Psychiatry Research Case Reports 2 (2023) 100126

Contents lists available at ScienceDirect

Psychiatry Research Case Reports

journal homepage: www.elsevier.com/locate/psycr

Integrating shared and unique approaches in personality assessment: A case formulation of emma

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ARTICLE INFO

Keywords:
Personality
Development
Dimensional
Case formulation
Clinical assessment
Youth

ABSTRACT

Even though the shift to a dimensional perspective on personality and psychopathology is increasingly substantiated by scientific evidence, clinicians may still struggle to apply this transition in clinical practice on an individual level. The question may not be *if* but *how* we adopt this 'new' perspective. In this paper we guide clinicians along McAdam's three-layered theoretical model of personality as a suitable approach for making this transition in clinical assessment. McAdam's model provides a dimensional and developmental framework that integrates nomothetic and idiographic approaches by assessing dispositional traits, characteristic adaptations and the narrative identity. As such, it may structure the process of assessment, case formulation and treatment planning. The developmental perspective makes it useful to gain a nuanced understanding of the personality of individuals of all ages, and may be particularly suitable for youth. In addition, with identity formation as a key developmental milestone, the inclusion of narrative identity is informative for this phase. The use of this framework is illustrated with a case formulation of Emma, an 18 year old women who is referred to specialized mental health care in the Netherlands. We draft a theoretically driven case-formulation and treatment plan. The picture of Emma, that is obtained by mapping her development along dispositional traits, characteristic adaptations and narrative identity, facilitates communication and treatment planning. As such, the case of Emma presents an example of clinical assessment that integrates unique individual and more standardized information to personality and simultaneously illustrates how clinicians may apply a dimensional, developmental theoretical framework of personality and psychopathology in clinical practice.

Hippocrates wrote *"It is more important to know what sort of person has a disease than to know what sort of disease a person has"* (Hippocrates). How does one come to know a person and understand its 'diseases'? This may be one of the core questions in mental health care. Two approaches to this question have been described, which could be termed the 'art and science' of clinical assessment (Garb, 2005; McAdams, 2015). As McAdams frames it "*If every life is a unique work of art, then science enters the picture when we begin to sense regularities amid all the diversity*"[3,(p.2)]. The 'art' refers to an idiographic approach, in which the focus is on the *unique* development of an individual. The 'science' refers to a nomothetic and standardized approach, in which the focus is often on common principles that influence human behavior and comparing individual scores with mean levels of interpersonal differences. Thus, information that is *shared* by groups of individuals is considered (Beltz et al., 2016). Rather than one being superior over the other, these two approaches are considered complementary, both providing valuable information about a person and his or her strengths and vulnerabilities (Porcerelli et al., 2011; Salvatore and Valsiner, 2010; Westen and Weinberger, 2004). In clinical assessment these two approaches meet; that is a personal (idiographic) understanding of (the development of) the individual is necessary to facilitate communication between a patient, their network and professionals which may increase understanding and motivation for treatment (Kuyken et al., 2009). This can however only be obtained if the person is also considered in the general context of shared human development, preferably using standardized methods. As such it has been stated that "*the study of a person begins as a science, but ends as an art*" (Millon et al., 2004) (p.120). In this paper we suggest that the model of personality development, described by Dan McAdams (McAdams, 2015), presents a helpful framework to integrate information concerning commonalities obtained from standardized methods, as often used in nomothetic studies, with idiographic information in clinical assessment, especially for youth. Within this framework one can combine the idiosyncrasies

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https://doi.org/10.1016/j.psycr.2023.100126
Received 8 November 2022; Received in revised form 23 April 2023; Accepted 6 May 2023

of the unique person within a general theoretical framework for the development of personality (and psychopathology). We will demonstrate that a multi-method, multi-informant and multi-conceptual clinical assessment and case formulation is designated to translate this theoretical model into helpful clinical guidelines. Further, we will elaborate on the possibilities and challenges associated with this perspective. We will illustrate this integration of (shared, group level) nomothetic and (unique, individual) idiosyncratic information in the case formulation of Emma, an 18-year-old woman who was referred to specialized mental health care.

1. McAdams's framework of personality development as a guideline for clinical assessment

McAdams's model of personality development is a comprehensive theoretical framework that integrates the idiosyncrasies of the individual with the commonalities in groups of people (McAdams and Pals, 2006). In this model, personality is conceptualized as a three-layered construct. It considers the person from three standpoints, the actor, the agent and the author, developing within a social and societal context. In the first layer (the person as actor) *dispositional traits,* refer to broad general dimensions of individual differences, accounting for inter-individual consistency and continuity in behavior, thought and feeling across situations over time; one's overall style. Dispositional traits resemble personality traits (like those described in the Five Factor Model) and their maladaptive equivalents (Widiger and Crego, 2019; Widiger et al., 2012). The second layer (the person as agent) referred to as *characteristic adaptations*, represents aspects of human individuality, that concern motivational, social-cognitive and developmental adaptations, contextualized in time, place and/or social role. These adaptations go beyond the stylistic performative present of the person as an actor, to the projected future of the person as an agent with a unique motivational agenda. As such, characteristic adaptations refer a broad range of constructs such as attitudes, values, mental representations of others, interpersonal behavior, social roles, goals and developmental tasks (McAdams and Pals, 2006). To illustrate, an example of a dispositional trait is being typically agreeable and helpful, the value and motivation to help individuals with mental health problems and have becoming a psychotherapist as a personal goal might be considered a characteristic adaptation (DeYoung, 2015). The third layer (the person as author), the *narrative identity,* represents a personal internalized story about the self and one's life that contributes to unity, meaning and purpose. Through autobiographical reasoning a person answers the questions 'who am I?', 'how did I become this person?' and 'where am I going?' by reconstructing his or her personality development from the present point of view (Habermas and Köber, 2015). As such, narrative identity serves to reconstruct one's past, connect it to one's experienced present, and extends this into one's imagined future (Adler, 2012). One's personal life story may be examined by considering three aspects: motivational and affective themes, autobiographical reasoning and structural characteristics (McLean et al., 2020). It is notable that this personal story, or subjective meaning making, has recently been suggested as particularly important for valid clinical assessment, early-detection of personality- and psychopathology and treatment planning (Lind, 2021).

