

## **ADOLESCENT PERSONALITY DISORDERS AND CONFLICT WITH ROMANTIC PARTNERS DURING THE TRANSITION TO ADULTHOOD**

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Longitudinal data were used to investigate the association of adolescent personality disorders with conflict between romantic partners during the transition to adulthood (i.e., age 17 to 27). Findings indicated that adolescent personality disorders (PDs) assessed at mean age 16 were associated with subsequent elevated partner conflict. Cluster B PD was associated with sustained elevations in partner conflict throughout the transition to adulthood. Cluster A and C PDs were associated with elevated partner conflict before age 23. Paranoid, schizoid, schizotypal, borderline, narcissistic, and obsessive-compulsive PD symptoms were independently associated with sustained elevations in partner conflict.

More than anything else, personality disorders (PDs) are characterized by marked disturbances in close interpersonal relationships. Among other maladaptive interpersonal behaviors, DSM-IV (American Psychiatric Association, 1994) specifies unstable relationships, exploitative and abusive behavior, passive-aggressive behavior, excessive dependency, and pathologically avoidant behavior as symptoms of PDs. In fact, 45% of the DSM-IV criteria for diagnosing Axis II disorders identify dysfunctional interpersonal behaviors as symptoms of PD, far more than the remaining criteria devoted to maladaptive cognition (23%), affective disturbances (20%), or other behaviors (12%) (Pilkonis, 2002). Not surprisingly, adults with PDs commonly have elevated rates of marital conflict and partner violence (Craig, 2003; Gondolf & White, 2001; Holtzworth-Monroe & Stuart, 1994). Parents with PDs have serious interpersonal conflicts with children that may manifest in verbal, emotional, or physical abuse (Johnson, Cohen, Kasen, Smailes, & Brook, 2001; Kaufman et al., 1998). Disturbances between parents and children and between romantic partners are important to

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understand insofar as they probably help generate and maintain PDs in young people.

Various developmental theories like attachment theory (Bowlby, 1973, 1980, 1982) emphasize how interpersonal experiences play an important role in normal and abnormal personality development. According to attachment theory, caregivers initially help young children regulate negative affect by being available and providing empathic responses that comfort infants and children in distress (Calkins, 2004; Mikulincer, Shaver, & Pereg, 2003), thus preventing them from being overwhelmed by affect before they gain emotional and cognitive resources necessary to cope with distress on their own. The child and caregiver normally act together to coregulate the child's affect—the child by seeking emotional comfort and the caregiver by supplying that comfort—thus making the parent–child relationship fundamental for organizing affect regulation as an early component of personality development. Depending on the availability and responsiveness of the caregiver, successful coregulation of affect is gradually “internalized” by the child and develops into a capacity for self-regulation of affect. Infants and children are thought to internalize the parent–child relationship in the form of lasting expectations of whether or not attachment figures will be available or helpful, especially in stressful or traumatic situations.

These expectations are known as “internal working models” of self and other and serve as templates for understanding, interpreting, and predicting the behavior of close significant others in the future. For example, when children learn that their attempts to elicit soothing or comforting responses from caregivers usually generate erratic or inconsistent responses instead, these children come to expect significant others to respond in a similar manner when they are older and feel a need for emotional support. In some cases, parental reactions to attachment behaviors will have the effect of invalidating the distress expressed by children, thus potentially severing the communicative function of emotion and teaching children to distrust their emotional experience of the world (Linehan, 1993). As a result, negative childhood experiences with primary caregivers are hypothesized to be the basis of internal working models for subsequent relationships and contribute to the development of maladaptive interpersonal relationships so characteristic of PDs.

Indeed, interpersonal experiences during childhood that disrupt secure attachment relationships have been shown to create conditions for maladaptive interpersonal behaviors and cognitions associated with PDs. For example, childhood neglect and maladaptive parenting have been found to be independently associated with elevated risk for PD even after accounting for childhood abuse and parental psychiatric disorders (Guzder, Paris, Zerkowitz, & Marchessault, 1996; Johnson et al., 1999, 2001; Ludolph et al., 1990). Traumatic experiences (extreme emotional invalidation) including childhood abuse, excessively harsh punishment, and other forms of victimization such as assault, bullying, and intimidation have been found to contribute to the onset of PD traits by promoting affective dysregulation, aggressive behavior, dissociative symptoms, interpersonal withdrawal, and

profound mistrust of others (Johnson, 1993; van der Kolk, Hostetler, Herron, & Fidler, 1994).

