2014

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Abstract

Recent changes to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* highlight the importance of identity dysfunction within several psychiatric diagnoses. Despite a long-standing tradition of identity research and theory in the developmental literature, there is limited work establishing intersections between clinical and developmental conceptualizations of identity problems. The relative lack of integration between decades of clinical and developmental work is unfortunate, and likely limits progress in both areas. In this commentary, the authors argue for greater interdisciplinary collaboration and highlight contributions from developmental and clinical theories, which, if integrated, could enhance identity scholarship. The developmental psychopathology perspective is introduced as an ideal framework to promote these goals.

Developmental researchers have established a rich and growing literature on identity. To date, hundreds of empirical and theoretical articles have been published on identity, the self, and related phenomena. This literature delineates identity formation, process or styles, structure, problems, and identity development across adolescence and emerging adulthood (Berzonsky, 1990; Kroger, Martinussen, & Marcia, 2010; Marcia, 1986; Westen, Betan, & Defife, 2011). The application of such work influences research, teaching, and clinical practice.

Clinical applications of identity theory and research began with Erikson (1956) and include identifying persons experiencing identity distress, observing outcomes of identity dysfunction, and clarifying mechanisms by which identity problems emerge, develop, and resolve. Over the past six decades, developmental scholars have delineated adaptive and maladaptive identity trajectories across the lifespan. Achieving a healthy identity allows one to navigate major life tasks and stages, achieve intimacy with others, and become autonomous (Erikson, 1968; Marcia, 1994; Phinney & Baldelomar, 2011). Problems arise when a person is unable to effectively

explore and/or commit to defining life roles and beliefs (Kroger, 2007; Marcia, 2006). Deficits in identity are associated with negative outcomes including psychopathology, poor coping strategies, impulsivity, and parent-child conflict (Ferrer-Wreder, Palchuk, Poyrazli, Small, & Domitrovich, 2008).

Clinical scientists have devoted very little attention to this area, despite the rich theoretical and empirical tradition supporting the importance of identity as a construct (Montgomery, Hernandez, & Ferrer-Wreder, 2008). While research funding agencies have targeted the amelioration of clinical disorders in recent decades, there have been few opportunities for translating developmental work into practice. Therefore, therapists, psychiatrists, and clinical psychologists are often unfamiliar with key developmental findings. Without a basic understanding of developmental findings, little guidance is available for distinguishing pathological identity problems from normative identity confusion (Marcia, 2006). Indeed, although initial formation largely takes place in youth, identity is a lifelong developmental task, and thus remains relevant across the lifespan. The disconnect between developmental research and clinical and practice is unfortunate given that mental health practitioners frequently encounter a range of identity problems, from developmentally appropriate levels of distress to severe disturbance.

The purpose of this article is to promote greater integration of developmental and clinical work by introducing areas of overlap and divergence in each field's conceptualization and study of identity problems. We describe identity problems from the newest edition of the Diagnostic and Statistical Manual (*DSM-5*; American Psychiatric Association, 2013) and from the developmental literature, highlighting contributions and areas for growth within developmental and clinical theories. In addition, we propose the developmental psychopathology perspective as a fruitful framework for approaching future research on problematic identity development. A comprehensive review of the developmental and clinical literatures on identity is beyond the scope here (for other discussions of this topic, see Kroger et al., 2010; Meeus, 2011; and Meeus, Van de Schoot, Keijsers, & Branje, 2012). Rather, this commentary is intended to call attention to the relevance of developmental research on identity for clinical scholars. Future areas for growth are identified and discussed toward the end of this commentary.

