providing structure and an explanatory model for understanding the adolescent’s actions and world view. Finally, the Home Plan supports motivation and positive behaviors by helping to establish a sense of competence as the adolescent increases his or her ability to contain and manage his or her affect in a more effective way. In essence, it represents the reality principles present in the family.

Strategies for Treatment

With AIT, there are a few key strategies that guide the general approach and specific actions; these are articulated in the tactics and techniques of this strategy. In general, these aspects are consistent with the object relation treatment model elaborated by Clarkin and colleagues (15,17).

Identifying the Dominant Object Relationship Dyads

The first strategy is to identify the dominant object relationship dyads as they are observed within the extra-transference relationship and within the transference. Understanding these dyads help to elucidate the adolescent’s awareness of them in interpersonal relationships and in the “here and now” interaction with the therapist. The therapist can do this with the use of a four-step process. The first step requires the therapist to experience and tolerate the confusion and the strong affects that are activated as the adolescent’s inner world unfolds in the process. These affects are observed simultaneously within the adolescent’s descriptions of his or her relationships with others (i.e., the extratransference relationships) and his or her reactions to those relationships as well as within the transference itself (i.e., is the patient suspicious, interested, paranoid?). The second step requires the therapist to identify the dominant object relations. For example, the adolescent may characterize himself or herself as the “helpless victim” in the relationship with the “attacking other” which is also experienced in the therapist, who observes the adolescent feels like the victim attacked by the therapist. Once the therapist is clear about the activated dyads, they can then be shared with the adolescent (step three). However, this is only done after extensive clarification within the here and now of the affect and behaviors that are activated.

During the final step of the process, the therapist attends to the patient’s reactions to the presentation

of the object relations that are present in the here and now, and returns to clarification to facilitate cognitive reflection, affect tolerance, and ultimately differentiation from the other (therapist) and integration (of self and other mental representations).

Transference and Countertransference

Adolescents maintain relationships with their parents, other family members, teachers, and peers. For adolescents with identity diffusion, these relationships are often distorted by the projections of their internal world. These projections are the transfer of the internal object relationship world onto the relationship in reality with the other person. Because these projections have more to do with the internal world than they do with objective reality, they create many interpersonal problems, which further contribute to the maintenance of identity diffusion.

Techniques in Adolescent Identity Treatment

Clarification

Clarification is understood as the therapist's invitation to the patient to explore and explain any information that is unclear, vague, puzzling, or contradictory. Clarification is particularly important, because the main affect of borderline patients is confusion. Often psychotherapists think that they have to understand their patients "without words" and without asking; they believe that it is a sign of understanding when they do not ask questions. However, with the technique of clarification, it is the opposite: the therapist shows that there are still things that are unclear and that he or she is also curious to truly understand the patient. He or she may say things like the following: "I didn't understand"; "Please explain that to me again"; and "If I understand you correctly...." The main message conveyed is that the therapist is truly interested in understanding what the patient means. By asking these questions, the therapist conveys the following ideas: "I am not perfect, and I need further explanation"; "I am honest, and I'm telling you that I don't yet understand"; and, "It's OK if someone is not perfect."

The specific areas to target with clarification are the affects, the object relationship dyads, and the various perspectives (i.e., with regard to the self, others, and time). The main goal of clarifying the affects is to facilitate the adolescent's ability to recognize when he or she is having an affective experience; he or she will also then be able to identify and name the affects and ultimately will develop the capacity to differentiate the locus of the origin of the affect (i.e., Is the locus of origin within the self or the other? Is it internal or external?).

Clarifying the object relationship dyads is one focus of treatment; with adolescents, this is an essential aspect of the developmental phase (i.e., the context of the task of differentiation from the family of origin and movement into the adult world). The focus of the clarification is on the differentiation of the self and other as well as the integration of the self-representation and other representations. This directly increases reflective functioning, because adolescents are encouraged to articulate their internal experience and to imagine the experience of the other. This facilitates increasing differentiation between the self and the other. Clarification allows the adolescent to develop awareness and a vocabulary of experience while identifying and tolerating the affects that emerge in the context of this increasing awareness and associated meanings.

Confrontation

The process of confrontation with an adolescent involves bringing the contradictory thoughts, feelings, and/or actions into the adolescent's awareness; this allows for their gradual integration, which results in improvement of affect and impulse tolerance, judgment, and interpersonal functioning.

The contradictory presentation is observed in the three channels of communication: the verbal, the non-verbal, and the therapist's countertransference. All of these aspects are used to assist the therapist's selection of what contradictory aspects of the material (i.e., thoughts, feelings, actions of the adolescent, as well as therapist countertransference) to confront the adolescent with and when to share these observed discrepancies. Confrontations are invitations to look at the contradictions in experience that have become more conscious during the clarification process. As indicated, sometimes these contradictions are within the adolescent's own experience, but often they exist between the adolescent's experience and therapist's experience. Usually these are tolerated best when they are provided tentatively, as hypotheses, about the observations and/or the meanings of these contradictions (e.g., "You tell me that you are not at all disappointed that your mother didn't call you on your birthday, but you struggle with tears. What do you think could this mean?") This process elucidates the areas of contradiction or inconsistency and brings them into the adolescent's awareness. It is used to mark specific aspects in the here and now of the adolescent's experience while simultaneously challenging the adolescent to reflect on his or her experience. The contradictions and inconsistencies, the defensive functions, and the unconscious motives are brought into conscious awareness and used to confront the adolescent's

distortions of reality. This further sets the stage for interpretation.