Based on attachment theory and these empirical findings, one might expect that PD would be associated with elevated romantic partner conflict in young adulthood. Although both cross-sectional and longitudinal studies have shown that conflict between romantic partners tends to be particularly frequent or severe when one or both partners have Axis I disorders (Coyne, Thompson & Palmer, 2002; Daley & Hammon, 2002; Gotlib, Lewinsohn & Seeley, 1998; Whisman & Bruce, 1999; Whisman, Sheldon, & Goering, 2000), few studies have examined the association of PDs with romantic partner conflict. This is particularly noteworthy because PDs are often conceptualized as disorders of interpersonal behavior (Whisman & Uebelacker, 2003).

Furthermore, the association of PDs with romantic partner conflict merits investigation because Axis II disorders are known to be associated with aggressive behavior, interpersonal conflict, and poor social functioning (Benjamin & Wonderlich, 1994; Bernstein et al., 1993; Johnson et al., 2000a, 2000b; Johnson, Chen, & Cohen, in press; Kooiman & Spinhoven, 1996; Matano & Locke, 1995; Oltmanns, Melley, & Turkheimer, 2002; Pincus & Wiggins, 1990; Quinton, Gulliver, & Rutter, 1995; Trull, Useda, Conforti, Doan, 1997). PDs are associated with marital difficulties, and marital separation or divorce (Flick, Roy-Byrne, Cowley, Shores, & Dunner, 1993; Reich, Yates, & Nduaguba, 1989; Samuels, Nestadt, Romanoski, Folstein, & McHugh, 1994; Truant, 1994; Zimmerman & Coryell, 1989). In a community sample of late adolescent women, Daley and colleagues found that PD symptoms were associated with subsequent partner conflict after depressive symptoms were controlled (Daley, Burge, & Hammen, 2000; Daley, Hammen, Davila, & Burge, 1998).

Nearly all the previous studies on the relationship between PDs and partner conflict have focused on how PDs may affect the average level of partner conflict. In contrast, few studies have investigated the trajectory of change in partner conflict and how PDs affect this trajectory. Karney and Bradbury (1997) argued that studying the trajectory of partner conflict over time provides more precise information about the nature of change in partner conflict than studying the average level of partner conflict. There is currently a lack of descriptive information regarding these trajectories and the variables that affect them (Fincham, 2003; Karney & Bradbury, 1995; Kurdek, 1999). Moreover, because PDs frequently co-occur with Axis I disorders (David, First, & Regier, 2002; Fabrega, Pilkonis, Mezzich, Ahn, & Shea, 1990; McGlashan et al., 2000), it is important to determine whether the effects of PDs on partner conflict are independent of Axis I pathology or are simply an artifact of association with Axis I.

Overall, it is expected that PDs will be associated with marked elevation of partner conflict from ages 17 to 27; however, the pattern of association between partner conflict and PD is expected to be cluster specific. According to the DSM-IV, personality disorders can be separated into three clusters based on descriptive similarities. Cluster A disorders (paranoid,

schizotypal, and schizoid) refer to individuals who can be characterized as odd or eccentric; Cluster B disorders (antisocial, borderline, narcissistic, and histrionic) are characterized as dramatic, emotional, or erratic; and Cluster C disorders (dependent, avoidant, and obsessive compulsive) can be characterized as anxious or fearful.

Based on the characteristics of these clusters, different patterns of association are expected between PD cluster and partner conflict depending on the centrality of interpersonal and affective regulatory deficits and distress to the disorder. Cluster B PDs, for example, are hypothesized to be at especially high risk for elevated and sustained partner conflict given the interpersonal and affective dysregulation that characterizes these disorders. In contrast to Cluster B PDs, Clusters A and C PDs are characterized, essentially, by avoidance of interpersonal intimacy (with the exception of dependent PD) although for very different reasons. For example, individuals with a Cluster A PD may avoid interpersonal intimacy because they are suspicious or do not feel any need to relate closely with another person, whereas those with Cluster C PDs might avoid interpersonal contact because they are anxious and afraid. Nevertheless, it is hypothesized that the association between partner conflict and individuals with Cluster A and C PDs will be similar and markedly different from the association between partner conflict and those with Cluster B PDs.

We report findings from the Children in the Community Study that document the hypothesized association between adolescent PD and subsequent changes in partner conflict during the transition to adulthood. Because averaging over individual PDs may conceal unique associations between PD and partner conflict, we conduct analyses at both the cluster level and the individual PD level. We use prospective assessments of PD at mean age 16 to predict later trajectories of partner conflict from age 17 to age 27 that were provided in narrative descriptions gathered during adulthood. To control for associations between PD and Axis I pathology, all statistical analyses adjust for co-occurring Axis I illness. Our review of the literature indicates that this is the first study to investigate these associations throughout the transition to adulthood.