Key Concepts from Developmental Research on Identity Problems

Formal inquiry regarding normative and problematic identity development began with Erikson (1950). He delineated key aspects of identity formation, including formative experiences in childhood and the process of establishing a coherent identity that occurs during adolescence (1956). According to Erikson, normative identity development occurs when a person explores available opportunities and options, and begins to make commitments to others and take on self-defining roles. Those who achieve a *consolidated identity* experience a sense of consistency across time and contexts, and demonstrate stable attitudes, beliefs, and values. This consistency is termed *self-continuity*, and has been referred to as the ''essence of identity'' (Chandler, Lalonde, Sokol, & Hallett, 2003; Dunkel, Minor, & Babineau, 2010, p. 251). It is not surprising that identity consolidation and self-continuity are associated consistently with psychological well-being (Dunkel, Mathers, & Harbke, 2011; Erikson, 1968; Lutz & Ross, 2003).

Erikson also delineated maladaptive identity processes and outcomes. He described a typical period of *identity crisis*, or a transitory phase during which an adolescent's identity is no longer

consistent with his or her past self-concept (Erikson, 1956). Erikson (1968) was clear that *identity confusion* is not a diagnostic entity, but rather a ''developmental disturbance,'' which is distinct from a ''malignant and more irreversible condition'' (p. 166). He defined *identity diffusion* as a more problematic outcome that can extend into adulthood. Diffused individuals experience sustained incoherence or identity confusion and an inability to commit to appropriate roles. Erikson (1968) also cautioned against strong negative identity choices (e.g., extreme nationalism or racism), and the tendency to unquestioningly adopt the values and views of others as one's own identity.

Marcia (1966) built upon Erikson's notions of exploration and commitment by operationalizing four *identity statuses* and conducting research on their psychological correlates. The first, *identity achievement*, is considered the highest state of identity development and describes individuals who have made commitments to their identity only after exploring and questioning their beliefs and values across multiple domains. The other three statuses delineated by Marcia include individuals who are experiencing identity problems: those in *moratorium* (exploring the sense of self, but unable to make a commitment), *foreclosure* (committing to identity prematurely without appropriate exploration), and *diffusion* (neither exploring nor committed to the self; Marcia, 1986). Several decades of research have indicated that those in diffusion have especially high rates of psychopathology and adjustment problems, including personality pathology, persistent emptiness, chronic boredom, affective distress, impulsivity, parent–child conflict, disrupted attachment, poor coping strategies, and symptoms of anxiety and depression (for a review, see Kroger & Marcia, 2011). The identity diffusion status is also associated with indecision about major life choices, difficulty forming intimate relationships, and reduced well-being (Adams, Ryan, Hoffman, Dobson, & Nielsen, 1984; Crawford, Cohen, Johnson, Sneed, & Brooks, 2004; Kernberg, 2006; Shanahan & Pychyl, 2007; Waterman, 2007).

Psychiatric Concepts of Identity Problems

The poor outcomes associated with the diffused identity status are consistent with psychiatric conceptualizations of identity-related distress. For example, working from clinical observations and building on Erikson's theory, Akhtar (1984) proposed that identity diffusion is an important focus of clinical attention and consists of six core features: (a) contradictory character traits, (b) temporal discontinuity in the self, (c) lack of authenticity, (d) feelings of emptiness, (e) gender dysphoria, and (f) inordinate ethnic and moral relativism. Subsequently, Wilkinson-Ryan and Weston (2000) identified key features of *identity disturbance* through empirical research. These include painful feelings of incoherence, inconsistencies in beliefs and behaviors, and difficulties with commitments (Weston, Betan, & Defife, 2011; Wilkinson-Ryan & Westen, 2000). They also found that identity disturbance is especially common in borderline personality disorder. Seeking to operationalize diagnostic criteria for identity problems for the *DSM-III* and *DSM-IV*, Berman, Montgomery, & Kurtines (2004) offered the notion of *identity distress*, which has generated a body of work delineating a unique type of distress associated with lack of coherent values and commitments (Berman & Weems, 2012).

However, diagnostic descriptions, diagnostically derived measures, and lists of correlated constructs are deficient relative to developmental accounts of the emergence and resolution of identity problems. In diagnostic formulations and correlational studies, the continuity between

normal and problematic identity is largely unexplored and presented without attention to etiology. Unfortunately, in the absence of alternatives, practitioners have been guided by psychiatric conceptualizations of identity, beginning with the *DSM-II* (American Psychiatric Association, 1968), where identity is considered almost exclusively in the context of significant maladaptation. Thus, the opportunity for translation of important developmental work into clinical practice is lost.

