Foreword

Personality disorders occupy an important and particularly challenging place in psychiatry. There is broad recognition that for affected individuals, personality disorders cause significant distress, impairment, and disproportionate health care utilization. In addition, several personality disorders, most notably borderline, narcissistic, and antisocial, often produce significant adverse effects on families, in workplaces, and, more broadly, for society. The clinical and societal significance of these disorders notwithstanding, there remains considerable disagreement on how best to define them and how to make reliable, clinically useful, and ultimately scientifically valid diagnoses.

The challenges facing the field of personality disorders, as well documented in this textbook, arise partly from difficulties that are common to the study of all psychiatric disorders: a lack of objective medical or neuropsychological diagnostic tests or of biomarkers that track severity or reflect improvement with treatment. As for essentially all psychiatric disorders, the personality disorders are poorly captured by the categorical diagnostic approach that has been the hallmark of DSM since its third edition (American Psychiatric Association 1980). Personality disorders, like almost all psychiatric disorders, are heterogeneous syndromes that result from the interaction of highly polygenic risk with diverse developmental and environmental factors; as a result these disorders would be better conceptualized in dimensional terms that are continuous with health and that recognize shared features within and across families of disorders (Sullivan et al. 2012). The clinical and scientific problems created by the imposition of a nosology based on discontinuous categories are perhaps greater for the study and treatment of personality disorders than for any other area of psychiatry. Personality represents a complex set of attributes that mediate how each human being experiences his or her self and understands and interacts with the external world, especially the social but also the nonsocial world. As described in several chapters of this textbook, it is an intensely active area of investigation to find the scientifically strongest—and at the same time clinically useful—approaches to capturing and enumerating personality traits. In the study of personality disorders, however, this task is further complicated by the need to identify boundaries among personality traits (and trait clusters) that are adaptive, maladaptive, or disordered, a scientific task complicated by the need to account for the context dependence of what can be judged adaptive versus pathological.

As is documented within this textbook, serious attempts were made in the
process of developing DSM-5 (American Psychiatric Association 2013) to create dimensional alternatives to the problematic contemporary categorical treatment of the personality disorders. The end result of this process is represented by an alternative diagnostic model contained within DSM-5, but not within the main section of the manual. This alternative model, detailed by the editors of this textbook in Chapter 24, “An Alternative Model for Personality Disorders: DSM-5 Section III and Beyond,” was rightly or wrongly judged too complex for the clinical community and too radical a departure from the status quo. Unfortunately, the problems with the status quo remain quite severe: these are described throughout the textbook, but perhaps most saliently in Chapter 3, “Articulating a Core Dimension of Personality Pathology.” Thus, for example, the current DSM-5 personality disorder categories discussed in the main text of the manual have the peculiar properties of being too broad and too narrow at the same time. In short, each personality disorder category is too broad in that it selects a highly heterogeneous group of individuals but also too narrow as evidenced by the remarkably high frequency of co-occurrence with other personality disorders and other DSM-5 disorders. As a result of the arbitrary and narrow diagnostic silos, the majority of patients with any personality disorder diagnosis receive more than one diagnosis, and often many.

Of course, it is far easier to identify problems than to propose solutions that will aid the clinicians who treat this challenging population or facilitate scientific advances aimed at better understandings and treatments. Perhaps the disagreements that surfaced in the development of DSM-5 can be taken as a starting point for progress in classification, which would represent a step toward strengthening the science by facilitating better clustering of patients for study.

The challenges taken on by the authors of this textbook might frighten all but the most stalwart clinicians and investigators, especially when combined with the task of treating such a demanding population. In a field that finds itself in a period of serious, but hopefully constructive disagreement, it is particularly important to have a textbook such as this one. It presents the clinical wisdom and scientific data that should be expected of a comprehensive volume. More importantly, it does not push the current controversies into the background, but addresses them head-on with many very interesting chapters written by protagonists in the attempts to advance better scientific understandings. Despite the unsettled nature of the classification, many chapters contained within this textbook bear powerful witness to advances in the understanding of personality disorders and to a very solid body of treatment research. Over the last decade it has been recognized that the course of many personality disorders, including the most researched disorder, borderline personality disorder, is not as fixed and monotonic as had previously been believed. Especially when treated with evidence-based psychosocial interventions and judicious use of medications, many patients can achieve reasonably good outcomes. Despite the challenges that remain, there has been significant and meaningful progress. Overall, I commend this textbook to mental health professionals as extremely useful and as capturing the excitement of this field.