## **METHOD**

### **SAMPLE**

The participants were 200 young adults (52% women; 92.5% European American; 7.5% African American), who completed detailed narrative interviews by telephone describing their transition from adolescence (age 17) to adulthood (age 27) with regard to a wide range of developmental domains. These 200 individuals were part of the Children in the Community Study sample, a cohort of 821 young adults, 50% women and 91% European American, who had been randomly selected as children on the basis of family residence in one of two upstate New York counties. Original mother interviews included a wide range of health and behavior questions concerning one off-

spring between 1 and 10 years old and demographic and contextual risk factors. Mothers and cohort offspring were interviewed three additional times with expanded parallel protocols which also included psychiatric diagnostic assessment of the youth. The families followed up were demographically representative of the sampled region (Cohen & Cohen, 1996) and from a broad spectrum of socioeconomic backgrounds and mixed rural, suburban, and urban residences. A subsample of this cohort was recruited for this narrative study. Participants were limited to those who had recently passed their 27th birthday in the period of the narrative data collection. An additional requirement was willingness to participate in lengthy telephone interviews. Nevertheless, the demographic characteristics of the narrative sample were closely similar to the larger cohort. The narrative interviews, which typically took 3 to 5 hours to complete, were conducted by telephone. At all interviews informed consent was obtained according to Institutional Review Board Standards, and an NIH Certificate of Confidentiality exists for these data. Additional information regarding the study methodology is available from previous reports (Cohen, Chen, Hamigami, Gordon, & McArdle, 2000; Cohen, Kasen, Chen, Hartmark, & Gordon, 2003) and the study website ([www.nyspi.cpmc.columbia.edu/childcom](http://www.nyspi.cpmc.columbia.edu/childcom)).

#### NARRATIVE INTERVIEWS

Narrative telephone interviews were carried out by intensively trained and supervised interviewers who were completely blind to previously gathered data on adolescent disorders or any other potential risks. Prior to the interview, respondents completed a "Life Chart" (Lyketsos, Nestadt, Cwi, Helthoff, & Eaton, 1994) covering changes in where they lived, worked, and studied. Life charts also detailed dates of graduations, special vacations or trips, engagements, marriage, births, major illness or victimization, special achievement or honors, or any other experiences that helped the respondent to reconstruct the 10-year period covered by the interview. Both the respondent and the interviewer had access to the life chart during the interview to help them record a narrative description of changes that occurred in seven domains of the person's life: residential, financial, educational, occupational, romantic, parental, and interpersonal. Respondents were asked about each domain separately between the years 17 to 27. The interviewer began with the situation in effect from the narrator's 17th birthday and assessed changes within each domain through the years until his or her 27th birthday. All interviews were tape recorded and double-coded by a second interviewer who was blind to scores assigned by the first interviewer. The resulting interrater intraclass reliability of partner conflict employed here is 0.92. The statistical analyses were conducted using the mean of the ratings provided by the two coders. A more comprehensive description of the narrative interviews is available from previous reports (Cohen et al., 2000; Cohen et al., 2003) or from the authors.

## STUDY MEASURES

*Adolescent Personality Disorders.* When this sample and the larger cohort from which it was drawn were first followed-up in 1983, there were no instruments designed to assess PDs in adolescents. Time and resource constraints prevented a separate instrument development study on this cohort. Instead, existing instruments for adults including the PDQ (Hyer, Rieder, Spitzer, & Williams, 1982; Hyer et al., 1988) were used to select and revise items from our longitudinal protocol to cover PD diagnostic criteria in adolescents. PD items were subsequently added to cover minor modifications in the diagnostic criteria in the DSM-IV. Personality disorders in this study were assessed using both self-reports and maternal reports of symptoms when respondents were on average 16 years old. Multiple informants have been found to improve prognostic prediction (Klein, 2003). When thus assessed during adolescence, 39 individuals (19.5%) in the narrative sample had PD. Seventeen individuals (8.5%) had Cluster A PDs, 26 (13.0%) had Cluster B PDs, and 8 (4.0%) had Cluster C PDs. Because DSM-IV specifies that antisocial PD cannot be diagnosed before age 18, this PD was not investigated along with other adolescent PDs.