Identity Problems in the *DSM*

Identity has appeared in the *DSM* since the 1960s. The *DSM-II* described alterations in ''patient's state of consciousness or in his identity, to produce such symptoms as amnesia, somnambulism, fugue, and multiple personality'' as a feature of *hysterical neurosis, dissociative type* (American Psychiatric Association, 1968). By the *DSM-III-R* (American Psychiatric Association, 1987), identity problems constituted a unique, stand-alone disorder. This edition described *identity disorder* as a pathological extreme of an identity crisis with excessive and prolonged uncertainty regarding long-term goals, career choice, friendship patterns, sexual orientation and behavior, religious identification, moral value systems, and group loyalties. However, when the *DSM-IV* was published (American Psychiatric Association, 1994), *identity problems* in these same areas were demoted to ''other conditions that may be a focus of clinical attention,'' with the more liberal criterion of ''uncertainty about multiple issues relating to identity'' (p. 685). *Identity disturbance* has also been included as a criterion for borderline personality disorder since the *DSM-III* (American Psychiatric Association, 1980).

Identity and *DSM-5*

Identity has a single entry in the index of the *DSM-5* (American Psychiatric Association, 2013): ''identity disturbance due to prolonged and intense coercive persuasion'' (p. 306), resulting, for example, from torture, experiences in cults, sects, or terror organizations. All references to ''identity disorder'' or ''identity problems'' such as those in the *DSM-III* and *DSM-IV* are absent. However, the *DSM-5* does present an ''Alternative DSM-5 Model for Personality Disorders'' (American Psychiatric Association, 2013, p. 761), which establishes identity as a construct of interest in a novel way. The alternative model ''aims to address numerous shortcomings of the current approach'' (p. 761), including previous inattention to the dimensions that underlie personality pathology. In order to effectively articulate a continuum of personality—from normal functioning to clinical problems—the *DSM-5* work group members aimed to identify several core dimensions of personality (Morey et al., 2011). Identity functioning is one such dimension (Bender, Morey & Skodol, 2011; Morey et al., 2011).

The proposed model of the diagnostic criteria for personality disorders is a substantial reformulation, which maps well onto longstanding developmental theory and recent empirical evidence (e.g., Kernberg, 1984, 1996; Morey et al., 2011). Healthy identity is defined as the ''experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience'' (p. 762, American Psychiatric Association, 2013), whereas *problematic identity* is rated on a 1–4 level scale delineating little to extreme impairment (see pp. 775–778).

It is important to note that this conceptualization elevates identity disturbance from a symptom of borderline personality disorder to a core feature of every personality disorder. The alternate model also includes (a) new general criteria, which are used to define core impairments of all personality disorders, and (b) specific pathological traits, which are used to differentiate the specific disorders from one another. Among the general criteria are significant impairments in self (identity and self-direction) and interpersonal (empathy and intimacy) functioning.

These ''self'' and ''interpersonal'' domains are more consistent with longstanding views of psychosocial development than with previous systems of personality disorder classification. For example, representations of self and interpersonal relationships are now explicitly described as reciprocally influential, consistent with Eriksonian notions of the interplay between intimacy and identity (and described by Crawford et al., 2004, and Kroger, 2005). In addition, and also consistent with Erikson (1956), functioning in these areas is conceptualized as existing along continua, with moderate or greater impairment being indicative of disorder. Implementing a more dimensional approach is now favored by many in the psychological community, including proponents of the developmental psychopathology perspective, as it can more accurately capture developmental nuances, allow for more flexibility in diagnosis, and better account for intraindividual change over time (Schmeck et al., 2013; Widiger & Trull, 2007). With identity taking a more prominent place in the *DSM-5*, developmental researchers have an important role in guiding of how to define and measure identity problems.