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References


Personality Disorders

Recent History and New Directions

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Personality Types and Personality Disorders

People are different, and what makes us different from each other has a lot to do with something called personality, the phenotypic patterns of thoughts, feelings, and behaviors that uniquely define each of us. In many important ways, we are what we do. At a school reunion, for example, recognition of classmates not seen for decades derives as much from familiar behavior as from physical appearance. To varying degrees, heritable temperaments that differ widely from one individual to another determine an amazing range of human behavior. Even in the newborn nursery, one can see strikingly different infants, ranging from cranky babies to placid ones. Throughout life, each individual’s temperament remains a key component of that person’s developing personality, added to by the shaping and molding influences of family, caretakers, and environmental experiences. This process is also bidirectional, so that the “in-born” behavior of the infant can elicit behavior in parents or caretakers that can, in turn, reinforce infant behavior: placid, happy babies may elicit warm and nurturing behaviors; irritable babies may elicit impatient and neglectful behaviors.

But even-tempered, easy-to-care-for babies can have bad luck and land in a nonsupportive or even abusive environment, which may set the stage for a personality disorder, and difficult-to-care-for babies can have good luck, protected from future personality pathology by specially talented and attentive caretakers. Once these highly individualized dynamics have had their main effects and an individual has reached late adolescence or young adulthood, his or her personality will often have been pretty well established. This is not an ironclad rule, however; there are “late bloomers,” and high-impact life events can derail or re-route any of us. How much we can change if we need to and want to is variable, but change is possible. How we define the differences between personality styles and personality disorders (PDs),
how the two relate to each other, what systems best capture the magnificent variety of nonpathological human behavior, and how we think about and deal with extremes of thoughts, feelings, and behaviors that we call PDs are all spelled out in great detail in the chapters that follow in this textbook. In this first chapter, I briefly describe how the American Psychiatric Association (APA) has approached the definition and classification of the PDs, building on broader international concepts and theories of psychopathology.

Although personality pathology has been well known for centuries, it is often thought to reflect weakness of character or willfully offensive behavior, produced by faulty upbringing, rather than to be a type of “legitimate” psychopathology. In spite of these common attitudes, clinicians have long recognized that patients with personality problems experience significant emotional distress, often accompanied by disabling levels of impairment in social or occupational functioning. General clinical wisdom has guided treatment recommendations for these patients, at least for those who seek treatment, plus evidence-based treatment guidelines have been developed for patients with borderline PD. Patients with paranoid, schizoid, or antisocial patterns of thinking and behaving often do not seek treatment. Others, however, seek help for problems ranging from self-destructive behavior to anxious social isolation to just plain chronic misery, and many of these patients have specific or mixed PDs, often coexisting with other conditions such as mood or anxiety disorders.

The DSM System

Contrary to assumptions commonly encountered, PDs have been included in every edition of the APA’s Diagnostic and Statistical Manual of Mental Disorders (DSM). Largely driven by the need for standardized psychiatric diagnoses in the context of World War II, the U.S. War Department, in 1943, developed a document labeled Technical Bulletin 203, representing a psychoanalytically oriented system of terminology for classifying mental illness precipitated by stress (Barton 1987). The APA charged its Committee on Nomenclature and Statistics to solicit expert opinion and to develop a diagnostic manual that would codify and standardize psychiatric diagnoses. This diagnostic system became the framework for the first edition of DSM (American Psychiatric Association 1952). This manual has subsequently been revised on several occasions, leading to new editions: DSM-II (American Psychiatric Association 1968), DSM-III (American Psychiatric Association 1980), DSM-III-R (American Psychiatric Association 1987), DSM-IV (American Psychiatric Association 1994), DSM-IV-TR (American Psychiatric Association 2000), and DSM-5 (American Psychiatric Association 2013). Figure 1–1 (Skodol 1997) portrays the ontogeny of diagnostic terms relevant to the PDs, from the first edition of DSM through DSM-5. DSM-IV-TR involved only text revisions but retained the same diagnostic terms as DSM-IV, and DSM-5 (in its main diagnostic component, Section II, “Diagnostic Criteria and Codes”) includes the same PD diagnoses as DSM-IV except that the two provisional diagnoses, passive-aggressive and depressive, listed in DSM-IV Appendix B, “Criteria Sets and Axes Provided for Further Study,” have been deleted. Additionally, Section III, “Emerging Measures and Models,” of DSM-5 includes an alternative model for personality disorders, which is reviewed extensively throughout this book.
Although not explicit in the narrative text, the first edition of DSM reflected the general view of PDs at the time, elements of which persist to the present. Generally, PDs were viewed as more or less permanent patterns of behavior and human interaction that were established by early adulthood and were unlikely to change throughout the life cycle. Thorny issues such as how to differentiate PDs from personality styles or traits, which remain actively debated today, were clearly identified.