Given the lack of other Axis II scales 20 years ago, it was not possible to demonstrate convergent validity by comparing our assessment of adolescent PDs with parallel assessments using different instruments. When our full sample was on average 33 years old, however, we assessed PDs using self-report items from our longitudinal protocol and the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) (Crawford et al., 2004). When categorical diagnoses made by self-report were compared with diagnoses made by structured clinical interview, concordance rates between our instrument and SCID-II structured interview for "any PD" were excellent ( $k = 0.44$ ) when compared with agreement achieved by other instruments (Clark, Livesley, & Morey, 1997) and even approached the test-retest reliability reported for the SCID-II ( $k = 0.48$ ). We also found excellent agreement between PD symptoms recorded with our self-report instrument and the parallel assessment using the SCID-II screen ( $r = 0.66, 0.78, \text{ and } 0.67$  for Cluster A, B, and C symptoms, respectively). We found reasonable stability between self-reported PD symptoms from age 22 to age 33 ( $r = 0.61, 0.64, \text{ and } 0.57$  for Cluster A, B, and C symptoms, respectively). Otherwise, the validity of assessment of PD symptoms in this study has been supported by many theoretically predicted associations with risks (Bernstein et al., 1996; Cohen, 1996), correlates (Bernstein, Cohen, Skodol, Bezirgianian, & Brook, 1993; Cohen, 1999), and outcomes (Johnson et al., 1999; Kasen et al., 2001).

*Partner Conflict.* Romantic conflict was assessed during the 120 months covered in the narrative interviews when the respondent had a romantic partner; that is, as indicated by any reported romantic commitment ranging from "going steady" to "married." On average, partici-

pants had a steady partner in 67% of the 120 months between their 17th and 27th birthdays. Statistically, time spent with a romantic partner did not differ for the 39 participants with a diagnosis of PD ( $M = 83.0$  months,  $SD = 33.3$ ) and the 161 participants without any PD diagnosis ( $M = 88.3$  months,  $SD = 32.7$ ). Ratings on the 0–99 range partner conflict scale were based on narrative descriptions of interactions with partner. Five reference points were defined in the study manual: 0 indicated no partner conflict; 25 indicated occasional mild disagreements; 50 reflected some arguing and bickering with infrequent flare-ups, most of which were resolved; 75 indicated ongoing arguments or confrontations and that flare-ups were not uncommon and were sometimes threatening; and 99 indicated severe conflict characterized by arguments and explosive flare-ups that posed the threat of psychological or physical abuse. Intermediate ratings were assigned, based on the narrative description when the respondent's level of conflict with partner was judged to be between these levels. The mean level of partner conflict during the 10-year interval between ages 17 to 27 for the months with a steady partner was 38.3 ( $SD = 19.6$ , range = 0 to 99), indicating that most of these individuals had a mild or moderate level of partner conflict.

*Reliability of Retrospective Reports.* To assess the reliability of retrospective reports in narrative interviews, we gathered data from an independent sample using the same narrative interview methods, measures, and double-coding used in the current study. The seven domains of adult role functioning covered in the current study (residential, financial, educational, occupational, romantic, parental, and interpersonal relationships) were assessed prospectively in the independent sample at three separate data intervals spanning approximately 3 years and then compared with a retrospective report covering the same domains gathered at a later date. Agreement between pooled ratings of narratives covering the short periods (prospective data) and the retrospective data for mean partner conflict was relatively high,  $r = 0.74$ ,  $p < 0.01$ . The prospective and retrospective agreement on linear trajectory over the full period also was relatively high,  $r = 0.68$ ,  $p < 0.01$ . The consistency observed across prospective and retrospective data may be viewed as partial evidence of validity as well as reliability of our narrative interviews because it was based on ratings by different interviewers and raters of independent descriptions of experiences.

*Control Variables.* We included Axis I disorders, participant sex, race, parental SES, marriage, and cohabitation as control variables in the analyses. The parent and youth versions of the Diagnostic Interview Schedule for Children (DISC-I: Costello, Edelbrock, Duncan, & Kalas, 1984) were administered prospectively in adolescence (mean age 16) to assess Axis I disorders. Youths and their mothers were interviewed sep-

arately, and both interviews were blind to the responses of the other informant. Symptoms were considered present if reported by either informant because the use of multiple informants has been found to increase the reliability and validity of psychiatric diagnoses (Bird, Gould, & Staghezza, 1992; Piacentini, Cohen, & Cohen, 1992). Previous research has supported the diagnostic reliability and validity of the DISC-I (Cohen, O'Conner, Lewis, & Malachowski, 1987) and of the diagnostic algorithms used in the present study (Cohen, Velez, Kohn, Schwab-Stone, & Johnson, et al., 1987). Fifty-four individuals (27.0%) had Axis I disorders (e.g., major depression, conduct disorder, generalized anxiety disorder, substance abuse disorders, etc.) with associated impairment at mean age 16. Parental SES was measured when participants were adolescents, and consists of a standardized sum of standardized measures of years of maternal and paternal education, maternal and paternal occupational status, and family income categories. Because PDs frequently co-occur with Axis I disorders (David et al., 2002; Fabrega et al., 1990; Farmer & Nelson-Gray, 1990; McGlashan et al., 2000), Axis I disorders were controlled statistically in tests of PD effects. Because of the extent of comorbidity among the Axis II disorders and the substantial correlations between criteria of different PDs (Clark, 1992; Clark et al., 1997; Daley et al., 2000; Livesley & Jackson, 1991; Widiger et al., 1991), other PD symptoms (other cluster PD) were controlled statistically when we tested for a specific PD (specific cluster PD). For example, we controlled non-borderline PD symptoms when we tested the relationships between borderline PD symptoms and partner conflict.

