

Proposed Changes in Personality and Personality Disorder Assessment and Diagnosis for *DSM-5* Part I: Description and Rationale

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A major reconceptualization of personality psychopathology has been proposed for *DSM-5* that identifies core impairments in personality functioning, pathological personality traits, and prominent pathological personality types. A comprehensive personality assessment consists of four components: levels of personality functioning, personality disorder types, pathological personality trait domains and facets, and general criteria for personality disorder. This four-part assessment focuses attention on identifying personality psychopathology with increasing degrees of specificity, based on a clinician's available time, information, and expertise. In Part I of this two-part article, we describe the components of the new model and present brief theoretical and empirical rationales for each. In Part II, we will illustrate the clinical application of the model with vignettes of patients with varying degrees of personality psychopathology, to show how assessments might be conducted and diagnoses reached.

Keywords: personality disorders, personality, *DSM-5*, assessment, diagnosis

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Overview of Proposed Model

A major reconceptualization of personality psychopathology has been proposed for *DSM-5* that identifies core impairments in personality functioning, pathological personality traits, and prominent pathological personality types. A comprehensive personality assessment consists of four components:

(a) Five identified severity levels of personality functioning based on degrees of impairment in core self and interpersonal capacities;

(b) Five specific personality disorder (PD) types, each defined by impairments in core capacities and a set of pathological personality traits, and one trait-specified type;

(c) Six broad, higher order personality *trait domains*, with 4–10 lower order, more specific *trait facets* within each domain, for a total of 37 specific trait facets;

(d) New general criteria for PD based on severe or extreme deficits in core capacities of personality functioning and extreme levels of pathological personality traits.¹

This four-part conceptualization and assessment focuses attention on identifying personality psychopathology with increasing degrees of specificity, based on a clinician's available time, information, and expertise. The assessment model is intended to facilitate identification of personality-related problems and their severity and to characterize these problems according to broad, clinically salient types, in association with patient-specific personality trait profiles. Both of these assessments are relevant whether a patient has a PD or not. The assessment of the general criteria for a PD insures that inclusion and exclusion criteria for a diagnosable disorder are met.

These new assessment components replace the PD assessment in *DSM-IV-TR*, which consisted of general PD diagnostic criteria and 10 individual PDs (plus two additional PDs in the Appendix), each identified by a specific polythetic criteria set. Severity and course specifiers were provided for all *DSM-IV-TR* disorders, but were not specific to personality psychopathology and were seldom applied to PDs. In Part I of this two-part article, we will describe the components of the proposed new model and present brief theoretical and empirical rationales for them. In Part II, we will illustrate the clinical application of the model with vignettes

of patients with varying degrees of personality psychopathology, to show how assessments might be conducted and diagnoses reached.

Levels of Personality Functioning

The Personality and Personality Disorders (P&PD) Work Group has proposed a measure of severity of impairment in core capacities central to personality functioning. Impairment in personality functioning forms the basis of a revised definition of PD and is used to rate criterion A of the general criteria. The severity of impairment captures variation both across and within personality disorder types.

Personality psychopathology fundamentally emanates from disturbances in thinking about oneself and others. Because there are greater and lesser degrees of disturbance in the self and interpersonal domains, a continuum of five levels of self and interpersonal functioning is provided for assessing individual patients. Table 1 depicts a summary of the levels of personality functioning scale. Scale anchor points for impairment in self and in interpersonal functioning at each level of the scale have been written for inclusion in *DSM-5* (see part II, Appendix A). We are currently scaling these anchor points, using Item Response Theory (IRT) methods to examine existing data sets and refine this characterization of the severity dimension before finalizing it for *DSM-5*.

Rationale for Developing a Model for Assessing Level of Personality Functioning

A recent study (Hopwood et al., in press) of patients with PDs participating in the Collaborative Longitudinal Personality Disorders Study (CLPS; Gunderson et al., 2000), demonstrated that, in assessing personality psychopathology, "generalized severity is the most important single predictor of concurrent and prospective dysfunction." The authors concluded that PD is

¹ At the time these papers were submitted, the four parts of the model were undergoing revisions, based on public comments received in response to the posting of proposed changes on the American Psychiatric Association's *DSM-5* website (www.DSM5.org), secondary data analyses, and a national survey. For the most part, the model presented here is the one posted, except as noted. The revised versions of the four parts will be tested in field trials.

Table 1
Levels of Personality Functioning^a

Personality psychopathology fundamentally emanates from disturbances in thinking about self and others. Because there are greater and lesser degrees of disturbance of the self and interpersonal domains, the following continuum comprised of levels of self and interpersonal functioning is provided for assessing individual patients. Each level is characterized by typical functioning in the following areas: Self: Identity integration, integrity of self-concept, and self-directedness Interpersonal: Empathy, intimacy and cooperativeness, and complexity and integration of representations of others As with the general diagnostic criteria for personality disorder, in applying these dimensions diagnostically, the self and interpersonal difficulties must: A. Be multiple years in duration B. Not be solely a manifestation or consequence of another mental disorder C. Not be due solely to the direct physiological effects of a substance or general medical condition D. Not be better understood as a norm within an individual's cultural background Self and Interpersonal Functioning Continuum _____ 0 = No Impairment _____ 1 = Mild Impairment _____ 2 = Moderate Impairment _____ 3 = Serious Impairment _____ 4 = Extreme Impairment
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^a The full scale with definitions of terms and detailed definitions of scale points is provided in **Appendix A: Levels of Personality Functioning** in Part II of this two part article.

optimally characterized by a generalized personality severity continuum with some additional specification of stylistic elements, derived from PD symptom patterns. This recommendation is fully consistent with Tyrer’s (2005) assertion that severity level must be part of any dimensionally specified system for assessing personality psychopathology. Neither the *DSM–IV–TR* general severity specifiers nor the Axis V GAF Scale have sufficient specificity for personality psychopathology to be useful in this regard. Consequently, the *DSM-5* P&PD Work Group proposes that a scale be included in the updated Manual that would allow clinicians to determine not only the existence of personality psychopathology, but also its severity.