In the first edition of DSM, PDs were generally viewed as deficit conditions, reflecting partial developmental arrests, or distortions in development secondary to inadequate or pathological early care-
The PDs were grouped primarily into personality pattern, personality trait, and sociopathic personality. Personality pattern disturbances were viewed as the most entrenched conditions, likely to be recalcitrant to change, even with treatment; these conditions included inadequate personality, schizoid personality, cyclothymic personality, and paranoid personality. Personality trait disturbances were thought to be less pervasive and disabling, so in the absence of stress these patients could function relatively well. If under significant stress, however, patients with emotionally unstable, passive-aggressive, or compulsive personalities were thought to show emotional distress and deterioration in functioning, and they were variably motivated for and amenable to treatment. The category of sociopathic personality reflected what were generally seen as types of social deviance; it included antisocial reaction, dyssocial reaction, sexual deviation, and addiction (subcategorized into alcoholism and drug addiction).

The primary stimulus leading to the development of a new, second edition of DSM was the publication of the eighth revision of the International Classification of Diseases (World Health Organization 1967) and the wish of the APA to reconcile its diagnostic terminology with this international system. In the DSM revision process, an effort was made to move away from theory-derived diagnoses and to attempt to reach consensus on the main constellations of personality that were observable, measurable, enduring, and consistent over time. The earlier view that patients with PDs did not experience emotional distress was discarded, as were the subcategories described above. One new PD was added, called asthenic PD, only to be deleted in the next edition of DSM.

By the mid 1970s, greater emphasis was placed on increasing the reliability of all diagnoses. DSM-III defined PDs (and all other disorders) by explicit diagnostic criteria and introduced a multiaxial evaluation system. Disorders classified on Axis I included those generally seen as episodic “symptom disorders” characterized by exacerbations and remissions, such as psychoses, mood disorders, and anxiety disorders. Axis II was established to include the PDs as well as specific developmental disorders; both groups were seen as composed of early-onset, persistent conditions, but the specific developmental disorders were understood to be “biological” in origin, in contrast to the PDs, which were generally regarded as “psychological” in origin. The decision to place the PDs on Axis II led to greater recognition of the PDs and stimulated extensive research and progress in our understanding of these conditions. (New data, however, have called into question the rationale to conceptualize the PDs as fundamentally different from other types of psychopathology, such as mood or anxiety disorders, and in any event the multiaxial system of DSM-III and IV has been removed in DSM-5.)

As shown in Figure 1–1, the DSM-II diagnoses of inadequate PD and asthenic PD were discontinued in DSM-III. Also in DSM-III, the DSM-II diagnosis of explosive PD was changed to intermittent explosive disorder, cyclothymic PD was renamed cyclothymic disorder, and both of these diagnoses were moved to Axis I. Schizoid PD was felt to be too broad a category in DSM-II and therefore was recrafted into three PDs: schizoid PD, reflecting “loners” who are uninterested in close personal relationships; schizotypal PD, understood to be on the schizophrenia spectrum of disorders and characterized by eccentric beliefs and nonradi-
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tional behavior; and avoidant PD, typified by self-imposed interpersonal isolation driven by self-consciousness and anxiety. Two new PD diagnoses were added in DSM-III: borderline PD and narcissistic PD. In contrast to initial notions that patients called “borderline” were on the border between the psychoses and the neuroses, the criteria defining borderline PD in DSM-III emphasized emotion dysregulation, unstable interpersonal relationships, and loss of impulse control more than persistent cognitive distortions and marginal reality testing, which were more characteristic of schizotypal PD. Among many scholars whose work greatly influenced and shaped the conceptualization of borderline pathology introduced in DSM-III were Kernberg (1975) and Gunderson (1984). Although concepts of narcissism had been described by Sigmund Freud, Wilhelm Reich, and others, the essence of the current views of narcissistic PD emerged from the work of Millon (1969), Kohut (1971), and Kernberg (1975).