## MODELS

The SAS PROC MIXED program was used to estimate random and fixed effects on the growth pattern of partner conflict between ages 17 and 27 (Littell, Milliken, Stroup, & Wolfinger, 1996; McArdle & Bell, 2000). In these models, longitudinal data on individuals are considered the basic "random" data, just as in cross-sectional data single individual variables are the basic units of analyses. Thus, the first step in these analyses examined the between participant differences ("random effects") in mean level, and in linear, quadratic, and cubic slope over age.<sup>1</sup> For our partner conflict data, the linear changes over age were not sufficient to describe the basic growth shape. We

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1. Partner conflict was rated only when a "partner" was reported, defined as a romantic partner with whom the participant was "going steady" or was more committed. Thus all random and fixed effects on partner conflict over this period were estimated only for those who had a partner in each month. These analyses were accomplished by use of a product term (present partner by predictor) to represent each fixed and random predictor. Details of these analyses and output are available from the authors on request.

**TABLE 1. Unstandardized Coefficients Associated with Adolescent Personality Disorder (PD) of Each Trajectory Parameter in Partner Conflict**

Predictor	Intercept (age = 22)	Linear Change	Quadratic Change	Cubic Change
Any PD ( <i>n</i> = 39)	5.324**	-1.600**	-0.179**	0.098**
Cluster A PD ( <i>n</i> = 17)	1.988*	-2.042**	-0.103	0.028
Cluster B PD ( <i>n</i> = 26)	7.784**	-2.037**	-0.223**	0.160**
Cluster C PD ( <i>n</i> = 8)	2.559*	-1.286	-0.683**	-0.018

*Note.* All parameter entries are maximum likelihood estimates fitted using SAS PROC MIXED. We have included any Axis I disorders, sex, race, SES, cohabitation, and marriage in each model and do not include their coefficients in this table. Each cluster PD was employed as a predictor in a separate model including as covariates any Axis I disorders, other cluster PD, sex, race, SES, cohabitation and marriage. \* $p < 0.05$ ; \*\* $p < 0.01$ .

found substantial random variance (individual differences) in the mean level and in the linear, quadratic, and cubic changes over age for months in which a partner was present. This random model was then the basis for examination of the fixed effects of linear, quadratic, and cubic age change (basic model). Following the basic model, we fitted separate conditional models for any PD disorder at mean age 16 and specific cluster PD and the potential conditionality of changes over age. The latter tested the impacts of the PDs on the trajectory of change in partner conflict. We also examined the effects of symptoms of an individual PD on partner conflict based on the basic model. Symptoms rather than diagnoses were used in these analyses because the number of diagnosed cases is too small to give sufficient statistical power for tests based on individual PD. In all analyses we controlled covariate effects of Axis I disorders, sex, race, parental SES, marriage, and cohabitation. We also controlled for the presence of other PDs when investigating diagnoses at the cluster level and when studying symptoms of individual PDs. Each model included a chi-square test of improvement of fit to the data. As noted, each analysis also was controlled for the presence or absence of a current romantic partner in each study month, so that findings reflect partner conflict only for those with a current steady partner.

## RESULTS

### ASSOCIATIONS OF ANY PD, CLUSTER A, B, AND C PD WITH PARTNER CONFLICT TRAJECTORY

Table 1 shows the independent effects of any adolescent PD; cluster A, B, and C PD on partner conflict; net of demographic, marriage, and cohabitation; adolescent Axis I disorder; and other cluster PD effects (Table 1 and Figures 1–4). Partner conflict of participants without PD declined from age 17 to age 19, and then increased rapidly until age 24 when it declined again. Participants with PD reported more partner conflict throughout this period with an average of 5.3 percentage points (PP) higher partner conflict than