This three-layered concept of the person as actor, agent and author conforms to a developmental framework (see Fig. 1). As an individual matures from infant to adult, the three layers emerge consecutively, following cognitive- emotional- and social developmental changes (McAdams and Pals, 2006). First, in infancy and early childhood, broad temperamental dimensions manifest that are conceptualized as dispositional personality traits later in life. Second, as individuals in middle childhood become increasingly aware of personal agency, this prompts the articulation of motivations and wishes that evolve into life-goals and values in adulthood. Third, when changes in cognitive capacities and social contexts facilitate autobiographical reasoning in adolescence, individuals start the construction of an explicit personal narrative that keeps evolving throughout life. As such, this layered framework may provide a nuanced understanding of the unique development of a person. Since personality and psychopathology are intrinsically intertwined, this person-centered approach to clinical assessment may also be helpful to understand manifestation of psychopathology (Luyten and Fonagy, 2022; Haslam et al., 2020; McCrae and Costa Jr, 2021).

2. McAdams's developmental perspective in the clinical assessment of youth

Most mental disorders manifest for the first time during youth (adolescence and emerging adulthood) (Solmi et al., 2021). The unique vulnerabilities and potentialities in this developmental phase create opportunities for early-detection and -intervention to improve prognosis. However, personality remains infrequently or incompletely assessed and intervened on in youth (O'Dwyer et al., 2020; Shields et al., 2021). Clinicians mention to be hesitant with diagnosing personality pathology in this phase, for instance due to the stigma that is associated with it (Sharp and De Clercq, 2020). For this reason, improvement of accurate and nuanced clinical assessment is particularly important for this group, it may signify the start of treatment and can be seen as an essential part thereof (Sharp, 2020; Finn, 2020). McAdam's model may be suitable for this goal, because of the developmental core and dimensional nature of the model. It appropriately describes the developmental dynamics in this phase by separating stable traits from current functioning in different social contexts. In addition, with narrative identity as integral part of personality development it dedicates attention to identity formation as one of this phase's key developmental tasks (Arnett, 2015). This facilitates early-detection and -intervention because identity disturbance and difficulties in transferring into and functioning in this new adult role can be seen as key characteristics of personality pathology (Sharp and De Clercq, 2020). Further, this multi-layered model facilitates a multi-conceptual approach, which is particularly suggested for personality assessment in youth (Reardon et al., 2018; Shiner and Allen, 2013).

3. A dimensional and developmental perspective in clinical practice

Dimensional models of personality and psychopathology might be difficult to implement in clinical practice for a number of reasons. First, a categorical approach offers cognitive benefits by providing provisional, pragmatic and transparent guidelines for professional communication (Zimmerman, 2021). Most clinicians indicate that they would like an alternative to the categorical model but prefer a mixed approach, partly because dimensional data do not easily translate into straightforward treatment plans (Bernstein et al., 2007; Ahn et al., 2009). Second, clinical usefulness – in a narrow sense – is determined by ease of use, communication and treatment planning. Clinical usefulness in a broader sense relates to diagnostic validity, including coverage and consistency with etiology and prognosis (Verheul, 2006). When it comes to a dimensional perspective on personality and psychopathology, reliability and structural validity of dimensional models in a broad sense has been convincingly established (Krueger and Eaton, 2010), but there is doubt whether – if ever – the transfer to this approach will be made if clinical usefulness in a narrow sense is not demonstrated and improved (Zimmerman, 2021; Bornstein and Natoli, 2019; Haeffel et al., 2021). Third, despite some studies that have suggested helpful guidelines, there is a paucity in literature on how to apply dimensional models of personality and psychopathology in clinical practice (Hopwood, 2018; Ruggero et al., 2019; Widiger and Mullins-Sweatt, 2010). There seems a need for practical, step by step, guidelines. The structural use of case formulations may be one of those guidelines that provides a roadmap to integrate the substantive amount of information following clinical assessment. Case formulations typically present integrated information about an individual based on a thorough understanding of underlying mechanisms of psychopathology and can be helpful to both pa-