Interpretation

Like confrontations, interpretations are hypotheses offered to the adolescent for his or her consideration. Unlike confrontations, which aim to bring the contradictions into awareness, interpretations help adolescents organize and develop meaning for their thoughts and actions. Interpretations focus on the intrapsychic functioning, which has been understood through the earlier clarifications and confrontations around the material that is conflicted. The goal is to help articulate the relationship between the various aspects of the adolescent's conscious material and to link this with the inferred unconscious material that is exerting influence on the adolescent's motivation and functioning. The interpretation links the contradictions between the verbal and non-verbal information and the countertransference.

In contrast with the process used for adults, interpretation involves an attitude of play when working with adolescents. Because adolescents are in the transition from childhood to adulthood and because their cognitive abstract reasoning skills are continuing to develop, it is often useful to incorporate metaphors and stories into the interpretation process.

The therapist will systematically work toward the full interpretation by providing language to articulate the affective experience in the context of the activated object-relationship dyads. He or she will also offer alternative possibilities (i.e., explanatory hypotheses) in an effort to provide concrete options from which the adolescent may choose. For example, "Could it be that you feel a, b, c, or none of these feelings in the situation you described?"

Therapeutic Stance

There are three attitudes that optimally support the therapeutic process of AIT: 1) openness and acceptance within the treatment structure; 2) optimism (holding a positive mental representation of the adolescent); and 3) curiosity and interest in wanting to know the adolescent as a person (not just within the context of his or her pathology). Optimism is a general attitude that allows the therapist to engage therapeutically because he or she has a vision of the adolescent's potential and is able to imagine the patient in health. It has a counterpart within the adolescent, which we refer to as the minimum "one square millimeter" of desire to change in treatment. Both are required for a successful treatment to occur.

The therapeutic stance is composed of the factors associated with all good therapists (e.g., genuineness, warmth, empathy), but in this case emphasis is placed on certain aspects that are particularly relevant to adolescents. A therapist is fully present when the body language, affect tone, and language are consistent and integrated with the cognitive curiosity directed toward understanding the adolescent's experience in all areas, but with particular attention to the here and now relationship.

Although there are many techniques that will greatly facilitate the adolescent's ability to move from a position of identity diffusion toward normal identity development, there is a simple premise upon which all the techniques are based. Adolescents, like children, learn primarily through actions. Therefore, it is the therapist's actions that the adolescents experience. A therapist who is genuinely interested in and curious about an adolescent's experiences is modeling a way to productively engage interpersonally. On a deeper level, it is important to engage the adolescents in the areas of being curious and interested in themselves as well as in their relationship with the therapist. Clinically, therapists observe that adolescents with personality pathology have often lost the natural curiosity toward and interest in things that is usually a prominent characteristic of children and normal adolescents. The therapist needs to focus on increasing the adolescents' curiosity and interest in their own experiences.

Working with the Families

Working with parents is one of the core aspects that differentiates work done with children and adolescents from that done with adult patients. There are variations among therapeutic approaches to when and how to work with the parents of adolescents. Typical psychotherapeutic work with adolescent and young adults places the family work much more in the background. With AIT, however, the therapist must work with the parents and families to support the changes that will occur within the adolescents as the treatment progresses. To do this, the therapist's stance toward the family, in the absence of any egregious boundary violations (e.g., the presence of sexual or physical abuse), is one of general acceptance that the family members have been doing the best they can; they may just not necessarily be using the most effective strategies or acknowledging the real impact of the pathology of the adolescent. Even "good enough" parents can appear to be quite disturbed under the loading of the severe disorder of their child.

Even in very disturbed relationships, there are intense bonds between children and their parents. If

the therapist does not include the parents in the treatment process, he or she underestimates their influence on the interactions that take place in the home and that maintain the disorder. Therapists also overestimate themselves if they take full responsibility for the adolescent. If the parents are viewed as terrible and invalidating, then the therapist siding with the adolescent's view of the terrifying and persecutory parents may cause the adolescent to fantasize about the therapist as a better parent (i.e., a "savior"). This risk fosters and maintains a split internal structure as opposed to the treatment goal of integration.

Psychoeducation

With AIT, psychoeducation is provided to parents to promote an understanding of the normal developmental tasks of adolescence as well as of the areas in which their child is having difficulties. Four areas are typically addressed: 1) communication and relationship building and maintaining; 2) limit setting; 3) safety/rescue/judgment/autonomy; and 4) affect management.

Information about what is normative and usual for adolescents gives parents a frame of reference within which to understand the areas that are problematic for their child. Psychoeducation also provides an opportunity for parents to become aware of what they may not have acknowledged about the depth and breadth of their child's difficulties. In rare cases, it may also help those parents who are too eager to find dysfunction in their child to normalize their view and expectations.

Clinical Significance

For a long period of time, the assessment and treatment of adolescents' personality pathology was completely dependent on concepts and instruments that had been developed for personality disorders in adults. In this sense, the adaptation of Dialectical Behavior Therapy for the treatment of adolescents with Borderline Personality Disorder was a major breakthrough (18); it was followed, in recent years, by the adaptation for adolescents of other treatment approaches for adults, such as Cognitive Analytic Therapy (CAT), Mentalization-Based Therapy (MBT), or Emotion Regulation Training (ERT) (19-21). Using the psychodynamic approach Transference-Focused Psychotherapy (TFP) our working group integrated family systems theory, behavioral concepts, and psychoeducation into the integrative therapeutic approach of AIT, which is attuned to the specific needs and difficulties of adolescents with severe identity pathology. The inclusion of the family is seen as essential to the success of this treatment. The results of an initial pilot study are promising (14). As a next step, we plan to evaluate

both the treatment outcomes and basic therapeutic processes of AIT as compared with DBT-A. The AIDA questionnaire can also be used as both a screening tool to detect emerging personality pathology in adolescence and an outcome measure to assess changes in identity disturbance from diffusion toward healthy identity integration.

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