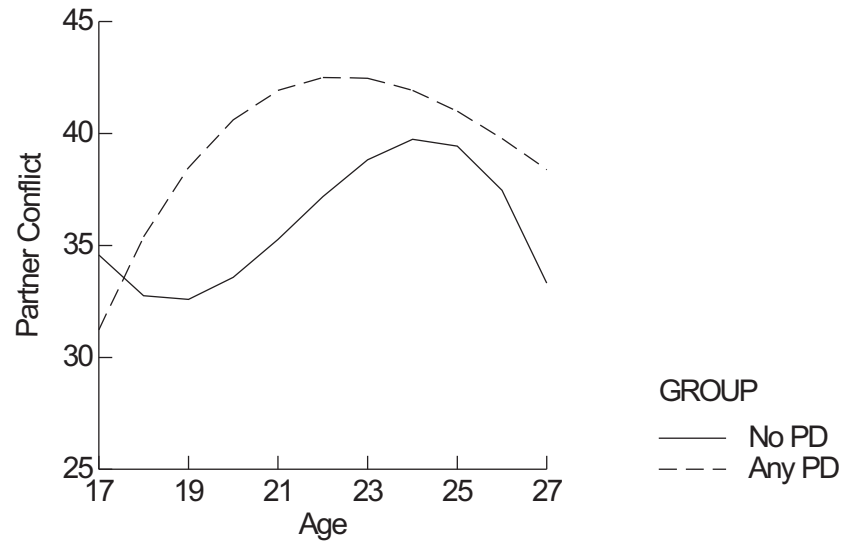


FIGURE 1. Partner conflict and any personality disorder.

those without PD. Partner conflict of participants with PD increased from age 17 to age 23, and then exhibited a modest decrease (Figure 1). Cluster A and C PD were associated with an increase in partner conflict before age 23 and a reduction in partner conflict after age 23 (Figures 2 & 4). Cluster B PD was associated with sustained elevations in partner conflict (Figure 3).

#### ASSOCIATIONS OF SPECIFIC PD SYMPTOMS WITH THE TRAJECTORY OF PARTNER CONFLICT

Table 2 shows the independent effects of specific adolescent PD symptoms on partner conflict after controlling for demographic variables, adolescent Axis I disorder, and other PD symptoms. Paranoid, schizoid, schizotypal, borderline, narcissistic, and obsessive-compulsive PD symptoms were independently associated with sustained elevations in partner conflict. After adjusting for control variables, dependent PD symptoms were associated with a sustained reduction in partner conflict. In these models histrionic and avoidant PD symptoms were not associated with partner conflict.

#### DISCUSSION

As expected, the Axis II clusters outlined in the DSM-IV were shown to have distinct patterns of association with partner conflict during the transition to young adulthood. This outcome supports the validity of clustering PDs on

**TABLE 2. Unstandardized Coefficients Associated with Personality Disorder (PD) Symptoms of Each Trajectory Parameter in Partner Conflict**

Predictor	Intercept (age = 22)	Linear Change	Quadratic Change	Cubic Change
Paranoid PD	2.056**	-0.300*	-0.082**	0.010
Schizoid PD	-0.155	-0.457**	0.126**	0.015
Schizotypal PD	0.557**	-0.296*	0.037*	0.020**
Borderline PD	0.885**	-0.694**	0.077**	0.051**
Histrionic PD	0.094	0.139	0.002	-0.003
Narcissistic PD	1.147**	-0.555**	0.034*	0.041**
Avoidant PD	-0.056	-0.008	0.034	0.002
Dependent PD	-1.606**	-0.315*	-0.039	-0.004
Obsessive-Compulsive PD	0.691**	-0.201	-0.012	0.034**

*Note.* All parameter entries are maximum likelihood estimates fitted using SAS PROC MIXED. Each PD scale was entered in a separate model includes any Axis I disorder, other PD symptoms, sex, race, SES, cohabitation and marriage. \* $p < 0.05$ ; \*\* $p < 0.01$ .

the basis of the phenomenological similarities. In particular, adolescent cluster B PD was associated with sustained elevations in partner conflict throughout the transition to adulthood. Clusters A and C, in contrast, were associated with elevated partner conflict before age 23 but then had lower levels of partner conflict when compared to those without PD. Each of these patterns needs to be contrasted with the normative pattern for those without disorders. The data indicate that the normative level of partner conflict changes over this period in a complex manner, with a sharp decline over the final high school years followed by an increase up to the middle 20s and a decline thereafter, when many of the partners being studied were spouses.

Adolescent symptoms of most PDs were independently associated with elevations in both the average level and the trajectory of change in partner conflict after adjusting for demographic variables, Axis I disorders, and symptoms of other PDs. There was also a significantly different change pattern in partner conflict between individuals with and without PD symptoms. These findings are particularly important because they highlight the fact that PD contributes independently to relationship discord over and above the effects of Axis I disorder, which is consistent with the conceptualization of PDs as disorders of interpersonal behavior (Whisman & Uebelacker, 2003). Furthermore, seven of the nine PD symptom scales studied here (all except histrionic and avoidant PD) had trajectories for partner conflict that differed from average trajectories after symptoms for all other PDs were taken into account.