Self and interpersonal functioning. It has been well-established that temperament, developmental processes, and environmental factors

influence how individuals typically view themselves and others. Bowlby (1969), a pioneer in the area of development and attachment theory, posited that individuals develop “working models” to help them deal with the external world, particularly interactions with other people. Working from a social–cognitive perspective, Anderson and Cole (1990) explored the idea that individuals form social categories based on representations of significant others. They demonstrated that nonclinical individuals exhibited pronounced false-positive errors in assessing new figures; that is, if the figure was assimilated into a significant-other category, subjects were quick to apply preconceived notions that were, in fact, quite inaccurate. Such studies provide evidence that existing relational and perceptual tendencies greatly influence one’s view of new people (Andersen & Chen, 2002).

If such biases occur in nonpersonality–disordered individuals, the phenomena are likely to be even more pronounced in people with personality psychopathology. An extensive literature demonstrates that PDs are associated with distorted thinking about self and others. Concepts of self-other representational disturbance are not restricted to psychodynamic formulations, but are present in theories of personality pathology across the spectrum, including interpersonal (e.g., Benjamin, Horowitz), cognitive–behavioral (e.g., Beck, Linehan, Young), and trait (e.g., Cloninger, Livesley) models (Bender & Skodol, 2007). In the empirical literature, a number of studies have shown representations of self and others by patients with borderline pathology to be particularly distorted and biased toward hostile attributions, compared to those of other types of patients (e.g., Blatt & Lerner, 1983; Westen, Ludolph, Lerner, Ruffins, & Wiss, 1990). Other studies (Donegan et al., 2003; Wagner & Linehan, 1999) investigating the link between disturbed interpersonal relations and emotional dysregulation, using Ekman faces as stimuli, have demonstrated that patients with borderline personality disorder (BPD) were significantly more likely to assign negative attributes and emotions to the picture of a face with a neutral expression. Such representational proclivities have also been established in the context of treatment: patients with BPD show the most difficulty in creating a helpful mental image of treatment providers and the treatment relationship, compared with pa-

tients with other PDs or Axis I disorders only (Bender et al., 2003; Zeeck, Hartmann, & Orlinsky, 2006). These studies support the notion that maladaptive patterns of mentally representing self and others serve as the substrates for personality psychopathology.

Livesley and Jang (2000) have conceptualized personality problems as difficulties in three self-other focused realms: 1) the adaptive self-system, allowing the individual to create and maintain integrated representations of self and others; 2) the capacity for intimacy; and 3) the ability to function effectively in society. Dimaggio and colleagues (Dimaggio, Semerari, Carcione, Procacci, & Nicolo, 2006) have suggested that individuals with PDs “possess problematical self-states, inadequate self-representations and restricted self-narratives, and poor self-reflection and self-regulatory strategies” (p. 610). Illustrating the centrality of self pathology in PDs, Morey (2005) demonstrated that a core dimension (characterized by varying degrees of narcissistic difficulties) could be identified that appreciably accounted for high rates of comorbidity found among presumably different forms of personality psychopathology. This finding is consistent with Ronningstam’s (2009) contention that narcissism—problems with the self and views of others—is much more pervasive in various types of character pathology than is currently represented by *DSM-IV-TR* PD diagnoses. Hence, we conducted a literature review that considers existing approaches to assessing personality psychopathology on self-other severity dimensions, and explores the utility of constructing a scale for *DSM-5* capturing levels of impairment in personality functioning, based on self-other problems (Bender, Morey, & Skodol, 2011), and are validating this scale using IRT methods.

Review of self-other dimensions. To guide our choice of relevant measures to review, we established a series of criteria. Each instrument should: a) contain salient dimensions, rather than categories; b) have a self-other orientation; c) have been employed in studies with clinical and/or personality-disordered samples; d) feature central concepts and components useful to a broad range of clinicians; and e) be applicable to rating clinical interview material, or be very informative in the development of a personality functioning scale

(one self-report measure was considered because of its particular pertinence).

We have reviewed a number of reliable and valid measures that assess personality functioning and psychopathology, which demonstrate that a self-other dimensional perspective has significant clinical and empirical utility (Bender et al., 2011). Reliable ratings can be made on a broad range of self-other constructs, such as identity (Gamache et al., 2009) and identity integration (Verheul et al., 2008), self-other differentiation and integration (Blatt, Stayner, Auerbach, & Behrends, 1996), sense of agency (Bers, Blatt, & Dolinsky, 2004), self-control (Verheul et al., 2008), sense of relatedness (Bers et al., 2004), capacity for emotional investment in others (Porcerelli, Cogan, & Hibbard, 1998), responsibility and social concordance (Verheul et al., 2008), maturity of relationships with others (Piper, Ogrodniczuk, & Joyce, 2004), and understanding social causality (Porcerelli et al., 1998).

Numerous studies using the measures designed to assess these and other related self-other capacities have shown that a self-other approach is informative in determining type and severity of personality psychopathology, in planning treatment interventions, and in anticipating treatment course and outcome. For example, maturity of relationships with others has been shown to be inversely correlated with the presence and severity of a PD diagnosis (Loffler-Stastka, Ponocny-Seliger, Fischer-Kern, & Leithner, 2005) and social cognition and object relations scores identified and differentiated among patients with different types of PDs (Hilsenroth, Hibbard, Nash, & Handler, 1993; Porcerelli, Hill, & Dauphin, 1995). Also, reflective functioning, that is, the ability to understand and interpret one’s own and others’ mental states, has been shown to be lower in patients with BPD than in other nonborderline patients (Fonagy et al., 1996) and to be inversely related to the number of Axis II PDs diagnosed in a given patient (Bouchard et al., 2008). In a study of 1,195 patients, Verheul et al. (2008) found that scores on each of five domains indicative of personality problem severity—self-control, identity integration, relational capacities, responsibility, and social concordance—distinguished between those with no PD,

those with one PD, and those with two or more PDs.

In the treatment realm, overall quality of object relations predicted the development of a positive therapeutic alliance and improvement as a result of treatment (Piper et al., 1991) and capacities for self–other differentiation and interpersonal relatedness have been shown to be sensitive to change in treatment (Diamond, Kaslow, Coonerty, & Blatt, 1990). Many other examples of the clinical utility of self-other constructs are evident from the review.