DSM-III-R was published in 1987 after an intensive process to revise DSM-III, involving widely solicited input from researchers and clinicians and following similar principles to those articulated in DSM-III, such as assuring reliable diagnostic categories that were clinically useful and consistent with research findings, thus minimizing reliance on theory. In DSM-III-R, no changes were made in diagnostic categories of PDs, although some adjustments were made in certain criteria sets—for example, they were made uniformly polythetic instead of defining some PDs with monothetic criteria sets (i.e., with all criteria required), such as for dependent PD, and others with polythetic criteria sets (i.e., with some minimum number, but not all criteria required), such as for borderline PD. In addition, on the basis of prior clinical recommendations to the DSM-III-R PD subcommittee, two PDs were included in DSM-III-R in Appendix A, “Proposed Diagnostic Categories Needing Further Study”: self-defeating PD and sadistic PD. These diagnoses were considered provisional.

DSM-IV was developed after an extensive process of literature review, data analysis, field trials, and feedback from the profession. Because of the increase in research stimulated by the criteria-based multiaxial system of DSM-III, more evidence existed to guide the DSM-IV process. As a result, the threshold for approval of revisions for DSM-IV was a higher one than that used in DSM-III or DSM-III-R. DSM-IV introduced, for the first time, a set of general diagnostic criteria for any PD, underscoring qualities such as early onset, long duration, inflexibility, and pervasiveness. These general criteria, however, were developed by expert consensus and were not derived empirically. Diagnostic categories and dimensional organization of the PDs into clusters remained the same in DSM-IV as in DSM-III-R, with the exception of the relocation of passive-aggressive PD from the “official” diagnostic list to Appendix B, “Criteria Sets and Axes Provided for Further Study.” Passive-aggressive PD, as defined by DSM-III and DSM-III-R, was thought to be too unidimensional and generic; it was tentatively retitled “negativistic PD” and the criteria were revised. In addition, the two provisional Axis II diagnoses in DSM-III-R, self-defeating PD and sadistic PD, were dropped, because of insufficient research data and clinical consensus to support their retention. One other PD, depressive PD, was proposed and added to Appendix B. Although substantially controversial, this provisional diagnosis was proposed as a pessimistic cognitive style,
presumably distinct from passive-aggressive PD or dysthymic disorder.

The diagnostic terms and criteria of DSM-IV were not changed in DSM-IV-TR, published in 2000. The intent of DSM-IV-TR was to revise the descriptive, narrative text accompanying each diagnosis where it seemed indicated and to update the information provided. Only minimal revisions were made in the text material accompanying the PDs.

Since the publication of DSM-IV, new knowledge has rapidly accumulated about the PDs, and discussions about controversial areas have intensified. Although DSM-IV had an increased empirical basis compared with previous versions of DSM, a number of limitations of the categorical approach were apparent, and many unanswered questions remained. Are the PDs fundamentally different from other categories of major mental illness such as mood disorders or anxiety disorders? What is the relationship of normal personality to PD? Are the PDs best conceptualized dimensionally or categorically? What are the pros and cons of polythetic criteria sets, and what should determine the appropriate number of criteria (i.e., threshold) required for each diagnosis? Which PD categories have construct validity? Which dimensions best cover the full scope of normal and abnormal personality? Many of these discussions overlap with and inform each other.

Among these controversies, one stands out with particular prominence: whether a dimensional approach or a categorical one is preferred to classify the PDs. Much of the literature poses this topic as a debate or competition, as if one must choose sides. Dimensional structure implies continuity, whereas categorical structure implies discontinuity. For example, being pregnant is a categorical concept, whereas height might be better conceptualized dimensionally because there is no exact definition of “tall” or “short,” notions of tallness or shortness may vary among different cultures, and all gradations of height exist along a continuum.