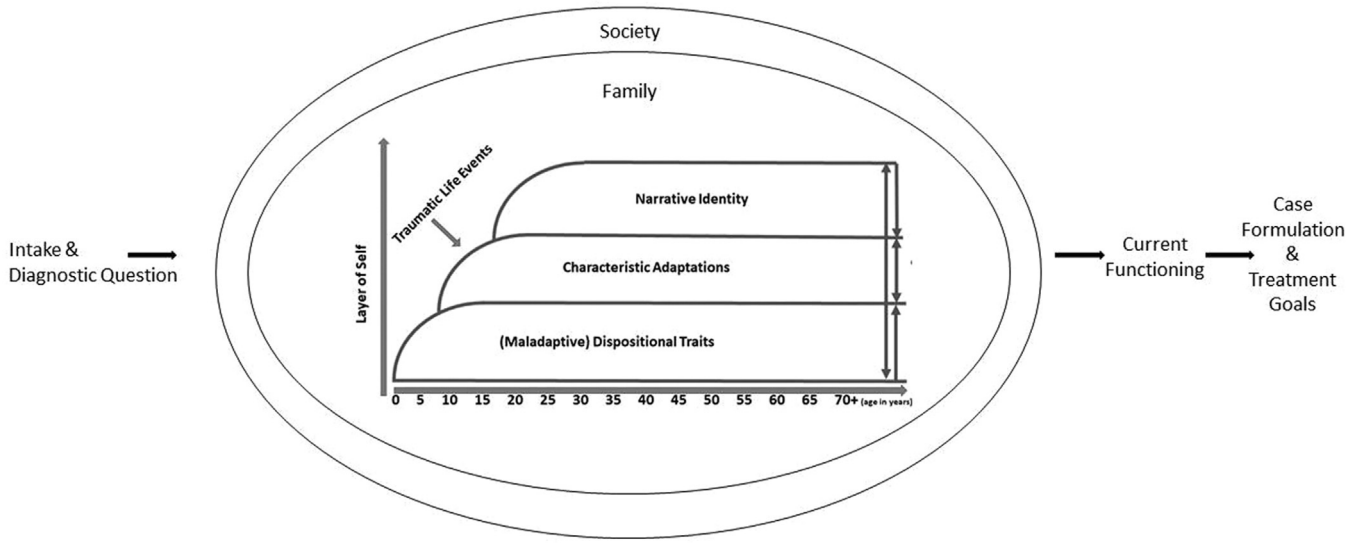

Fig. 1. Adapted version of the integrative model of personality development (McAdams, 2013) as a framework for clinical practice to structure clinical assessment.

tients and therapists for education, motivation, and treatment planning (Hagmayer et al., 2021; Macneil et al., 2012). However, practical guidelines based on a valid theoretical framework to aid in the selection of information for a case formulation are often lacking. They are frequently purely idiosyncratic and formulations about the same patient may vary between clinicians (Flinn et al., 2014). Educating clinicians in how to systematically construct case formulations seems to help to improve the quality of these formulations (Kuyken et al., 2005).

Considering these obstacles we conclude that applying McAdams multi-layered model may be a helpful step forward in making dimensional and developmental models clinically useful, especially for youth. In supplementary material A we suggest guidelines for applying this model in clinical assessment. We will illustrate how we have used this framework to get to know and understand Emma, a young woman referred to specialized mental health care. We will further illustrate how we have integrated information following clinical assessment and constructed a case formulation that aided in treatment planning. Emma (name is a pseudonym) provided verbal and written consent for using her information in this manuscript, and cooperated by providing feedback on the text.

4. The case of Emma

4.1. Case introduction

Emma is an 18 year old young adult, self-identified woman who is referred by her general practitioner to specialized mental health care for diagnostic assessment and treatment planning. The referrer's question was whether her difficulties could be classified as either a Borderline Personality Disorder (BPD) or an Autistic Spectrum Disorder (ASD). Emma was searching for help in gaining insight in herself and why she kept getting disappointed and frustrated in social situations, such as family and intimate relationships, and in her study. For instance, she described how she missed and longed for connectedness with and attention from her parents whom, from her perspective, predominantly gave attention to her younger brothers. In addition, she told emotionally about the on-and-off relationship with her boyfriend, whom she often supported emotionally and practically, without receiving the emotional support she needed from him in return. These interpersonal problems were Emma's main concern, that in her experience triggered and increased symptoms of depression, anxiousness, attention deficits and feelings of demoralization. Emma longed for treatment to help her navigate these symptoms and difficulties.

4.2. Instruments

4.2.1. Emma as actor

Emma's role as actor was examined by considering her dispositional trait scores on the PID-5–100 [Personality Inventory for DSM-Porcerelli et al., 2011; Maples et al., 2015; Koster et al., 2020)]. The PID-5 is a self-report questionnaire with five maladaptive personality trait domains and 25 trait facets. Considering these maladaptive variants of the Big Five personality traits matches this setting of specialized mental health care, in which most variance on the personality trait dimensions will be captured by examining more extreme levels trait scores. Emma's mother indicated Emma's dispositional scores on the PID-5-IBF [Informant Brief Form; (Rossi et al., 2011)], a 25 item other-report questionnaire with five maladaptive dispositional trait domains.

4.2.2. Emma as agent

Emma's role as agent with personal motives and goals was considered by examining her characteristic adaptations in the interpersonal domain. Included were the following self-report questionnaires: RQ [Relationship Questionnaire; (Bartholomew and Horowitz, 1991)], IIP-32 [Inventory of Interpersonal Problems; (Horowitz et al., 2000)], the NRI-BSV [Network of Relationships Inventory-Behavioral Systems Version; (Furman and Buhrmester, 2009)] and developmental milestones measured by the DML [Developmental Milestones List, see description (Koster et al., 2022)] supplemented by information from a clinical interview.

4.2.3. Emma as author

Emma's role as author with a personal narrative was examined by asking her to elaborate on a turning point in her life. The 'turning point' was chosen as a brief assessment of narrative identity at an important moment of transition. This turning point interview is widely used in empirical studies as a brief but informative alternative to the elaborate full life story interview entailing multiple life chapters (McAdams, 2015; McLean and Pratt, 2006). We further considered her personal narrative by administering the Thematic Apperception Test [TAT; (Murray, 1951)] which was scored with the SCORS-G method (Stein and Slavin-Mulford, 2017) and by taking into account her overall style of self-disclosure.