At present, there are disconnects between (a) the current identity literature, which emerged from the developmental perspective, (b) the diagnostic system, written primarily by psychiatrists who may have limited knowledge of developmental psychology in general and identity development in particular, and (c) increasing expectations from funding agencies to integrate biological mechanisms and processes, despite the historical absence of funding for developmental or clinical research on identity. We assert that developmental research needs to inform clinical conceptualizations of identity-related processes, including the identification and assessment of identity-related dysfunction. However, disciplinary boundaries often impede clinical researchers and therapists from integrating decades of developmental and sociological theories into their work. These limitations could be overcome through a careful integration across literatures and cross-disciplinary collaboration. Such efforts could extend the boundaries of clinical and developmental science, with promise for intervention and prevention applications.

Distinguishing Overlapping Constructs

There are several barriers that make it challenging to integrate identity research across disciplines. A primary stumbling block is the proliferation of identity related concepts and terms that seem to describe similar phenomena. Operationalizing identity constructs, applying them consistently across different fields, and thus diminishing redundancy would allow for more effective cross-disciplinary communication. For example, it seems likely that current constructs from the developmental and clinical areas represent points along a continuum of identity functioning (e.g., ranging from identity consolidation to identity disturbance with individuals moving along the continuum fluidly across development). A dimensional conceptualization of identity functioning reflects current knowledge, as identity problem appear to exist on a spectrum of severity, and is consistent with both Eriksonian notions of lifespan psychosocial development

(Erikson, 1956) and the developmental psychopathology perspective (Kaufman, Cundiff, & Crowell, in press).

Unfortunately, identity terms are often conflated. For example, the terms *identity disturbance* and *identity diffusion* are frequently used interchangeably. The American Psychiatric Association defines pathological identity disturbance in borderline personality disorder as ''markedly and persistently unstable self-image or sense of self'' (American Psychiatric Association, 2000). Identity diffusion, as defined and observed by Erikson, Marcia, and others (e.g., Meeus et al., 2012) can be part of a normative developmental course. Identity disturbance (which is consonant with Erikson's distinction of ''acute identity confusion,'' (1956, p. 121) is ''when identity diffusion becomes clinically relevant or genuinely psychopathological'' (Westen, Betan, & Defife, 2011, p. 306). However, despite efforts to distinguish these related terms, the cutoff between identity diffusion and identity disturbance remains unclear. This ambiguity makes it difficult to tease apart which negative outcomes are attributed to identity diffusion, and which to more severe identity disturbance. For example, literature from the developmental perspective cites identity diffusion as being associated with various forms of pathology. However, the individuals included in the identity diffusion status in these studies likely had a range of identity disturbance, from moderate to severe. Conceptualizing available terms as existing on a continuum may aid in standardizing the language used to describe identity problems.

In addition to the proliferation of identity terms, there are also distinctions between the constructs of *self* and *identity*, which are frequently ignored or misunderstood. The Alternative Model of Personality Disorders proposed in the *DSM-5* defines personality disorder as manifesting through impairments in ''self functioning,'' which includes two aspects, ''identity'' and ''self-direction'' (American Psychiatric Association, 2013, p. 761). The literatures on self and identity have developed in relative isolation from each other, with work in one area seldom referencing work in the other (Schwartz, Luyckx, & Vignoles, 2011). In one attempt to remedy this, Schwartz and colleagues (2012) referred explicitly to the ''self-system'' (p. 1209) and drew links between developmental notions of self-organization, self-concept, and identity in the development of a healthy personality in early adolescence. Combining integrative conceptualizations such as these with a broad approach will aid in our understanding of identity problems and ultimately improve efforts to prevent and treat them. We propose that the developmental psychopathology perspective provides an effective framework for uniting developmental and clinical perspectives, and offers a potentially fruitful paradigm for integrative work on identity problems.