We know, of course, that the DSM system is referred to as categorical and is contrasted with any number of systems referred to as dimensional, such as the interpersonal circumplex (Benjamin 1993; Kiesler 1983; Wiggins 1982), the three-factor model (Eysenck and Eysenck 1975), several four-factor models (Clark et al. 1996; Livesley et al. 1993, 1998; Watson et al. 1994; Widiger 1998), the “Big Five” model (Costa and McCrae 1992), and the seven-factor model (Cloninger et al. 1993). How fundamental is the difference between the two types of systems? Elements of dimensionality already exist in the traditional DSM categorical system, represented by the organization of the PDs into Cluster A (odd or eccentric), Cluster B (dramatic, emotional, or erratic), and Cluster C (anxious or fearful). In addition, a patient can just meet the threshold for a PD or can have all of the criteria, presumably a more extreme version of the disorder. Certainly, if a patient is one criterion short of being diagnosed with a PD, clinicians do not necessarily assume that there is no element of the disorder present; instead, prudent clinicians would understand that features of the disorder need to be recognized if present and may need attention. Busy clinicians, however, often think categorically, deciding what disorder or disorders a patient “officially” has. In practice, when a patient is thought to have a PD, clinicians generally assign only one PD diagnosis, whereas systematic studies of clinical populations utilizing semistructured interviews show that patients with personality psychopathology generally have multiple PD diagnoses.
Personality Disorders


In the early 2000s, the APA convened, in collaboration with the National Institute of Mental Health (NIMH), a series of research conferences to develop an agenda for DSM-5, the proceedings of which were subsequently published. In an introductory monograph (Kupfer et al. 2002), a chapter was devoted to personality and relational disorders, in which First et al. (2002) stated that “the classification scheme offered by the DSM-IV for both of these domains is woefully inadequate in meeting the goals of facilitating communication among clinicians and researchers or in enhancing the clinical management of those conditions” (p. 179). In that same volume, in a chapter on basic nomenclature issues, Rounsaville et al. (2002) argued that “well-informed clinicians and researchers have suggested that variation in psychiatric symptomatology may be better represented by dimensions than by a set of categories, especially in the area of personality traits” (p. 12). Subsequently, an entire monograph, “Dimensional Models of Personality Disorders: Refining the Research Agenda for DSM-V” (Widiger et al. 2006), was published, presenting in-depth analyses of dimensional approaches for the PDs. Shortly thereafter, a Work Group on Personality and Personality Disorders was established by the APA, and efforts were launched to develop a dimensional proposal for the PDs for DSM-5. This process is described in detail in the final chapter of this volume (Chapter 24, “An Alternative Model for Personality Disorders: DSM-5 Section III and Beyond”). It was challenging for the work group to reach a consensus in support of a single dimensional model for the PDs to be used in clinical practice, just as it had been difficult for the field. In the end, a hybrid dimensional and categorical model was proposed, and this model was approved by the APA as an alternative model and placed in Section III of DSM-5, whereas the DSM-IV criteria-defined categorical system was retained in Section II of the manual, for continued use. The alternative model includes six specific PDs, plus a seventh diagnosis of personality disorder—trait specified that allows description of individual trait profiles of patients with PDs who do not have any of the six specified disorders. In addition, the alternative model involves assignment of level of impairment in functioning, an important additional element of dimensionality when making PD diagnoses. As described in Chapter 7, “Manifestations, Assessment, and Differential Diagnosis,” the alternative model also presents a coherent core definition of all PDs, as moderate or greater impairment in self and interpersonal functioning.

Questions have been raised about the stability of the PDs over time, even though their enduring nature is one of the generic defining features of the PDs in DSM-5 Section II. Personality pathology is often activated or intensified by circumstance, such as loss of a job or the end of a meaningful relationship. In the ongoing findings of the Collaborative Longitudinal Personality Disorders Study (CLPS), for example, stability of DSM-IV–defined PD diagnoses reflected sustained pathology at or above the diagnostic threshold, but substantial percentages of patients showed fluctuation over time, sometimes being above and sometimes below the diagnostic threshold. In the CLPS, which used a stringent definition of remission (the presence of no more than two criteria for at least 1 year), 85% of patients with DSM-IV–defined borderline personality disorder at intake showed remission at the 10-year follow-up point. However, impairment in functioning was much slower to remit, perhaps consistent with more recent evidence demonstrating that
trait-defined PDs are more persistent over time than DSM-IV–defined PDs (Hopwood et al. 2013).