Most of the measures evaluated, however, were designed for use in research and require intensive training to implement. Thus, it is not practical to simply adopt any specific, published measure for clinical use in *DSM-5*. At the same time, because many of the constructs included in these instruments can be measured reliably and have significant validity and utility in characterizing the presence and degree of personality psychopathology, they serve as the foundation for creating a new severity dimension. To this end, we have synthesized concepts across models to form a foundation for rating personality functioning on a continuum.

Personality Disorder Types

The P&PD Work Group proposes five specific PD types, to be rated on a dimension of graded membership: antisocial/psychopathic, avoidant, borderline, obsessive–compulsive, and schizotypal. Each type is identified by core impairments in personality functioning and is associated with a trait list specifying its component pathological personality traits. Each is similar—though not identical to—the corresponding *DSM-IV-TR* PD. The other *DSM-IV-TR* PDs and the large residual category of PD Not Otherwise Specified (PDNOS) will be represented solely by the core impairments combined with specification by individuals’ unique sets of personality traits, based on their most prominent descriptive features, and a diagnosis of *PD Trait Specified* (PDTS) would be given. See Table 2, *DSM-5* Borderline Personality Disorder Type with Matching and Traits, for an example of a type description, the rating scale, and the component traits of the borderline type. See Table 3, *DSM-IV-TR* Personality Disorder to *DSM-5* Type and Trait Cross-Walk, for the representa-

tion of all *DSM-IV-TR* PDs by *DSM-5* types and traits.

Rationale for Proposing Five Specific Personality Disorder Types

The proposal for specified PD types in *DSM-5* has four main features: 1) a reduction in the number of specified types from 10 to 5; 2) description of the types in a narrative format that combines typical deficits in self and interpersonal functioning and particular trait configurations; 3) a dimensional graded membership rating of the degree to which a patient matches each type; and 4) a rating of the personality traits most commonly associated with each personality type. The justifications for these modifications in approach to diagnosing PD types include the excessive comorbidity among *DSM-IV-TR* PDs, the limited validity for some existing types, arbitrary diagnostic thresholds included in *DSM-IV-TR*, and instability of current *DSM-IV-TR* PD criteria sets. Each of the *DSM-IV-TR* PDs, levels of self and interpersonal functioning, dimensional representations of PD categories, and the relationship of pathological personality traits to PD has been the topic of an extensive literature review conducted by Work Group members. Highlights of these reviews appear in the sections that follow.

Considerable research has shown excessive co-occurrence among PDs diagnosed using the categorical system of the *DSM* (Oldham, Skodol, Kellman, Hyler, & Rosnick, 1992; Zimmerman, Rothchild, & Chelminski, 2005). In fact, most patients diagnosed with PDs meet criteria for more than one. In addition, all of the PD categories have arbitrary diagnostic thresholds (i.e., the number of criteria necessary for a diagnosis). PD diagnoses have been shown in longitudinal follow-along studies to be significantly less stable over time than their definition in *DSM-IV-TR* implies (e.g., Grilo et al., 2004). The reduction in the number of types is expected to reduce comorbid PD diagnoses, the use of a dimensional rating of types recognizes that personality psychopathology occurs on continua, and the replacement of specific behavioral PD criteria with traits is anticipated to result in greater coverage and increased diagnostic stability.

Number and specification of types. Five specific PDs are being recommended for reten-

T2

T3

Table 2

Borderline Personality Disorder Type With Matching and Traits

Individuals who match this personality disorder type have an extremely fragile self-concept that is easily disrupted and fragmented under stress and results in the experience of a lack of identity or chronic feelings of emptiness. As a result, they have an impoverished and/or unstable self structure and difficulty maintaining enduring intimate relationships. Self-appraisal is often associated with self-loathing, rage, and despondency. Individuals with this disorder experience rapidly changing, intense, unpredictable, and reactive emotions and can become extremely anxious or depressed. They may also become angry or hostile, and feel misunderstood, mistreated, or victimized. They may engage in verbal or physical acts of aggression when angry. Emotional reactions are typically in response to negative interpersonal events involving loss or disappointment.

Relationships are based on a perceived need for others for survival, excessive dependency, and a fear of rejection and/or abandonment. Dependency involves both insecure attachment, expressed as difficulty tolerating aloneness; Intense fear of loss, abandonment, or rejection by significant others; and urgent need for contact with significant others when stressed or distressed, accompanied sometimes by highly submissive, subservient behavior. At the same time, intense, intimate involvement with another person often leads to a fear of loss of an identity as an individual. Thus, interpersonal relationships are highly unstable and alternate between excessive dependency and flight from involvement. Empathy for others is severely impaired.

Core emotional traits and interpersonal behaviors may be associated with cognitive dysregulation, i.e., cognitive functions may become impaired at times of interpersonal stress leading to information processing in a concrete, black-and white, all-or-nothing manner. Quasi-psychotic reactions, including paranoia and dissociation, may progress to transient psychosis. Individuals with this prototype are characteristically impulsive, acting on the spur of the moment, and frequently engage in activities with potentially negative consequences. Deliberate acts of self-harm (e.g., cutting, burning), suicidal ideation, and suicide attempts typically occur in the context of intense distress and dysphoria, particularly in the context of feelings of abandonment when an important relationship is disrupted. Intense distress may also lead to other risky behaviors, including substance misuse, reckless driving, binge eating, or promiscuous sex.

Instructions: Rate the patient's personality using the 5-point rating scale shown below. Circle the number that best describes the patient's personality.