The Developmental Psychopathology Perspective

Developmental psychopathology is an integrated perspective that applies developmental methods and theories to the study of pathological outcomes. Sroufe and Rutter (1984) formalized this framework and outlined several broad tenets that set the approach apart from related scientific fields. The focus of developmental psychopathology is narrower than that of developmental psychology, yet developmental psychopathology scholars consider normative development the foundation for understanding risky and resilient trajectories. This perspective is also distinct from a purely clinical framework, which often fails to consider the role of normative development (e.g., distress is viewed as common and often helpful in spurring growth or problem resolution).

The unique purview of developmental psychopathology is to understand the origins and course of psychological problems and disorders, the varying manifestations of psychopathology across development, the precursors and sequelae of psychological problems, and the relation between disordered and nondisordered patterns of behavior (Sroufe & Rutter, 1984). This focus extends beyond mere description. Developmental psychopathology psychologists search for greater specificity regarding biological vulnerabilities, risk and resilience, and how biology × environment interactions shape developmental trajectories (Beauchaine, 2001). Multiple etiological mechanisms are presumed to underlie typical and problematic developmental courses, as no single biological system or environmental trigger is assumed to explain behavior in isolation.

Developmental psychopathologists consider normal and abnormal development mutually informative for understanding the emergence and maintenance of mental health problems. Indeed, many psychiatric disorders represent extreme presentations of normative processes, or reflect a failure to traverse one or more typical developmental milestones (Cicchetti & Rogosch, 2002; Macfie, 2009; Sroufe & Rutter, 1984). Furthermore, persons may shift between adaptive and maladaptive trajectories across development. Thus, research outcomes are viewed as fluid and changeable rather than definitive endpoints (see Beauchaine & McNulty, 2013). Importantly, developmental repertoires emerge hierarchically across time, with success at later developmental stages building upon previous accomplishments (Werner, 1957). For this reason, those with early problems are at heightened risk for negative trajectories. Without understanding developmentally normative traits and behaviors, defining psychopathology is arbitrary. For example, it can be difficult to discern when maladaptation is an extreme variant of a common characteristic or when it emerged from a distinctly pathological trajectory. Drawing the line between ''normal'' and ''abnormal'' is challenging, especially if one does not consider the fluidity between typical and atypical development and the range of potential outcomes.

Identity Problems and Developmental Psychopathology

We argue that developmental psychopathology is a useful paradigm through which to study identity related problems for several reasons. Most important, identity formation is a crucial developmental process that occurs across the lifespan, and is linked to adaptive and maladaptive outcomes. Furthermore, identity disturbance is associated with several psychiatric disorders, for example, personality disorders (e.g., Jørgensen, 2010; Kernberg, 2006; Marcia, 2006; Stern et al., 2010), eating disorders (Farchaus Stein & Corte, 2007; Wheeler, Adams, & Keating, 2001; Winston, 2005), mood disorders (Drucker & Greco-Vigorito, 2002; Inder et al., 2008), and schizophrenia (Lysaker & Lysaker, 2004). Within the psychiatric tradition, these disorders are defined as distinct conditions, and overlapping etiological mechanisms are often overlooked. In contrast, developmental psychopathologists are interested in common vulnerabilities and risk processes that underlie broad classes of behavior (i.e., mediating and moderating factors). The developmental psychopathology framework is well-suited to study the emergence of identity problems in psychopathology and the covariation of identity and psychological problems across development.

In addition, identity distress can occur outside of clinical diagnoses (Wiley et al., 2011). Findings accruing in this area of research suggest, for example, that identity distress/disruption can

occur after individuals experience natural disasters, particularly among those who have had negative reactions to previous traumatic stress exposure (Scott et al., this issue). Interactions such as these can be best interpreted from a perspective that accounts for multiple developmental pathways that vary as a result of historic and systemic influences. Identity development is influenced by a number of interacting variables, yet these interactions across biological systems and psychosocial processes have often not been emphasized (one exception is research on pubertal timing; e.g., Mendel, Turkheimer, & Emery, 2007). We see the developmental psychopathology paradigm as an elegant amalgamation of the developmental and clinical perspectives, and thus an appropriate lens through which to view normative identity processes and identity disturbance.