Conclusion

This brief review of the history of the classification of personality pathology serves as a window on the progress in our field and in our understanding of the PDs. Increasingly, a stress/diathesis framework seems applicable in medicine in general, as a unifying model of illness—a model that can easily apply to the PDs. Variable genetic vulnerabilities predispose us all to potential future illness, which may or may not develop depending on the balance of specific stressors and protective factors.

The PDs can be thought of as maladaptive exaggerations of nonpathological personality styles, resulting from predisposing temperaments combined with stressful circumstances. Neurobiological abnormalities have been demonstrated in at least some PDs, as is the case in many other psychiatric disorders. Our challenge for the future is to better characterize variations in personality psychopathology and determine whether and how PDs are different from other classes of psychiatric disorders. As we learn more about the etiologies and pathology of the PDs, it will no longer be necessary, or even desirable, to limit our diagnostic schemes to atheoretical, descriptive phenomena, and we can look forward to an enriched understanding of personality pathology, better treatments, and guidance for prevention.

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The diagnosis of personality disorders (PDs) according to explicit criteria, and their placement on Axis II of the multiaxial diagnostic system of DSM-III (American Psychiatric Association 1980), have had beneficial effects on this often confusing and poorly understood area of psychopathology. Since the innovations of DSM-III, assessment methods have been developed and refined, and sound research on PDs has increased dramatically. Axis II provided a framework with which to determine the independent consequences of personality psychopathology for the individual and for society and the impact of PDs on the course and outcomes of other forms of psychopathology. It is now generally understood that PDs are prevalent in both clinical and community settings. They are associated with high rates of social and occupational impairment and predict slower recovery, more likely relapse, and a more chronic course for a host of other mental disorders. These broad effects of personality psychopathology have costly implications for both individual well-being and society.

Critiques of DSM’s approach to the diagnosis of PD, however, appeared almost immediately after the publication of DSM-III (Frances 1980, 1982). DSM’s exclusively categorical approach has resulted in well-documented problems: extensive co-occurrence of PDs such that most patients receiving a PD diagnosis
have personality features that meet criteria for more than one (e.g., Grant et al. 2005; Oldham et al. 1992; Zimmerman et al. 2005); extreme heterogeneity among patients with the same PD diagnosis, meaning that two patients with a particular disorder may share very few features (Johansen et al. 2004); temporal instability of PD diagnoses occurring at rates incompatible with the basic definition of a PD (Gunderson et al. 2011; Zanarini et al. 2012); arbitrary diagnostic thresholds in polythetic criteria sets with little or no empirical basis, resulting in the reification of disorders as present or absent with variable levels of underlying pathology (Balsis et al. 2011) and limited validity and clinical utility (Hyman 2010; Morey et al. 2007, 2012); poor coverage of personality pathology such that the diagnosis of PD not otherwise specified (PDNOS) has been the most commonly diagnosed (Verheul and Widiger 2004); and poor convergent validity of PD criteria sets such that patient groups diagnosed by different methods may be only weakly related to one another (Clark et al. 1997). None of these problems was successfully addressed in the ensuing iterations of DSM, including DSM-IV (American Psychiatric Association 1994).

As a consequence of these myriad problems, DSM-IV PD diagnoses have often not been used (e.g., “Diagnosis Deferred on Axis II”), have been underused (e.g., PDNOS), or have been erroneously used (e.g., diagnoses made on the basis of too few of the required criteria). Despite these long-recognized and significant shortcomings, however, the criteria for PDs in DSM-5 Section II, “Diagnostic Criteria and Codes,” have not changed from those in DSM-IV.

The Personality and Personality Disorders (P&PD) Work Group for DSM-5 was charged with developing a new approach to the PD section that would begin to rectify some of these problems (Kupfer et al. 2002; Rounsaville et al. 2002). When the work group began its deliberations, a study endorsed by influential North American (Association for Research on Personality Disorders) and international (International Society for the Study of Personality Disorders) PD research organizations surveyed PD experts and found that 74% thought that the DSM-IV categorical approach to PDs should be replaced, 87% stated that personality pathology was dimensional in nature, and 70% supported a mixed categorical-dimensional approach to PD diagnosis as the most desirable alternative to DSM-IV (Bernstein et al. 2007). Hybrid models combining elements of dimensions and categories have been suggested by PD experts since before the publication of DSM-IV (Benjamin 1993; Blashfield 1993).