- 5 Very good match: Patient exemplifies this type
- 4 Good match: Patient significantly resembles this type
- 3 Moderate match: Patient has prominent features of this type
- 2 Slight match: Patient has minor features of this type
- 1 No match: Description does not apply

Rate the extent to which the patient has the following traits associated with the borderline type:

Trait	0	1	2	3
	Very little or not at all	Mildly Descriptive	Moderately Descriptive	Extremely Descriptive
1. Negative emotionality: Emotional lability				
Having unstable emotional experiences and mood changes; having emotions that are easily aroused, intense, and/or out of proportion to events and circumstances	0	1	2	3
2. Negative emotionality: Self-harm				
Engaging in thoughts and behaviors related to self-harm (e.g., intentional cutting or burning) and suicide, including suicidal ideation, threats, gestures, and attempts	0	1	2	3
3. Negative emotionality: Separation insecurity				
Fears of rejection by, and/or separation from, significant others; distress when significant others are not present or readily available	0	1	2	3
4. Negative emotionality: Anxiousness				
Feelings of nervousness, tenseness, and/or being on edge; worry about past unpleasant experiences and future negative possibilities; feeling fearful and threatened by uncertainty	0	1	2	3
5. Negative emotionality: Low self-esteem				
Having a poor opinion of one's self and abilities; believing that one is worthless or useless; disliking or being dissatisfied with one's self; believing that one cannot do things or do them well	0	1	2	3

(table continues)

Table 2 (continued)

Trait	0	1	2	3
	Very little or not at all	Mildly Descriptive	Moderately Descriptive	Extremely Descriptive
6. Negative emotionality: Depressivity				
Having frequent feelings of being down/ miserable/ depressed/ hopeless; difficulty “bounding back” from such moods; belief that one is simply a sad/ depressed person	0	1	2	3
7. Antagonism: Hostility				
Irritability, hot temperedness; being unfriendly, rude, surly, or nasty; responding angrily to minor slights and insults	0	1	2	3
8. Antagonism: Aggression				
Being mean, cruel, or cold-hearted; verbally, relationally, or physically abusive; humiliating and demeaning of others; willingly and willfully engaging in acts of violence against persons and objects; active and open belligerence or vengefulness; using dominance and intimidation to control others	0	1	2	3
9. Disinhibition: Impulsivity				
Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; failure to learn from experience	0	1	2	3
10. Schizotypy: Dissociation proneness				
Tendency to experience disruptions in the flow of conscious experience; “losing time,” (e.g., being unaware of how one got to one’s location); experiencing one’s surroundings as strange or unreal	0	1	2	3

tion in *DSM-5*: antisocial/psychopathic (possibly with subtypes), borderline, schizotypal, avoidant, and obsessive–compulsive. Antisocial/psychopathic, borderline, and schizotypal PDs have the most extensive empirical evidence of validity and clinical utility (e.g., Skodol et al., 2002a; Skodol et al., 2002b; Patrick, Fowles, & Krueger, 2009; Siever & Davis, 2004). For example, in the CLPS, patients with severe PD types, such as schizotypal and borderline, have been found to have significantly more impairment at work, in social relationships, and at leisure than patients with less severe types, such as obsessive–compulsive PD, or with major depressive disorder in the absence of PD. Avoidant PD was in between (Skodol et al., 2002c). Even the less impaired patients with PDs (e.g., obsessive–compulsive PD), however, have moderate to severe impairment in at least one area of functioning (or a Global Assessment of Functioning rating of 60 or less). Patients with obsessive–compulsive PD are also among the most common in community (Torgersen, 2009) and clinical (Stuart et al., 1998) populations, have increased levels of

mental heath treatment utilization (Bender et al., 2001), and along with borderline PD, are associated with the highest total economic burden in terms of direct medical costs and productivity losses of all PDs (Soeteman, Hakkart-van Roijen, Verheul, & Busschbach, 2008). With respect to current models of psychopathy (Patrick et al., 2009), the proposed trait-based prototype for antisocial/psychopathic PD would include both traits related to the disinhibition component (i.e., traits corresponding most directly to the adult features of *DSM-IV-TR* antisocial PD) and traits related to the construct of meanness (i.e., traits related to callousness/lack of remorse, conning/manipulativeness, and predatory aggression). There is abundant evidence that the impulsive-antisocial (disinhibited-externalizing) and affective-interpersonal (boldness-meanness) components of psychopathy differ in terms of their neurobiological correlates and etiologic determinants, which provides a strong foundation formulating and testing questions in relation to possible antisocial and psychopathic PD subtypes.

Table 3
DSM–IV–TR *Personality Disorder* to DSM-5 *Type and Trait Cross-Walk*

DSM–IV–TR PD	DSM-5 PD type	Prominent personality traits/(domains) ^a
Paranoid	PD Trait Specified (PDTS) ^b	Suspiciousness (NE) Intimacy avoidance (DT) Hostility (A) Unusual beliefs (S)
Schizoid	PDTS	Social withdrawal (DT) Social detachment (DT) Intimacy avoidance (DT) Restricted affectivity (DT) Anhedonia (DT)
Schizotypal	Schizotypal (4 or 5)	Eccentricity (S) Cognitive dysregulation (S) Unusual perceptions (S) Unusual beliefs (S) Social withdrawal (DT) Restricted affectivity (DT) Intimacy avoidance (DT) Suspiciousness (NE) Anxiousness (NE)
Antisocial	Antisocial/Psychopathic (4 or 5)	Callousness (A) Aggression (A) Manipulativeness (A) Hostility (A) Deceitfulness (A) Narcissism (A) Oppositionality (A) Irresponsibility (DS) Recklessness (DS) Impulsivity (DS)
Borderline	Borderline (4 or 5)	Emotional lability (NE) Self-harm (NE) Separation insecurity (NE) Submissiveness (NE) Anxiousness (NE) Low self-esteem (NE) Depressivity (NE) Suspiciousness (NE) Hostility (A) Aggression (A) Impulsivity (DS) Recklessness (DS) Dissociation proneness (S) Cognitive dysregulation (S)
Histrionic	PDTS	Emotional lability (NE) Histrionism (A)
Narcissistic	PDTS	Narcissism (A) Manipulativeness (A) Histrionism (A) Callousness (A)
Avoidant	Avoidant (4 or 5)	Anxiousness (NE) Separation insecurity (NE) Pessimism (NE) Low self-esteem (NE) Guilt/shame (NE) Intimacy avoidance (DT) Social withdrawal (DT)

(table continues)

Table 3 (continued)

<i>DSM-IV-TR</i> PD	<i>DSM-5</i> PD type	Prominent personality traits/(domains) ^a
Dependent	PDTS	Restricted affectivity (DT) Anhedonia (DT) Social detachment (DT) Submissiveness (NE) Anxiousness (NE) Separation insecurity (NE)
Obsessive-compulsive	Obsessive-compulsive (4 or 5)	Perfectionism (C) Rigidity (C) Orderliness (C) Perseveration (C) Anxiousness (NE) Pessimism (NE) Guilt/shame (NE) Low self-esteem (NE) Restricted affectivity (DT) Oppositionality (A) Manipulativeness (A)
Depressive	PDTS	Pessimism (NE) Anxiousness (NE) Depressivity (NE) Low self-esteem (NE) Guilt/shame (NE) Anhedonia (DT)
Passive-aggressive	PDTS	Oppositionality (A) Hostility (A) Guilt/shame (NE)
PD not otherwise specified (PDNOS)	PDTS	Individual trait profile

Note. NE = Negative Emotionality; DT = Detachment; A = Antagonism; DS = Disinhibition; C = Compulsivity; S = Schizotypy.