Integrating Biological System Perspectives

Scholars have long argued that identity formation is influenced by interacting systems, yet most ignore the influence of genetic and physiological systems on psychosocial processes (Montgomery & Sorell, 2001). Developmental and clinical scholars may benefit from adopting biological measures into their identity research. As stated above, the developmental psychopathology perspective views behavioral and emotional outcomes as the product of continuously transacting factors functioning at various levels (within the individual, and his or her environment). In order to obtain a comprehensive understanding of behavior, multiple systemic inputs must be examined.

In addition to the suitability of the developmental psychopathology perspective for uniting the clinical and developmental fields, its emphasis on biosocial interactions fits with granting agencies' recent organizational shift. The National Institute of Mental Health now calls for research proposals that incorporate biological processes, and arguably, much research in psychology is headed in this direction (Beauchaine, Neuhaus, Brenner, & Gatzke-Kopp, 2008). This shift is well founded since most contemporary accounts of psychopathology and normative development acknowledge the significance of biological and environmental influences on behavior. Biology $\times$ Environment interactions often account for more variance in key outcomes than either effect in isolation (see e.g., Beauchaine et al., 2008). Our biopsychosocial understanding of identity could benefit from incorporating variables from multiple levels of analysis, including biological measures.

A Unified Perspective

Explicit collaboration between members of the clinical and developmental communities is essential if we wish to address the barriers that limit our understanding of identity problems—including how to prevent and ameliorate them. At present, developmental and clinical researchers often operate independently of one another. Each discipline maintains a separate lexicon of identity terms and constructs, making integration across the fields challenging. A unified approach that incorporates developmental theory into clinical research and practice is needed to bridge these gaps.

A common framework such as the developmental psychopathology perspective would improve identity-related research and practical applications in several ways. First, it would

facilitate the development of a common language for describing identity related constructs and a shared understanding of the latent meaning of these phenomena. Second, this framework would provide clinical and developmental identity researchers a means for articulating common goals and identifying shared research methods. A third and related benefit that the developmental psychopathology paradigm offers is an emphasis on assessing how multiple systems shape developmental outcomes (e.g., genetic, physiological, and contextual levels of analysis).

Both clinical and developmental areas stand to benefit from working collaboratively. As stated above, clinical psychologists have focused largely on pathology and maladaptation, often failing to consider normative trajectories or examine when atypical trajectories serve adaptive purposes. Greater attention to etiology is needed in clinical research, especially when considering adult presentations, as it provides information that is useful in diagnosis, informs treatment decisions, and thereby improves clinical outcomes (Cicchetti & Toth, 1998). In addition, the psychiatric manual categorizes disorders discretely and often misses naturally occurring variation. The developmental paradigm has allowed scholars to describe a range of identity functioning and identify how some identity struggles are normative or even beneficial under some circumstances (for a review, see Marcia, 2006; Van der Werff, 1985). At the same time, developmental researchers could pay greater attention to abnormal trajectories, because individuals do not reach adulthood with identity problems in the absence of other psychosocial problems or, in severe cases, emotional and behavioral dysfunction (Erikson, 1956; Sroufe & Rutter, 1984). The developmental psychopathology perspective may add to the growing research regarding effective intervention for those struggling with identity disturbances.

Common Goals: Research Aims for Future Work

In addition to facilitating the development of a common language for identity-related constructs, using a developmental psychopathology framework would encourage cross-disciplinary work with shared research goals and common methods. Both clinical and developmental researchers are invested in elucidating identity processes and outcomes. However, the present study of identity may be viewed as pre-paradigmatic in many ways (Kuhn, 1962). At present, there are many types of research questions being asked with limited agreement regarding which aspects of identity functioning are most important. There are competing views and methods for investigating identity processes and outcomes, and much is still unknown. Applying the developmental psychopathology paradigm to identity research would highlight important areas for growth and capitalize on the strengths of the clinical and developmental disciplines.