4.2.4. Emma's symptom distress

Emma's main symptoms were examined by considering her scores on the nine subscales of the Symptom Questionnaire [SQ-48; (Carlier et al.,

2012)]. The general severity of Emma's symptoms was assessed by considering her scores on the Satisfaction with Life Scale [SWLS; (Pavot and Diener, 2008)] and the Level of Personality Functioning Scale [LoPFS-BF; (Weekers et al., 2019)].

4.3. Process

Following Emma's intake with a resident in psychology and a psychiatrist (MD), who identified her curiosity and motivation for self-exploration, she was indicated for clinical assessment. This assessment was conducted by two trainee clinical psychologists (PsyD), supervised by a senior clinical psychologist (PsyD) and was commenced as a collaborative process (Finn, 2020). It was decided to have Emma's clarifying questions as the primary focus, instead of the referent's question for classification of a categorical DSM-5 diagnosis. A personal assessment question was formulated: 'Who am I, how did I become who I am and how can I take into account my strengths and difficulties in daily life?' Emma understood how the answer could aid in determining the right focus for her treatment. Subsequently, self- and parent-report information about Emma was systematically collected. Following a multi-method, -informant and -concept approach, the instruments included clinical interviews with Emma and her parents, self- and other-report questionnaires, and projective material. For several measures (the PID-5–100, the IIP-32, the LoPFS-BF and the SQ-48) standardized norm scores were available which made it possible to consider Emma's scores in a nomothetic (*shared)* context. With the other instruments *unique* personal information concerning Emma was obtained. We collaborated with Emma to gain an understanding of her as an actor, agent and author: the development of and her current dispositional personality traits, characteristic adaptations and subjective experience of the past, present and future integrated in a personal narrative. We collaborated with Emma's parents to gain understanding of their perspective on Emma, as well as their parenting style and experiences. One individual-, one parent- and one family-session were dedicated clinical interviews discussing Emma's developmental and family context, her personal narrative as well as the contextual narrative. Moreover, one session was dedicated to the administration of several instruments selected along McAdams model. This collaboration with Emma and her parents facilitated self-exploration and was not separate from, but an essential part of her treatment. Thereafter, this information was integrated in a case formulation and discussed to help Emma come to an understanding of her development as a person, her struggles and strengths, as well as treatment goals that fitted her personal goals toward mental health.

5. Results

5.1. A developmental and contextual perspective

Emma is born as the eldest daughter in a native Dutch, intact family with two younger brothers. She lives at home and, at the moment of diagnostic assessment, has a boyfriend on-and-off. Her mother works full-time and her father works part-time, following a burn-out a few years ago. One of Emma's brothers is diagnosed with autism spectrum disorder (ASD) and due to his functioning difficulties he received a lot of attention. In the direct or extended family no one else is diagnosed with a developmental disorder such as ASD or Attention Deficit Hyperactivity Disorder (ADHD), but multiple family members (father, mother, cousins) recognize some symptoms of these disorders themselves, including Emma. Based on her developmental history Emma did not meet the criteria of any developmental disorder as listed in DSM-5 (ASD, ADHD; American Psychiatric Association, 2013). Her parents further describe Emma's character from a young age as 'someone who sets high standards both for herself and others, who is interested, attention seeking and full of initiatives'. They report to have somewhat different parenting styles, mother more flexible and father relatively more strict. However, they often seem to fall short of Emma's parenting-standards, in her eyes they could both be more consistent and considerate. Emma reports to have experienced trauma, namely long-term implicit and explicit bullying at primary and high school and emotional abuse. Her parents were aware of the bullying and report to have tried to support her, but they were not able to stop it. Before referral to this mental health care center Emma had just finished high school and was tested with above average cognitive capacities. On the one hand she performed well in school and is described as ambitious and social, on the other hand she had problems with staying focused on school work and fitting in with peers.

5.2. Emma as actor: dispositional traits

Emma's scores on maladaptive personality traits were, in comparison to a non-clinical norm-group, high (> +2 SD) on the trait domains Negative Affectivity and Antagonism and above average (> +1 SD) on the trait domains Disinhibition and Psychoticism. She endorsed particularly high scores on the trait facets Anxiousness, Attention Seeking, Distractibility and Eccentricity. Characteristic of her profile were the overall high scores on most trait domains and facets, pointing to both the stability and severity of Emma's difficulties in a broad range of situations. The low score on the trait facet submissiveness was notable. Mother's report of Emma's maladaptive trait domains was in line with Emma's self-report, with the characteristic high levels of Negative Affectivity and Antagonism. This profile of high emotionality, impulsivity and friction was congruent with the anamnestic information in the clinical interviews: from a young age Emma could be characterized as a strong-willed and sensitive girl with intense emotions who was heavily bullied by peers and not always prone to cooperate. Arguments, disagreements, broken trust and friendships are mentioned as important themes along with strong feelings of disappointment, sadness about not fitting in and anger about not being understood.

5.3. Emma as agent: characteristic adaptations

Whilst Emma's mother self-identified most with a secure attachment style, Emma self-identified with an anxious attachment style: '*I would like to have intimate relationships with others, but I feel as if others don't want to be close to me. I am unhappy if I don't have close relationships, but sometimes it seems that I care more about other people than they care about me'.* The relationship between Emma and her parents could be characterized by anxiousness and avoidance: Emma longs for and values a close bond with her parents, however her history of disappointment in this relationship leads her often to respond dismissively and avoidant to possibilities for or attempts at connection. The relationship with her boyfriend is, similarly to how it is with her parents and has been in friendships, characterized by ups and downs: closeness alternating with conflicts often caused by disappointment resulting from unmet expectations. Emma scored above average (> 1SD) on almost all problematic interpersonal behaviors, her profile being characterized by the two highest scores on the needy and controlling subscales. It is notable that despite her social difficulties, she also indicated support in close attachment relations. This points to her social qualities and the centrality of her motive to connect with others. Emma values social relations and strives to repeatedly invest in them even though they cause stress and conflict. Reflecting on these outcomes, she acknowledged this motivation to invest in friendships and a romantic relationship. Particularly, she wants to make new friends at her study in a foreign town next year, however she feels anxious and concerned thinking about this. She often feels 'different and alone', because it seems that others do not have the same norms, values and interests as her. She reports to *'work hard to become a better version of herself every day',* to be '*willing to go the extra mile for others*' and to '*always deliver on her promises'*, but others rarely seem to acknowledge Emma's efforts or show the same dedication to relationships and self-development in her experience. She is often disappointed