^a Several additional traits have been listed for selected disorders, based on an analysis of the content of the personality disorder type descriptions. A further revision of the list will be based on the results of field trials. ^b Whenever patients impairment in personality functioning is sufficiently severe to warrant a PD diagnosis, but their patterns of impairments and associated traits do not match one of the five types, a diagnosis of PD Trait Specified (PDTS) is made.

The other *DSM-IV-TR* PDs (paranoid, schizoid, histrionic, narcissistic, dependent, depressive, and negativistic), and the residual category of PDNOS will be diagnosed as PD trait specified (PDTS) and represented by the general PD criteria combined with descriptive specification of patients' personality trait profiles, based on their most prominent descriptive features. Literature reviews conducted by the Work Group support conceptualizing them as one or more dimensions of personality psychopathology rather than as types.

Dimensional representation of types. A "person-centered" dimensional approach to existing categories is the prototype matching approach originally described by Shea and colleagues (Shea, Glass, Pilkonis, Watkins, & Docherty, 1987). Embedded in their Personality Assessment Form (PAF) are brief de-

scriptive paragraphs emphasizing the salient features of each *DSM-III* PD, with ratings of descriptiveness made on a 6-point scale. In the context of the National Institute of Mental Health Treatment of Depression Collaborative Research Program, the factor structures of the clinician-rated PAF and an extensive self-report battery of personality traits were similar (Pilkonis & Frank, 1988) indicating construct validity. Patients with PDs according to their prototype ratings had a significantly worse outcome in social functioning and were more likely to have residual symptoms of depression than were patients without PD (Shea et al., 1990), similarly to results of longitudinal studies using standard *DSM-IV* diagnostic criteria assessed by semistructured interview (Grilo et al., 2005; Skodol et al., 2005).

The prototype dimensional model has subsequently been empirically derived and elaborated by Westen and colleagues (Shedler & Westen, 2004; Westen, Shedler, & Bradley, 2006). Twelve personality syndromes (including one representing psychological health) were identified from a large national sample of clinicians, who rated patients using the Shedler-Westen Assessment Procedure-200 (SWAP-200; Shedler & Westen, 2004; Westen & Shedler, 1999a, 1999b). Each syndrome has then been represented by a paragraph-length narrative prototype description. Using this system, a clinician compares a patient to the description of the prototypic patient with each disorder and the “match” is rated on a 5-point scale from 5 = *very good match* to 1 = *little or no match*. Prototype ratings have been demonstrated to have good interrater reliability, with a median $r = .72$ in 65 nonpsychotic patients seeking outpatient treatment (Westen, DeFife, Bradley, & Hilsenroth, in press).

Westen et al. (2006) have reported that this method reduced comorbidity among Cluster B PDs, predicted external validators (adaptive functioning, treatment response, and etiological factors) as well as *DSM-IV* PD diagnoses, and was rated higher on measures of clinical utility (e.g., ease of use, description, communication) than the corresponding *DSM-IV* PDs. Spitzer and colleagues (Spitzer, First, Shedler, Westen, & Skodol, 2008) also conducted a study of the clinical relevance and utility of five dimensional systems for PDs that have been proposed for *DSM-5*: (1) a criteria counting model based on current *DSM-IV-TR* diagnostic criteria, (2) a prototype-matching model based on current *DSM-IV-TR* diagnostic criteria, (3) a prototype matching model based on the SWAP, (4) the Five-Factor Model (FFM), and (5) Cloninger’s Psychobiological Model. A random national sample of psychiatrists and psychologists applied all five systems to a patient under their care and rated the clinical utility of each system. The two prototype matching models were judged most clinically useful and relevant. The authors concluded that prototype matching systems most faithfully capture personality syndromes seen in practice and allow for rich descriptions without a proportionate increase in time or effort.

Rottman and colleagues (Rottman, Ahn, Sanislow, & Kim, 2009) found that clinicians made

fewer correct diagnoses of PDs and more incorrect diagnoses when given ratings of patients on a list of the 30 facet traits of normal-range personality derived from the NEO-PI-R (Costa & McCrae, 1992) than when given prototype descriptions based on either the SWAP or *DSM-IV* criteria. And, on most questions about clinical utility, including about treatment planning and prognosis, the prototype systems were rated as superior. According to the authors, these findings indicate that personality traits in the absence of clinical context are too ambiguous for clinicians to interpret: although it may be possible to describe PDs in terms of the FFM, mentally translating personality traits back into syndromes or disorders is cognitively challenging, at least when the trait profiles are based on extremes of normal-range traits.

Samuel and Widiger (2006) have found, however, greater clinical utility for the FFM compared to a dimensional rating of *DSM-IV* PD categories. Specifically, while the FFM and *DSM-IV* dimensions were rated equally easy to use and facilitated professional communication, the FFM was rated more useful for global personality description, communication with clients, comprehensive description of personality difficulties, and treatment planning. Even though all of the respondents were psychologists and the dimensional model of *DSM-IV* PD categories involved criteria counting, rather than prototype ratings, the results of this study were interpreted by the authors as supporting an integrated model of personality pathology that maximized the strengths of various models for future editions of the DSM.