Among the chief areas for investigation are the processes producing and maintaining various identity trajectories. Many youth with identity distress or confusion will not develop identity disturbance or a personality disorder, and adults who meet severe identity disturbance criteria likely traversed different developmental trajectories to the disorder. However, predicting who will develop healthy versus moderate or poor outcomes is currently very difficult. The etiology, causal mechanisms, and correlates of identity dysfunction are only partially established, and identity problems are, theoretically, multiply determined (Erikson, 1968).

Individuals who find themselves on an ''atypical'' identity trajectory may have failed to resolve the exploration and commitment phases of identity formation, and/or missed an earlier developmental task essential to identity consolidation. For example, researchers have found

that identity problems are more frequent among those with disrupted family relationships (e.g., Forthun, Montgomery, & Bell, 2006; Schwartz et al., 2005). While some research has identified early markers of identity problems or factors influencing the stability and continuity of identity outcomes across development (e.g., Adams, Ryan, & Keating, 2000; Duriez, Luyckx, Soenens, & Berzonsky, 2012; Kroger et al., 2010; Luyckx, Duriez, Klimstra, & De Witte, 2010; Meeus, 2011; Meeus et al., 2012; Waterman, Geary, & Waterman, 1974), longitudinal studies beginning in childhood are needed to identify trajectories that lead to optimal and problematic outcomes. Knowing more about the progression of normative identity development, beginning in early childhood, is essential to uncovering where problems arise in those on an atypical trajectory. Continuing such research efforts would enhance identity theory and elaborate the elegant framework of lifespan psychosocial development proposed by Erikson (Hearn et al., 2012).

Another nuance worth consideration is that identity problems may manifest in a relatively stable form across development (e.g., confusion regarding the self), or change across time (e.g., confusion regarding the self, then substance use problems, then personality pathology including identity disturbance). In some cases, heterotypic continuity or the change in diagnostic presentation over time is caused by expected and developmentally appropriate shifts in personality organization across the lifespan. Early predictors of adult psychopathology are frequently distinct from their later expressions. Without examining developmental milestones across childhood and adolescence, early markers for later identity problems may be easy to overlook entirely. Although adolescence is the developmental period associated with elevated rates of identity problems and psychopathology (Kroger, 2007; Marcia, 2006), greater attention to developmental precursors is needed.

Early identity problems may also mark risk for a range of later psychiatric diagnoses, suggesting that it may be a core impairment underlying psychopathology broadly. Although identity problems have been cited as occurring across many conditions (e.g., personality disorder; eating disorders; bipolar disorder, schizophrenia), further research is needed to establish whether identity problems (a) precede and influence these outcomes, (b) are the result of experiencing mental illness, and/or (c) are connected to a third variable that also predicts psychopathology. Again, these questions cannot be addressed without attention to developmental trajectories. Developmental theory would suggest that identity problems influence later psychopathology because a sense of self develops at a relatively early age.

In an empirical test of similar propositions, Crawford and colleagues (2004) drew on Erikson's notions of identity consolidation versus identity diffusion to examine developmental trajectories of personality disorder symptoms across middle adolescence and early adulthood. Consistent with theory, the authors found that ''diffuse identity,'' operationalized as Cluster B (borderline, histrionic, and narcissistic) personality disorder symptoms, was associated with lower well-being and with less inclination toward intimacy in young adulthood. This study is largely consistent with the developmental psychopathology perspective, as the researchers investigated outcomes longitudinally and were informed by developmental principles.