in her standards of being devoted to progress, the other, honesty, punctuality and living up to promises. In that case '*she would rather be alone than with an idiot*', she stated resolutely, than at least she knows what she can expect. Emma talked about two important life-goals: first, to have close bonds with others who appreciate her and that are 'on the same level', meaning that they are also willing to work on themselves and are honest in and devoted towards the relationship. Second, to find a study that interests her. At the moment of assessment she is exploring options for further study and leans towards a bachelor study in pedagogics or psychology. Her dream is to both start a family with a supportive husband and have a successful and well-paid career, so that she can provide a stable life to her family in a nice neighborhood.

5.4. Emma as author: narrative identity

Emma described two turning points: 1) the moment she became vegan and felt confident in this choice, even though she was the only one in her family and 2) the moment her relationship ended: '*When Michael and I broke up, I immediately had the feeling of peace that I longed for. I felt stronger than in the whole period leading up to this break-up, that I wanted to put myself first. I am the main character in my life and I lost sight of that. That was because of me, I just lost peace'*. These turning points seem characteristic for the overall tone of Emma's personal narrative. She narrates about many disappointments in the past, among which the traumatic experiences of being bullied and emotionally abused, that have taught her to rely on herself and not on others. It is a highly agentic narrative. She is responsible for crafting the life she wants is what she tells herself. This seems to cause a conflict with her values and goals, since she longs for close and mutually supportive relationships both in the present and in her imagined future. Her story is consequently filled with contradicting themes of wanting to be understood and loved versus loneliness, being successful versus failing, wanting to achieve versus not caring and hope versus depression. These contradictions seem difficult to integrate into a coherent and meaningful story that contributes to purpose for the life she desires. Further, in the projective material, Emma tended to describe people's personalities and internal states in minimally elaborated ways and narrated often about personal needs or relationship struggles. Narratives showed references to being somewhat invested in moral values and signs of passive-aggressiveness. To gain a complete and nuanced understanding of Emma's personal story, information was structured along the three general characteristics of narrative accounts (McLean et al., 2020).

5.4.1. Motivational and affective themes

Emma's narratives are characterized by both a drive to get ahead (agency) and get along (communion), however these seemed to be contradictions: The agentic choice to become a vegan set her apart from her family and the description of her relationship reflects the struggle with feeling communion while staying agentic. The turning point narratives had a neutral or slightly positive and decisive emotional tone. However, the affective quality of representations in the TAT was negative, as were her overall narrative themes and self-representations.

5.4.2. Autobiographical reasoning

At intake Emma asked '*Do I need a diagnosis to understand myself or get the right treatment?*' This reflective attitude is one that characterized Emma throughout the process next to the continuous description of situations in which she feels pulled between two opposite contradictions. Emma is somewhat reflective in these narratives, but has the tendency to contrast the two seemingly difficult to integrate opposites (for instance feeling understood and accepted vs. feeling misunderstood and ignored), which usually have only one way out: 'doing it alone'. Thus, the narratives show signs of personal and temporal continuity, but emphasize her anxious attachment style.

5.4.3. Structural aspects

Emma's narratives are relatively coherent and elaborate. They provide a reasonable amount of detail, cause-and-effect language and interpretive aspects, in which the story is related to some aspect of the self. An example of this is the story Emma tells with TAT picture 3 BM, in which there is no sign of fusion with the image, but she states that she recognizes herself in the picture: '*This is a girl who sits on the floor there are scissors next to her… I think she is very depressed. She wants to hurt herself. The depression makes her feel nothing and everything at the same time… I think she won't do it… Yes I think something will cross her path that will be a small light at the end of the tunnel'*.

5.5. Symptom distress

Emma's psychopathological symptom score profile, characterized by above average to high scores on all symptoms and a low score on vitality, may be termed 'severe'. She scored above average on agora- and social phobia and depression (> 1 SD) and high (> 2 SD) on somatic and cognitive complaints, aggression, anxiety and study/work-related problems. However, her general satisfaction with life and self- and interpersonal functioning problems were rated as average, indicating that she felt positive about some areas of her life. The scores on reaching developmental milestones confirmed this image, Emma indicated that she was not doing well on social developmental tasks (such as having satisfactory friendships and being able to trust friends), but felt relative ease and confidence in individual developmental tasks (such as taking care of personal belonging and learning in school).

6. The case formulation of Emma

A psychiatric case formulation may typically follow the order of clinical manifestation, pathological processes and etiology (Chisolm and Lyketsos, 2012). However, in this case formulation we choose a different structure, namely to answer Emma's personal assessment question along the lines of McAdams's model. As such, we now describe etiology (developmental context and dispositional traits, including genetic vulnerability and traumatic experiences), pathological processes (characteristic adaptations and narrative identity), clinical manifestation and treatment goals. Fig. 2 depicts a visual presentation of this formulation.