The findings from this study highlight the importance of examining the effects of PD at both the individual PD and cluster level. Averaging over individual PDs in Clusters A and B resulted in an accurate summary of the overall trajectory of partner conflict from late adolescence to young adulthood. Averaging over individual PDs in Cluster C, however, concealed effects at the individual PD level, namely that dependent PD was associated with

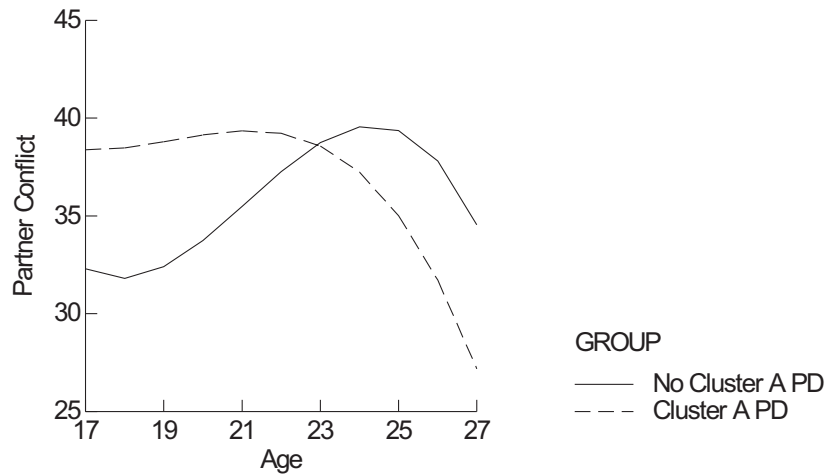


FIGURE 2. Partner conflict and Cluster A personality disorders (PD).

lower levels of partner conflict throughout the transition period. This finding must be interpreted with some caution because it only occurred in models controlling for Axis I disorders and all other Axis II symptoms. Nevertheless, after accounting for other disturbances, dependent PD symptoms appear to be associated with lower partner conflict when compared with normative levels observed from age 17 to 27. In this context, it appears wisest to infer that the lower partner conflict associated with dependent PD in these models reflects a tendency to avoid conflict or perhaps deny its presence among people with elevated dependent traits.

Adolescents with Cluster A PDs were associated with higher partner conflict than those without PD before age 23 but with less partner conflict thereafter. Despite these changes over time, adolescents with Cluster A PDs maintained steady rates of being in romantic relationships both before and after age 23. On average they reported having romantic partners during 90 of the 120 months (75%) between age 17 and 27, a rate that was actually higher than the rate for the total sample (67%). As reported elsewhere (Cohen et al., in press), Cluster A PD symptoms also were associated with early parenthood compared to the norm. Early parenthood is associated with higher partner conflict (Booth & Edwards, 1985; Helms-Erikson, 2001).

While these findings help explain partner conflict before age 23, they fail to address why rates dropped below the norm thereafter. It may be that deficits in interpersonal skills associated with Cluster A PDs led to elevated partner conflict before age 23, thereby generating dysphoric affect that strained or