Although important strides have been made in identity research, there are many areas ripe for investigation. In addition, conceptualizations of identity problems influence funding allocation for prevention and treatment programs. Thus, strengthening conceptualizations of identity dysfunction across development will improve clinical research and interventions, and produce better outcomes for many individuals. The following topics are consistent with developmental and

developmental psychopathology perspectives, and present opportunities for fruitful cross-disciplinary collaborations. Researchers could:

- Test the validity and utility of the alternate personality disorders proposal in the *DSM* (American Psychiatric Association, 2012; Morey et al., 2011), which includes identity as a central construct.
- Identify continuous measurement approaches that include potential cutoffs between normative identity confusion and more severe disturbance (Kaufman et al., under review; Westen et al., 2011).
- Chart the developmental course from early problems to later disturbance, including key transitions in development (Hearn et al., 2012).
- Specify etiological factors that influence the onset, course, and outcomes of normative and clinical identity problems, including biological and contextual factors and their interactions across development (e.g., Schwartz et al., 2005).
- Expand identity research to incorporate other predictors of internalizing and externalizing pathology, such as trait impulsivity and emotion dysregulation (e.g., Crowell, Beauchaine & Linehan, 2009).

We believe much of this work could be more easily accomplished through a shared paradigm for identity research, such as the one outlined herein. The use of diverse methodologies to examine complex developmental systems will allow for the most thorough investigation of these questions, thereby enhancing scholarship relevant to developmental and clinical scholars who focus on identity.

Shaping the Future of Identity Research and Intervention

In this article, we have suggested that the developmental psychopathology perspective is a fruitful framework for enriching identity scholarship. This approach would encourage more dimensional measurement of identity, on multiple levels of analysis, across the lifespan. Without additional understanding of the salient issues connected to each developmental period and how they are navigated successfully, atypical patterns and their later consequences will continue to be difficult to distinguish. Identity research stemming from a developmental psychopathology perspective may facilitate the establishment of developmentally sensitive norms for identity problems. If identity is to take a prominent place in our diagnostic system, as it has in the proposed Alternate Model, these contributions will become even more important.

There is a great need for effective interventions targeting promoting positive identity development in addition to preventing or ameliorating identity problems (Eichas, Meca, Montgomery, & Kurtines, 2014). However, identity intervention scholarship is an area that, while growing, is still in its infancy. Intervention procedures should be informed by developmental principles, as understanding adaptive identity formation processes elucidate targets for prevention and treatment efforts (Ferrer-Wreder, Montgomery, Lorente, & Habibi, 2014). For example, many scholars have found that the family context is important for identity development (e.g., Adams, Ryan, & Keating, 2000; Schwartz et al., 2005). Given this evidence, practitioners may seek to intervene at a family systems level. Empirical studies examining well-being in relation to identity are also refining our understanding (e.g., the importance of maintaining some commitments while

revising others; Luyckx, Schwartz, Soenens, Vansteenkiste, & Goosens, 2010; Schwartz et al., 2012). Researchers in the developmental domain have created ''indicated'' interventions that target individuals likely to benefit because of developmental stage (adolescence and emerging adulthood; Kurtines et al., 2008; Meca et al., 2014) or circumstance (experiencing a crisis such as a natural disaster; Wiley et al., 2011). Others in the clinical domain have addressed symptoms of disturbed identity through approaches that amplify the sense of self through therapeutic conversation (Korner, Gerull, Meares, & Stevenson, 2006).

Unlike some developmentally transient issues addressed in prevention work and clinical practice, identity is a lifelong developmental process. Therefore, adopting a lifespan developmental perspective is especially important for those who seek to prevent or treat identity problems. In the past, there has been a large gap between how those specializing in child and adolescent treatment view the importance of developmental factors for clinical care compared with how those treating adults view these factors (e.g., Ingram & Price, 2010). We argue that every clinician and interventionist would benefit from adopting a developmentally sensitive approach. Identity, similar to other developmental processes, may not be the direct treatment goal for each case a clinician sees. Similarly, prevention programs may target positive identity development only as a mediator of problematic or pathological trajectories. In contrast, we believe that supporting positive identity processes ameliorating identity problems across the lifespan will foster well-being and prevent or relieve distress for many individuals. Greater interdisciplinary collaboration between developmental psychopathologists and identity scholars will create new opportunities to promote these goals.

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