Such a categorical-dimensional hybrid had been developed in a DSM-5 planning meeting (Krueger et al. 2007), which preceded the formation of the P&PD Work Group and the start of work group discussions. A mixed approach improves on the DSM-IV system by striking a balance between introducing new elements called for by the field (e.g., dimensional elements) and maintaining continuity (e.g., preservation of PD categories)—an approach that takes into account research developments since the time of DSM-III, while still aiming to be minimally disruptive to clinical practice and research.

The alternative model for PDs in DSM-5 Section III, “Emerging Measures and Models” (American Psychiatric Association 2013), consists of assessments of the following: 1) new general criteria for PDs, 2) impairment in personality functioning, 3) pathological personality traits, and 4) criteria for six specific PDs.
Impairments in personality functioning and pathological personality traits are fundamentally dimensional in nature and, when combined with other DSM-IV-like inclusion and exclusion criteria, yield categorical diagnoses of the six PDs and a category called personality disorder—trait specified (PD-TS) for all other PD presentations. All six of these PDs were included in DSM-IV, but in the new model they are more consistently and coherently represented by impairment and trait manifestations. In this chapter, we review the rationale behind the alternative, hybrid model and discuss future research needs relevant to the possible inclusion of the model in the main section of the next revision of DSM.

**General Criteria for Personality Disorder**

The DSM-IV general criteria for a PD (GCPD) describe an enduring pattern of inner experience and behavior that is manifest in two or more of the following areas: cognition, affectivity, interpersonal functioning, and impulse control. These general criteria were introduced without justification or indication of an empirical basis. There is no mention of the GCPD in the PD chapters of the *DSM-IV Sourcebook* (Gunderson 1996; Widiger et al. 1996) or in papers that described the development of the revised classification (Frances et al. 1990, 1991; Pincus et al. 1992; Widiger et al. 1991). The DSM-IV GCPD do not appear to be specific for PDs; other chronic mental disorders seem likely to also meet the GCPD, leading to problems in differential diagnosis. Furthermore, the specific criteria for individual PDs in DSM-IV are often inconsistent with the GCPD, creating additional possible confusion.

In the DSM-5 Section III GCPD (see the appendix to this textbook), the DSM-IV A criterion is divided into two criteria: the new Criterion A requires moderate or greater impairment in personality functioning, and the new Criterion B requires the presence of pathological personality traits. All PDs in Section III include specific, typical expressions of these A and B criteria, and PD-TS includes the GCPD A and B criteria themselves, making all PD diagnoses in DSM-5 Section III consistent with the GCPD.

**Impairment in Personality (Self and Interpersonal) Functioning**

Self and interpersonal impairments are at the core of personality psychopathology. Hopwood et al. (2011) demonstrated empirically that the DSM-IV PD criteria most strongly related to a PD severity dimension (based on a count of all criteria) were preoccupation with social rejection, fear of social ineptness, feelings of inadequacy, anger, identity disturbance, and paranoid ideation. The nature and importance of these criteria are consistent with the proposition that at the core of PDs of all types is disturbance in how one views one’s self and other people. Previously, Morey (2005) demonstrated that difficulties in empathic capacity, at varying levels, can be found at the core of all types of personality psychopathology (for a detailed discussion of this self-other core of personality psychopathology, see Chapter 3, “Articulating a Core Dimension of Personality Pathology,” in this volume).

DSM-IV PD criteria are heavily oriented toward self and interpersonal difficulties. In the DSM-IV GCPD, the “cognition” area under Criterion A gives “ways of perceiving and interpret-
The process of formulating the core impairments in personality functioning that are central to PDs began with a literature review (Bender et al. 2011) that considered a number of reliable and valid clinician-administered measures for assessing personality functioning and psychopathology. The review demonstrated that a self-other dimensional perspective has an empirical basis and significant clinical utility. Numerous studies using measures of self and interpersonal functioning have shown that a self-other approach is informative in determining the existence, type, and severity of personality pathology. For example, Salvatore et al. (2005) illustrated that patients with paranoid PD (PPD) typically see themselves as weak and inadequate, and view others as hostile and deceitful. Patients with narcissistic PD (NPD) have been found to have dominant states of mind pervaded by distrust toward others and feelings of either being excluded or being harmed (Dimaggio et al. 2008). Jovev and Jackson (2004) demonstrated that individuals with avoidant PD (AVPD) utilize maladaptive schemas centering on a self that is defective and shame-ridden, expecting to be abandoned because of their shortcomings, and that persons with obsessive-compulsive PD (OCPD) are burdened by a schema of self-imposed, unrelenting standards. Eikenaes et al. (2013) found that patients with AVPD could be distinguished from patients with social phobia on the basis of having more problems with self-esteem, identity, and relationships. Several studies have found the representations of self and others of patients with borderline PD (BPD) to be more elaborated and complex than those of other types of patients, but also more distorted and biased toward hostile attributions (e.g., Blatt and Lerner 1983; Lerner and St. Peter 1984; Stuart et al. 1990; Westen et al. 1990). For example, patients with BPD are significantly more likely to assign negative attributes and emotions to the picture of a face with a neutral expression (Donegan et al. 2003; Wagner and Linehan 1999).