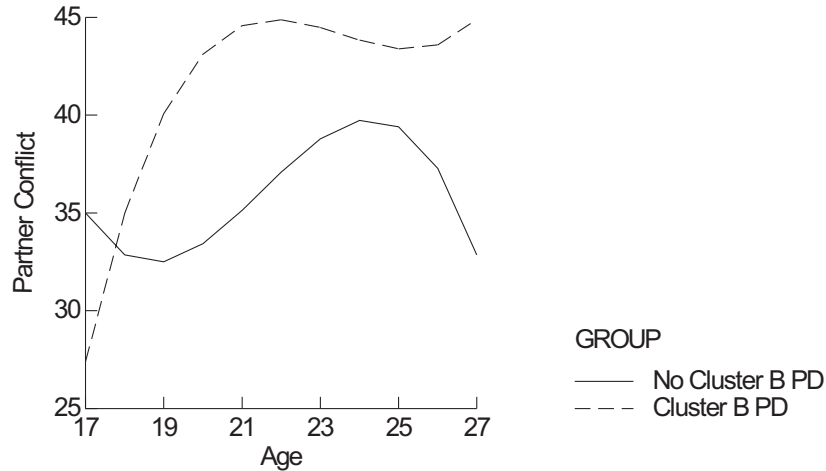


FIGURE 3. Partner conflict and Cluster B personality disorders

overwhelmed whatever coping resources were available to these adolescents. By early adulthood, these young people may have learned to avoid unwanted affect by withdrawing or otherwise avoiding interpersonal conflicts with romantic partners. Thus the observed effect in Figure 2 may reflect the emergence of defensive interpersonal strategies that enabled young people with Cluster A disturbances to remain in romantic (and parenting) relationships and regulate unwanted affect at the same time. While the trajectory for partner conflict in adolescents with Cluster C PDs resembles the corresponding trajectory for Cluster A PDs, the underlying process in some ways appears different. Specifically, young people with Cluster C PDs had steady romantic partners less of the time, particularly prior to age 23 (42.2%), than those with Cluster A PDs. Although most adolescents with Cluster C PDs avoided early romantic relationships, those who did develop relationships may have had unreasonable expectations of being “looked after” or protected, perhaps thus compensating for fears of losing romantic partners. Over time more of these anxious young adults may have learned how to maintain romantic relationships by avoiding conflict that might jeopardize that relationship.

The findings from this investigation highlight the interpersonal deficits that are characteristic of Cluster B disorders. For example, Linehan (1993) proposed that borderline personality disorder, a prototypical dramatic cluster B PD, results from the interaction between a biological vulnerability to emotion dysregulation and invalidating environments, which are character-

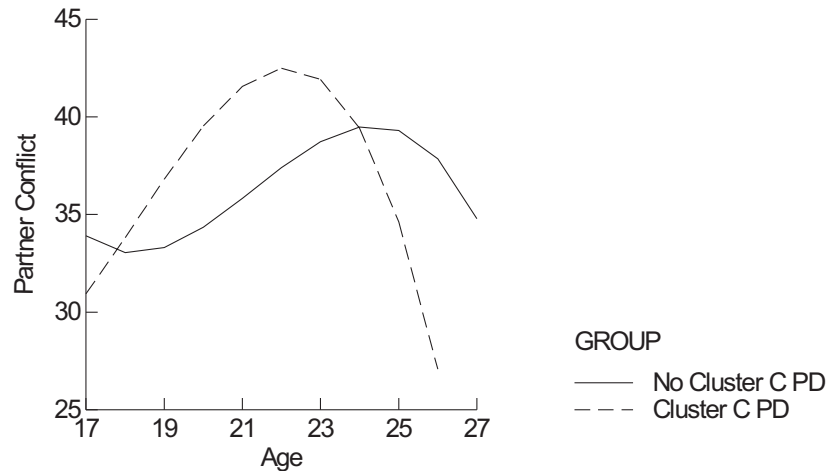


FIGURE 4. Partner conflict and Cluster C personality disorders (PD).

ized by caregivers who (a) respond erratically and inappropriately to private emotional experiences; (b) are insensitive to people's emotional states; (c) have a tendency to over or under react to emotional experiences; (d) emphasize control over negative emotions; and (e) have a tendency to trivialize painful experiences and/or attribute such experiences to negative traits (e.g., lack of motivation or discipline). This interaction between emotional vulnerability and invalidating environments results in the inability to label and modulate emotions, tolerate emotional or interpersonal distress, and trust private experiences as valid.

The present findings may have important clinical and public health implications. Our findings suggest the potential value of a careful assessment of PDs among individuals and couples who present with relationship difficulties. Partner conflict associated with adolescent PD, especially Cluster B PDs, appear to increase the risk for long-term disturbances in romantic relationships. Early clinical interventions that target PD symptoms in adolescents and young adults may serve to reduce interpersonal dysfunction at a time when individuals are still learning about and gaining experience in intimate relationships. In other words, clinical interventions may have greater impact if undertaken before long-term interpersonal dysfunction sets in and takes root in committed romantic relationships. Research has indicated that most PDs can be treated effectively with psychotherapy (Perry, Banon, & Ianni, 1999). It will be of particular interest for future studies to examine whether PD treatment can be made more effective by emphasizing that PDs

tend to be associated with adverse interpersonal consequences, such as partner conflict.

To our knowledge, these are the only published findings regarding the impact of adolescent PD on changing partner conflict throughout the transition from adolescence to early adulthood. Relationships with romantic partners are clearly one of the major foci of this developmental period. These findings need to be viewed with study limitations in mind. As is generally the case for studies of partner conflict, these data were self-reported, with potential biases of self-presentation. There is also the potential for failures to recall, or for distorting bias in recall, perhaps induced by knowledge of the romantic "outcome." Our "prospective/retrospective" validating study was reasonably reassuring in this respect, but such concerns remain. The present study also has numerous methodological strengths, including the use of a prospective longitudinal design, assessment of partner conflict by detailed narrative description during the transition from adolescence to adulthood, and the use of multilevel growth models for repeated measure data. In this study, we assessed partner conflict across a wide age range, using a representative community-based sample. For these reasons, the present study contributes to an increased understanding of how adolescent personality disorders affect the trajectory of change in partner conflict during the transition to adulthood.

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