Emma's *personal assessment question* was "Who am I, how did I become this person and how can I take into account my strengths and difficulties in daily life?' Emma, her parents and the clinician collaborated to gain an understanding of Emma's personality development to answer this question, using various assessment methods. Emma's *developmental context*, is formed by growing up as the eldest daughter in an intact family with two younger brothers, one of which claimed a lot of parental attention. Her family bonds contain(ed) support and warmth at times, however conflict, unmet emotional needs, not feeling safe and being disappointed seem to have been present continuously. Emma's profile of *dispositional traits*, compared to the profiles of other adolescents, can be characterized by high levels of maladaptive traits overall. Considering her most elevated scores, these seem to predominantly reflect a general tendency to be emotionally unstable. She furthermore tends to be more combative or argumentative than her peers and may generally be described as strongly 'engaged' rather than 'detached or estranged'. This profile of elevated trait scores, which has more often been indicated as a vulnerability trait profile associated with severe psychopathology, implies that strong emotions seem to have a large influence on Emma and also affect her behavior and interactions with others. On the one hand, strong positive emotions of curiosity and joy may urge her to act impulsively, on the other hand strong negative emotions of worry or anxiety may easily distract her and make her crave support, attention or control. This partly reflects Emma's *genetic vulnerability* for a difficult temperament and psychopathology, in interaction with *traumatic experiences* of years of being severely bullied and lack of support when needed. This context has shaped Emma. Her need for close connection, attention

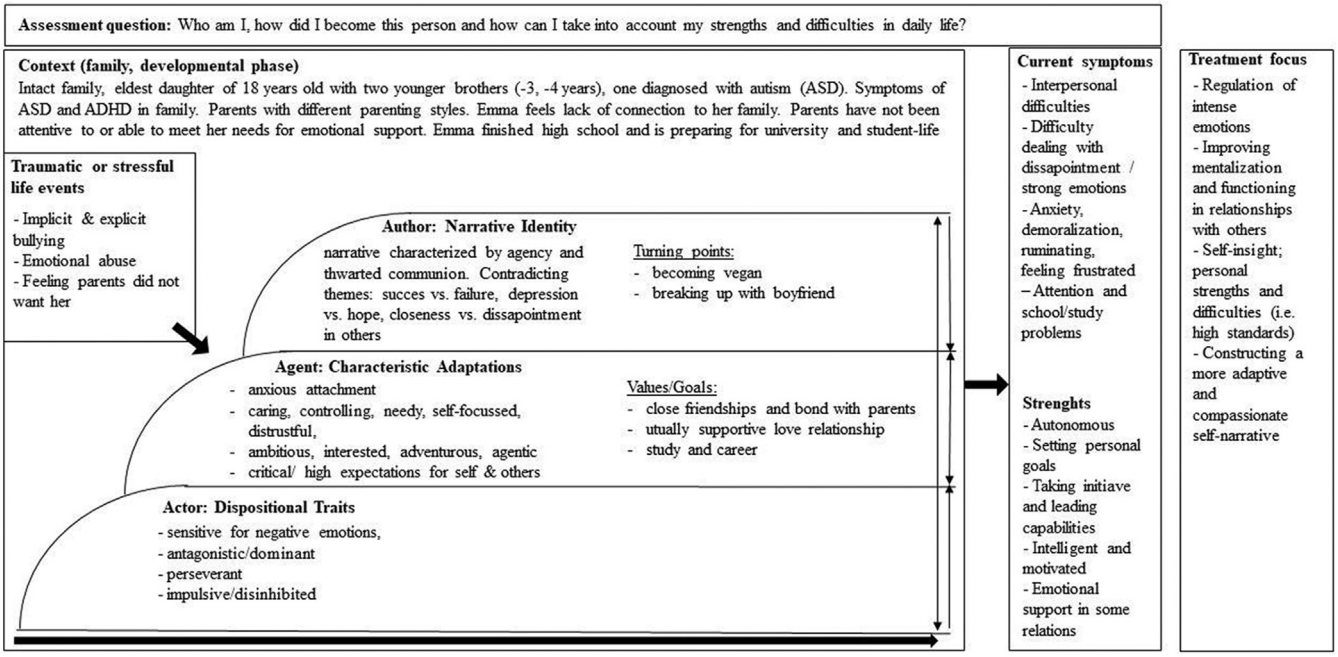

Fig. 2. Information of Emma's clinical assessment structured in an adapted version of McAdams's (2013) framework of personality development.

and control was frustrated regularly, given her strong emotions, she often felt deeply misunderstood and different. It seems that as a result, she *characteristically adapted* to becoming hesitant in allowing people to come close or accepting help, despite a strong longing for closeness and attention. Emma's standards are high, which helps her to be ambitious and reach personal goals. However, compared to her peers, Emma can be dismissive and dismayed more than average when these standards are not met, complicating both the relation with herself and with others. These processes of interaction have shaped her *narrative identity*. Her story has strong references to needing to be autonomous and longing for connection, two seemingly contradictory goals that lead to ambivalent feelings. Statements like 'I do not fit in' and 'I am better of alone' characterize her narrative, that speaks of disappointments in herself and others. Such incompatible contradictions are themes in Emma's personal story, and seem to be at the core of her *symptoms*. Emma is not optimistic about or wholly satisfied with her life, despite some life-areas in which she is functioning well and has similar scores as her peers. However, compared to her peers, she experiences severe cognitive, emotional, somatic and behavioral symptoms, particularly anxiety, attention problems, ruminating and feeling frustrated and troubled. This limits her in her goals and dreams, as a young lady in emerging adulthood, to take steps towards taking on a responsible adult role in which she maintains a satisfactory love relation and friendships and successfully finishes a study and starts a career. Based on this understanding of Emma, emotion regulation, functioning in relationships with others as well as gaining insight in personal strengths and difficulties can be marked as important *treatment goals* that are likely to contribute to reaching these personal goals. It will be a challenge for Emma to build trust in the relationship with the therapist as well as tolerate disappointments or slow change. However, Emma's motivation, perseverance, intelligence, tendency to be engaged and eagerness to learn about herself will further support her in reaching these goals.