Hybrid model of PD diagnosis. A number of recent studies support a hybrid model of personality psychopathology consisting of ratings of both disorder and trait constructs. Morey and Zanarini (2000) found that FFM domains captured substantial variance in the borderline diagnosis with respect to its differentiation from nonborderline PDs, but that residual variance not explained by the FFM was significantly related to important clinical correlates of BPD, such as childhood abuse history, family history of mood and substance use disorders, concurrent (especially impulsive) symptoms, and 2- and 4-year outcomes. In the CLPS, dimensionalized *DSM-IV* PD diagnoses predicted concurrent functional impairment, but this diminished over time (Morey et al., 2007). In contrast, the FFM provided less

information about current behavior and functioning, but was more stable over time and more predictive in the future. The Schedule for Non-adaptive and Adaptive Personality (SNAP) model performed the best, both at baseline and prospectively, because it combines the strengths of a pathological disorder diagnosis and normal range personality functioning. In fact, a hybrid model combination of FFM and *DSM-IV* constructs performed much like the SNAP. The results indicated that models of personality pathology that represent stable trait dispositions and dynamic, maladaptive manifestations are most clinically informative. Hopwood and Zanarini (in press) found that FFM extraversion and agreeableness were incrementally predictive (over a BPD diagnosis) of psychosocial functioning over a 10-year period and that borderline cognitive and impulse action features incremented FFM traits. They concluded that both BPD symptoms and personality traits are important long-term indicators of clinical functioning and supported the integration of traits and disorder in *DSM-5*.

Personality Traits: Domains and Facets

The P&PD Work Group proposes six broad, higher order personality trait domains—negative emotionality, detachment,² antagonism, disinhibition, compulsivity, and schizotypy—each comprised of several lower order, more specific, trait facets. The broad trait domains are listed below in **boldface**, with the initially proposed trait facets comprising each domain following. The proposed trait model is in the process of empirical validation and may change depending on the data analytic results, so it should be considered preliminary (see Part II, Appendix B, Clinician’s Personality Trait Rating Form, for current definitions of both the trait domains and facets).

Negative emotionality. Emotional lability, anxiousness, submissiveness, separation insecurity, pessimism, low self-esteem, guilt/shame, self-harm, depressivity, suspiciousness.

Detachment. Social withdrawal, social detachment, intimacy avoidance, restricted affectivity, anhedonia.

Antagonism. Callousness, manipulativeness, narcissism, histrionism, hostility, aggression, oppositionality, deceitfulness.

Disinhibition. Impulsivity, distractibility, recklessness, irresponsibility.

Compulsivity. Perfectionism, perseveration, rigidity, orderliness, risk aversion.

Schizotypy. Unusual perceptions, unusual beliefs, eccentricity, cognitive dysregulation, dissociation proneness.

Rationale for a Six-Domain Trait Dimensional Diagnostic System for PD

The rationale for this pathological personality trait model has been described in detail elsewhere (Krueger & Eaton, in press; Krueger et al., 2011) and is summarized here.

Why a trait-based system? A number of problems have plagued the Axis II PD system since its implementation in *DSM-III*. These have been well and repeatedly documented, so we summarize rather than exhaustively review this evidence here, encapsulating it into the following five points: (1) excessive comorbidity, (2) excessive within-diagnosis heterogeneity, (3) marked temporal instability, (4) no clear boundary between normal and pathological personality, and (5) poor convergent and discriminant validity. As summarized by Trull and Durrett (2005), “...[PDs] although described as such, may not represent distinct diagnostic entities. Their overlap indicates that the classification is not efficient or optimal, and their conceptualization and operationalization in existing assessment instruments may be problematic” (p. 360).

Excessive comorbidity. In 2007, Clark wrote, “PD comorbidity has been investigated so much that one would think the topic exhausted, but it is such a fundamental issue that PD-comorbidity research is still increasing” (p. 236; Clark, 2007). Clark documented the increase from 1985 through 2005, and a recent simple PsycINFO search crossing “personality disorder(s)” and “comorbidity or co-occurrence” found that this trend still continues: in the 4 years from 2006 through 2009, already as many articles on PD comorbidity have been published as between 2000 and 2005. This re-

² In the Work Group’s original proposal, this domain was named *introversion*, but in response to comments posted on the *DSM-5* website, we are proposing changing it to *detachment*. This increases the consistency of labeling, because all of the other domain names reflect the high, typically maladaptive, end of the dimension, and the new label does so as well.

search continues unabated because distinctiveness of diagnoses is a desideratum, perhaps even a condition sine qua non, for a valid nosology, yet *DSM*'s Axis II so clearly fails in this regard that it must remain a focal topic of research until the system is rectified. Typical comorbidity rates in clinical samples are 40–50% or higher, not only with other Axis II PDs, but also with Axis I disorders (e.g., Clark, 2005; Krueger, 2005; Zimmerman et al., 2005).

A trait-based diagnostic system helps to resolve the excessive comorbidity problem, which plagues all aspects of mental disorder classification, by acknowledging its fundamental source: individuals too easily meet criteria for multiple PD diagnoses because the personality traits that fundamentally comprise PDs overlap across diagnoses. Note that the *DSM* affirms that traits are the basic building block of personality pathology. The *DSM* definition of PD is explicitly trait based: "Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Personality Disorders" (cited from an online version of *DM-IV-TR*).

The difficulty is that (1) this definition is not instantiated in the *DSM* PD diagnostic criteria which, instead, are specific and limited manifestations of the underlying traits and (2) the particular trait combinations that are set forth in the *DSM*, as a whole, do not represent "areas of density" in the multivariate trait space that has been identified empirically. In familiar words, the *DSM* PD diagnoses fail to "carve nature at her joints." Traits can combine in virtually an infinite number of ways—which accords with our day-to-day sense that all individuals have their own unique personalities.

Therefore, a PD diagnostic system that is trait-based not only in definition but also in its assessment—that is, actually using traits themselves as the diagnostic criteria—provides a means to describe the personality—normal or abnormal—of every patient. In doing so, a trait-based diagnostic system both (1) provides the clinician with a complete personality characterization of each patient and (2) explains the personality similarities and differences between and among patients (Krueger, Skodol, Livesley,

Shrout, & Hunag, 2007). This has the highly beneficial effect of addressing not only the comorbidity problem, but also the high prevalence of PDNOS diagnoses (Verheul, Bartak, & Widiger, 2007). That is, in a fully trait-based system, all patients have a specified personality profile, so it is impossible to have a profile that is "not otherwise specified."