The above answer to the initial assessment question was discussed with Emma. In addition it was presented to her in a letter, in order to facilitate clear and personal communication and the opportunity for self-reflection (Finn, 2020). She was moved by this concise summary of her development and could see how seemingly separate experiences and situations emphasized the same feeling and cognition again and again. She agreed that this description reflected her core problems and should be used to base a further treatment plan on, in which specific interpersonal and cognitive problems could be incorporated. We furthermore discussed her major treatment goals, along the important themes and identified problems that stood out in the case formulation (Ingram, 2012). These were first, the ability to regulate her strong emotions. Second, the wish to be connected to others in a meaningful way and reflect on (and break with) recurrent characteristic patterns in social relationships. Third, the feeling of disappointment in both herself and social relations both now and in the past and the goal to divert this personal story from the dominant black-and-white perspective by exploring nuances and practicing mentalization. These goals were then prioritized along sub- and process goals and provided direction for appropriate focus and methods for treatment. Given the evidence for the benefits of multiple forms of individual or group psychotherapy with these type of treatment goals (Lambert and Ogles, 2004), a shared decision (Zisman-Ilani et al., 2021), taking into account Emma's personal preferences, was made to start individual psychotherapy. Her characteristic interpersonal profile of being relatively dominant and distrustful were relevant to monitor and address in the therapeutic relationship. From the outcomes of the assessment it may be expected that, with her dispositional profile, Emma will keep experiencing some emotional instability throughout her life. However, insight in her personality profile, her way to adapt to challenges in life and her manner of meaning making are important for identity formation. It may help her to gain realistic expectations from herself and others. Emma's personal story may be broadened and strengthened by reflecting in each session on her strengths both currently, as she practices with new behavior and cognitions, and in situations in the past that may be an exception to her seeming 'rule' that she is better of alone. This recognition and integration of self-information in the personal narrative was noted an explicit treatment goal and matched her personal motivation for treatment. It would furthermore be used to inform and involve her social network.

7. Discussion

Emma's process illustrates how information collected through collaborative assessment along the dimensions of McAdams' theoretical

model, could aid in getting to know and understand a person in a nuanced and developmentally appropriate way (McAdams and Pals, 2006). Therewith, this model may provide a bridge between theory and clinical practice in moving the transition to a dimensional perspective on personality and pathology in clinical practice forward. The theoretical model and practical case formulation guideline helped to structure the process of clinical assessment. It facilitated communication with Emma, in terms of self-understanding, with Emma's social network, in terms of involvement and psycho-education, and amongst clinicians in terms of case formulation and treatment planning. In addition, it facilitated understanding of Emma's strengths and difficulties, her personal treatment goals and motivation for treatment. As such, this clinical assessment did not only provide insight and directions for treatment, but in fact was an essential *part of* treatment (Finn, 2020).

7.1. McAdams's model in clinical assessment with youth

We want to highlight three aspects of clinical assessment along the lines of McAdams's model that relate to its clinical usefulness in assessments with youth: First, with identity formation being a key developmental task for youth, this model facilitates its central role by collection of standardized and unique information on narrative identity as a separate dimension of personality. In the case of Emma, this focus on her personal narrative has been informative. It appeared that her meaning making problems, in which disappointment and contradictions autonomy and connectedness often played a role, in interplay with her dispositions of being highly emotional and disagreeable, constituted the core of her difficulties. Indeed, it has been found that elements of the narrative identity as well as personality traits are strongly related to psychopathology and well-being and therewith are complementary in gaining a nuanced understanding of one's characteristic adaptations (Sue et al., 2021; Waszczuk et al., 2021). Narrative identity accounts are also informative for early-intervention as they may indicate entries for change by revealing which narrative characteristics contribute to the maintenance of a dominant maladaptive personal story (Adler and Clark, 2019; McAdams and Janis, 2004).

Second, this framework is in line with the shift in our current scientific understanding of psychopathology and its etiology as a dimensional and developmental phenomenon strongly intertwined with personality. Adolescents whom are admitted to specialized mental health care often deal with complex and diffuse mental problems, on top of the dynamic developmental phase they are in. This was notable in Emma, who finds herself on the verge of taking on adult roles and setting goals that extend far into the future. In clinical practice, severe psychopathology in this phase is often indicated as 'other-specified' or 'unspecified' or by several comorbid clinical diagnoses. For instance, in the Netherlands 21% or 71% (depending on whether co-occurrence with formal personality disorder diagnoses is allowed) of individuals in specialized mental health care were diagnosed with a 'personality disorder not otherwise specified' (Verheul et al., 2007). This 'unspecified' diagnosis would have also been conceivable for Emma. However, such classifications are non-informative both for patients and clinicians and require elaboration on strengths, vulnerabilities and the extent to which these may be relatively stable or changeable with treatment. McAdam's model goes beyond categorical classifications, and is conceptually related to the Alternative Model of Personality Disorders [AMPD; (American Psychiatric Association, 2013; Mulay et al., 2018)]. However, it emphatically extends and integrates it to fit a dimensional and developmental perspective (McCrae and Costa Jr, 2021). In this assessment we discussed symptoms of the categorical diagnoses of ASD, ADHD and BPD as of secondary importance, but integrated Emma's intra- and interpersonal, cognitive and emotion regulation difficulties into the understanding of her as a whole person. It has been found that dispositional traits and such dimensional descriptions may be superior to categorical diagnosis for early-intervention in guiding treatment planning, prognostic hypotheses and insight in therapeutic needs (Waszczuk et al., 2021; Bagby et al., 2016).

Third, collaborative assessment as a method for early-detection and -intervention matches the developmental phase youth are in, which is characterized by (self-)exploration. It provides a context in which youth walk the line between self-verification and disintegration, as they together with an assessor investigate and reflect on their current self and development (Finn et al., 2013). In the case of Emma this match between her need for self-exploration and the process of collaborative assessment was notable. This phase, in which there are leaps in cognitive, emotional and social development, may be viewed as a 'window of opportunity' for learning and development, in which the brain is flexible, exploratory and open to social-affective influences facilitating identity formation (Costa Jr et al., 2019; Crone and Dahl, 2012). As such, clinical assessment may be a *risk* or a *reason,* in this developmental phase: A *risk* because, when assessment and discussion thereof is disorder-centered and developmentally insensitive, its outcome may contribute to stigma, pathological self-concept and behavior to manage a stigmatized identity, particularly (Elkington et al., 2012). A *reason* because a case formulation that meaningfully integrates standardized and unique information may contribute to self-understanding. To reach this goal, reflective feedback should match youths zone of proximal development (Tharinger et al., 2013).

7.2. Limitations of this model and method

There are several general limitations of this model and method that must be discussed and overcome in order to obtain the described benefits. First, clinicians must gain a solid understanding of McAdams three-layered model of personality development. This requires theoretical knowledge combined with conceptual and integrative thinking and may therefore not be easy to adopt for everyone. Adding to the complexity of this model and the necessity of conceptual integration is the fact that the three layers are not as neatly separated from each other as they may seem. The distinction between dispositions and adaptations may be difficult to make, they are most likely overlapping (Henry and Mõttus, 2020). For example, there is discussion whether attachment style may be seen as disposition or adaptation (McAdams and Pals, 2006). Therefore some instruments may fit into multiple layers. In addition, self-report instruments always have overlap with the narrative identity layer, as they touch upon one's self-concept and subjective meaning making. In this assessment for instance, the TAT was used, for which the results may fit both 'within' the layer of characteristic adaptations and the layer of narrative identity. There are many methods to assess one's narrative identity particularly. The most elaborative and rigorous method may be the full life story interview (McAdams, 2015; McAdams, 2018). This interview contains many chapters that may also be used as prompts separately, such as high, low or turning points (McLean et al., 2020; McLean and Pratt, 2006). These brief prompts may be informative, but do not contain as much information as the full life story interview. Moreover, it must be taken into account that, examining narrative identity is inseparable from examining a patients verbal abilities. In addition, a general limitation of describing individuals' personality profiles 'in a vacuum' may have the risk of static rather than process based description. While McAdams model allows for the description of developmental processes over time, it does not prompt the description of (day-to-day) interactional processes between individuals and their social environment. There is a push in the field in which the importance of dynamic processes for understanding psychopathology is increasingly emphasized (Hofmann and Hayes, 2019; Rau et al., 2023). Future studies may suggest how these processes may be incorporated in case formulations along this model.

To tackle some of these difficulties we suggest some steps for information selection and a straightforward case formulation guideline (see Supplementary material A). It must be noted that the scientific accuracy and clinical usefulness of this elaborate process of clinical assessment

that was executed for Emma justifies that it may be time consuming, as is the fact that it provides the start of treatment. Limitations of this particular clinical assessment with Emma were the lack of assessment of 'adaptive' dispositional traits, such as the Big Five, only maladaptive dispositional trait scores (PID-5) were available. These may have an overlap with symptoms and may provide a towards pathology biased indication of dispositional traits. Furthermore, cognitive functions were not tested (no neuropsychological assessment was conducted), which could have provided additional important information concerning the study-problems. However, Emma did exhibit relatively high mentalizing capacities, which made this assessment possible. Conducting such an assessment with clients who have limited cognitive ability or deficient mentalizing capacities may require different methods. Also, the family session was conducted solely with Emma and her parents, not with her two brothers. This could have provided additional information concerning the family dynamics.

In conclusion, to come to '*know what sort of person has a disease*' we discussed the value of the three-layered theoretical framework of McAdams. This framework seems clinically useful in a broad and narrow sense by providing diagnostic validity, including coverage and consistency with etiology and prognosis, by structuring choice of instruments and case formulations and by facilitating communication about the process of clinical assessment, treatment goals and planning. This framework, that is integrative of both dimensional and developmental perspectives, seems especially suited for youth. Given the empirical evidence for personality and psychopathology as intertwined dimensional concepts, the onset of most mental disorders in adolescence and the benefits of early-detection and -intervention, this developmental phase is particularly designated for accurate clinical assessment. Case formulations could subsequently provide a roadmap for meaningful integration of shared (i.e. the commonalities of groups of people) and unique (i.e. the idiosyncrasies of the individual) aspects of personality following collaborative clinical assessment. We have demonstrated the clinical usefulness and the particular value of this framework for youth with the assessment process of Emma and provide step-by-step guidelines in supplementary material A and B.

Funding

No external funding was obtained for this study

Declaration of Competing Interest

All authors report no conflict of interest.

Acknowledgments

We would like to wholeheartedly acknowledge and thank Emma (name is a pseudonym) for allowing us (with both verbal and written permission) to use her personal story and assessment results for this paper and for providing feedback on the manuscript.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.psycr.2023.100126.

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Further reading

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