Excessive within-diagnosis heterogeneity. This problem with the current PD diagnoses is the flip side of the comorbidity coin. As stated earlier, the current *DSM* diagnostic criteria assess limited manifestations of the traits that purportedly comprise the diagnoses. As a result, given the polythetic nature of the current PD diagnoses (Trull & Durrett, 2005), individuals with markedly different overall trait profiles can meet criteria for the same diagnosis by sharing a small number of specific behaviors, or even only one.³ As with comorbidity, this problem is addressed with a trait-based diagnostic system, because such a system directly reflects the degree of similarity or difference between individuals. To be sure, the general diagnostic category of PD is designed to accommodate the naturally occurring heterogeneity of personality. Unlike the "NOS" category of *DSM-IV-TR*, however, the heterogeneity of personality features within a PD will be fully specified, rendering it understandable rather than obfuscating.

Marked temporal instability. The discrepancy between PDs as "enduring patterns" and the empirical reality of short-term retest kappas around .55 (Zimmerman, 1994; see also Grilo et al., 2004; Shea et al., 2002) was a conceptual puzzle for the field, until data began to emerge recently, documenting that the *DSM* criteria were a mix of more stable trait-like criteria and less stable state-like criteria (e.g., McGlashan et al., 2005; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005), rendering PD diagnoses as a whole less stable than their trait components. Limiting PD diagnostic criteria to more stable traits, and considering the more state-like features that occur in individuals with PD to be associated symptoms rather than elements of the diagnoses per se, would both eliminate the conceptual-empirical gap in PD with regard to temporal stability, and

³ This assumes the diagnoses are made using only the specific diagnostic criteria, without regard for the overarching defining features of the disorders.

also focus clinicians on the layered nature of psychopathology in these individuals. That is, after addressing clients' acute problems, the focus of treatment should turn to their problematic traits for long-term positive outcomes. An alternative view (see the section "Hybrid Model of PD Diagnosis") is that PD is a combination of stable traits and more transient symptoms. Further research from genetic and other viewpoints is needed to address the question of which approach has greater validity. The *DSM-5* model most likely will reflect the latter approach, as it preserves more continuity with the current PD diagnostic system.

No clear boundary between normal and pathological personality. The continuity between normality and pathology is not unique to personality. For example, subclinical anxiety and depression also have large literatures, and repeatedly have been shown to be continuous with more severe manifestations of these disorders (e.g., Judd, Schettler, & Akiskal, 2002). In the case of personality, this is especially well documented, because of the extensive body of normal personality psychological research conducted over the last 90 years (see Allport, 1921) and recent reviews and meta-analyses that have documented clearly that an integrative structure can encompass the entire domain (Markon, Krueger, & Watson, 2005; O'Connor, 2002, 2005; Saulsman & Page, 2004; Trull & Durrett, 2005). Implementing a trait-based system for PD diagnosis, therefore, provides the beneficial option of assessing any patient's personality (i.e., not just those with PD). Insofar as personality has been shown to be an important modifier of a wide range of clinical phenomena (e.g., Rapee, 2002), adopting a dimensional model will strengthen not only PD diagnosis, but *DSM-5* as a whole.

Poor convergent and discriminant validity. The typical relation of convergent and discriminant validity is like that of sensitivity and specificity: as one increases, the other decreases. Thus, is it astonishing that both the convergent and discriminant validity of PD measures are quite poor (Clark & Harrison, 2001; Clark, Livesley, & Morey, 1997). Average kappas for specific PDs or even any PD are in the low .30s across different interview measures and less than .30 for interview versus self-report questionnaires (Clark et al., 1997). This certainly may reflect some unreliability of the measures per se, but also likely indicates that reliably operationalizing the *DSM* PD constructs is dif-

ficult due to the nature of the constructs themselves (see Shea, 1992; Clark, 2007). When this fact is considered, it becomes clear why PD research findings are inconsistent; in fact, it is noteworthy that there are any consistent research findings across different PD diagnostic measures. In sharp contrast, personality trait measures are remarkably congruent—with well-established convergent and discriminant validity, and a strong consensus for a two-through five-factor, hierarchical model of personality has developed in the field over the past quarter century (see Markon et al., 2005). This fact leads us directly to our next question:

Why these six domains? Considerable evidence relates current *DSM* PDs to four broad, higher order trait domains of the FFM of personality: neuroticism, extraversion, agreeableness, and conscientiousness (e.g., O'Connor, 2005; Saulsman & Page, 2004). Indeed, a quick PsycINFO search revealed that since 2000, an average of more than one article every month has been published on the topic. Widiger and Simonsen (2005) reviewed the literature on personality pathology and found 18 extant models. They then demonstrated that, for the most part, these models could be subsumed by the same common four-factor model. We, therefore, concluded that these four factors should be included in any proposed PD-trait model. Because we are proposing a model, first and foremost, of personality pathology, we decided to focus on the maladaptive end of each dimension, and thus initially proposed the four trait domains of negative emotionality, detachment, antagonism, and disinhibition. The latter three are the typically maladaptive ends of extraversion, agreeableness, and conscientiousness, respectively. Nonetheless, because adaptive personality traits can serve as protective factors against mental disorder and/or as strengths in psychological treatment, a separate group, including some P&PD Work Group members, but also additional experts, is developing a proposal for including adaptive traits in *DSM-5*.

Meta-analyses also indicate that FFM openness is not strongly related to PD and that, conversely, FFM traits tap only the social and interpersonal deficits of schizotypal PD, and not the cognitive or perceptual distortions and eccentricities of behavior (O'Connor, 2005; Saulsman & Page, 2004). Similarly, Widiger and Simonsen (2005) considered schizotypy to

be a dimension belonging within the schizoprenic spectrum—where schizotypal PD is placed in the ICD—but they also acknowledged that a fifth factor of schizotypy or, more normatively, unconventionality, might belong in the personality/PD domain as well. Subsequently, several studies have been published supporting the latter; that is, demonstrating that the schizotypy domain forms an important additional factor in analyses of both normal and abnormal personality (Chmielewski & Watson, 2008; Tackett, Silberschmidt, Krueger, & Sponheim, 2008; Watson, Clark, & Chmielewski, 2008). Therefore, to address this FFM lacuna, we decided to add this alternative fifth factor, which we currently have named schizotypy.

Saulsman and Page’s (2004) meta-analyses further revealed that obsessive–compulsive PD is not well covered by the FFM, which indicates that compulsivity is more than simply extreme conscientiousness (see also Nestadt et al., 2008). Specifically, conscientiousness is conceptualized as an adaptive trait so that, in essence, one can never have too much of it. For example, individuals extremely high in conscientiousness recognize when their striving for perfection reaches the point of diminishing returns and flexibly turn their attention to the next task, whereas individuals high in compulsivity persist in striving for perfection when doing so actually compromises excellence. Given the radically different nature of the proposed system compared to that in *DSM-IV-TR*, we thought it was important to maintain continuity to the extent possible, and thus to provide coverage of all traits relevant to the *DSM-IV-TR* PDs. Therefore, we added a sixth domain of compulsivity to address this otherwise missing element.

Finally, the proposed specific trait facets were selected provisionally as representative of the six domains, based on a comprehensive review of existing measures of normal and abnormal personality, as well as recommendations by experts in personality assessment. In measurement-model development, it is recommended initially that one be overinclusive rather than underinclusive, because it is easier to collapse dimensions and eliminate redundant or irrelevant traits at a later stage than it is to add missing elements (see Clark & Watson, 1995). Thus, the proposed trait-facet set is provisional, and likely to be overcomprehensive and overly complex. Accordingly, we expect that a number

of the proposed facets may be highly correlated and so can be combined into a smaller number of somewhat broader facets. It is also possible that some facets are misplaced and will be moved to a different domain; others may prove unreliable or structurally anomalous and be eliminated. In any case, we currently are testing the structural validity of the trait model, before finalizing it for the *DSM-5*.

Definition and General Criteria for a PD

The P&PD Work Group proposes a revised definition of PD and a corresponding revised set of general criteria. Self and interpersonal pathology; extreme levels on one or more pathological personality traits; relative stability over time; across situation consistency; adolescent onset; and exclusions for causation by other mental disorders, substances, or general medical conditions comprise the general criteria for PD proposed for *DSM-5* (see Table 4).

T4

Rationale for Definition and General Diagnostic Criteria for Personality Disorder

The proposed classification will retain the diagnosis of PD but change diagnostic criteria because the *DSM-IV-TR* criteria are poorly defined and not specific to PD. General criteria for PD were first introduced in *DSM-IV*, without theoretical or empirical justification. Incorporation of dimensional classification into *DSM-5* necessitates the use of criteria for general PD that are distinct from trait dimensions, because an extreme position on a trait dimension is a necessary but not sufficient condition to diagnose PD (Wakefield, 1992, 2008). Literature reviews reveal a few systematic definitions that clearly differentiate PD from trait extremity (Livesley, 2003; Livesley & Jang, 2005) and indicate that PD implies pervasive disorganization in personality structure and functioning that is manifested as a broad failure to develop important personality structures and capacities needed for adaptive functioning. These adaptive failures are manifested as: (1) the failure to develop coherent sense of self or identity; and (2) chronic interpersonal dysfunction (Livesley, 1998). Evaluation of self pathology will be based on criteria indexing three major develop-

Table 4
Definition and General Criteria for Personality Disorder

Definition: Personality disorders represent the failure to develop a sense of self-identity and the capacity for interpersonal functioning that are adaptive in the context of the individual's cultural norms and expectations.	
A. Adaptive failure is manifested in one or both of the following areas:	
1. Impaired sense of self-identity as evidenced by one or more of the following:	
i. Identity integration. Poorly integrated sense of self or identity (e.g., limited sense of personal unity and continuity; experiences shifting self-states; believes that the self presented to the world is a façade)	
ii. Integrity of self-concept. Impoverished and poorly differentiated sense of self or identity (e.g., difficulty identifying and describing self attributes; sense of inner emptiness; poorly delineated interpersonal boundaries; definition of the self changes with social context)	
iii. Self-directedness. Low self-directedness (e.g., unable to set and attain satisfying and rewarding personal goals; lacks direction, meaning, and purpose to life)	
2. Failure to develop effective interpersonal functioning as manifested by one or more of the following:	
i. Empathy. Impaired empathic and reflective capacity (e.g., finds it difficult to understand the mental states of others)	
ii. Intimacy. Impaired capacity for close relationships (e.g., unable to establish or maintain closeness and intimacy; inability to function as an effective attachment figure; inability to establish and maintain friendships)	
iii. Cooperativeness. Failure to develop the capacity for prosocial behavior (e.g., failure to develop the capacity for socially typical moral behavior; absence of altruism)	
iv. Complexity and integration of representations of others. Poorly integrated representations of others (e.g., forms separate and poorly related images of significant others)	
B. Adaptive failure is associated with extreme levels of one or more personality traits.	
C. Adaptive failure is relatively stable across time and consistent across situations with an onset that can be traced back at least to adolescence.	
D. Adaptive failure is not solely explained as a manifestation or consequence of another mental disorder.	
E. Adaptive failure is not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).	

mental dimensions in the emergence of a sense of self: differentiation of self-understanding or self-knowledge (*integrity of self-concept*); integration of this information into a coherent identity (*identity integration*); and the ability to set and attain satisfying and rewarding personal goals that give direction, meaning, and purpose to life (*self-directedness*). These dimensions capture important aspects of self and identity problems described in the clinical literature (see Cloninger, 2000; Horowitz, 1979; Kernberg, 1984; Kohut, 1971) in a format that is consistent with cognitive approaches to personality. Interpersonal pathology is evaluated using criteria indexing failure to develop the capacity for empathy, sustained intimacy and attachment (labeled *intimacy* in the proposal), prosocial and cooperative behavior (labeled *cooperativeness* in the proposal) and complex and integrated representations of others. This component reflects a second emphasis in the clinical literature (see Rutter, 1987; Benjamin, 1996). Empirical support for the revised definition of PD has been presented in the section on Levels of Personality Functioning.

Conclusions

A major reconceptualization of personality psychopathology has been proposed for *DSM-5* that identifies core impairments in personality functioning, pathological personality traits, and prominent pathological personality types. A comprehensive personality assessment consists of four components: levels of personality functioning, personality disorder types, pathological personality trait domains and facets, and general criteria for personality disorder. This four-part assessment focuses attention on identifying personality psychopathology with increasing degrees of specificity, based on a clinician's available time, information, and expertise. In Part I of this two part article, we have described the components of the new model and presented brief theoretical and empirical rationales for each.

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