Reliable ratings can be made on a broad range of self-other constructs, such as identity and identity integration, agency, self-control, sense of relatedness, capacity for emotional investment in and maturity of relationships with others, responsibility, and social concordance. The most reliable (ICC ≥ 0.75) dimensions found in the measures considered in the review by Bender et al. (2011) were identity, self-direction, empathy, and intimacy. These were retained for the definition of personality functioning in the DSM-5 alternative model. The definitions of these four elements are presented in Table 24–1.

Self-other constructs have shown robust reliability and validity in characterizing PDs. Criterion-level reliability
studies have found that criteria related to self (e.g., chronic emptiness, identity disturbance) and interpersonal (e.g., unstable or stormy relationships) functioning are rated as having reliability equal to or greater than other BPD criteria (e.g., affective instability, physically self-damaging acts), with no significant differences between self and interpersonal criteria (Frances et al. 1984; Gamache et al. 2009; Grilo et al. 2004, 2007; Gunderson et al. 1981; Pfohl et al. 1986; Zanarini et al. 2002a, 2003). A two-item self-report measure of personality functioning (one self item, one interpersonal item) had good test-retest reliability across four DSM-5 Academic Centers Field Trial sites (pooled ICC=0.686) (Narrow et al. 2013).

Verheul et al. (2008) assessed core components of personality functioning in 2,730 patients and community members in the Netherlands using the Severity Indices of Personality Problems (SIPP-118), a self-report questionnaire. Twelve of 16 facets of personality functioning distinguished patients with PDs from psychiatrically healthy comparison subjects and patients with other mental disorders, with a median effect size of 0.92 (moderate to large) for the differences between PD and normal samples. The 16 facets factored into five higher-order domains: self-control, identity integration, relational capacities, social concordance, and responsibility. Each of the five domains distinguished patients with no PDs from those with one PD and those with two or more PDs. These results were replicated in a sample of 767 adolescent patients and comparison subjects by Feenstra et al. (2011), who found that all 16 SIPP-118 personality functioning facets reflected greater impairments in patients with PDs. Patients with the most PD traits (criteria) had the most impairment in the five domains of the SIPP-118, with self-control and identity integration showing the largest differences. Berghuis et al. (2012) assessed personality functioning with the General Assessment of Personality Disorder and the SIPP-118, PDs with the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), and personality traits with the NEO Personality Inventory—Revised (NEO-PI-R) in 424 patients. Principal component analysis clearly distinguished general personality dysfunction from personality traits. The general personality dysfunction model consisted of three factors: self-identity dysfunction, relational dysfunction, and prosocial functioning. These three studies, involving almost 4,000 patients and control sub-

### Table 24–1. Elements of personality functioning

<table>
<thead>
<tr>
<th><strong>Self:</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Identity:</strong> Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Self-direction:</strong> Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Interpersonal:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Empathy:</strong> Comprehension and appreciation of others’ experiences and motivations; tolerance of differing perspectives; understanding the effects of one’s own behavior on others.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Intimacy:</strong> Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.</td>
<td></td>
</tr>
</tbody>
</table>
jects, lend strong support for the inclusion of impairment in personality functioning (both self and interpersonal) in Criterion A of the GCPD.

Morey et al. (2011) conducted secondary analyses of data from two of the previously mentioned studies in the Netherlands (Berghuis et al. 2012; Verheul et al. 2008) with more than 2,000 patient and community subjects who had completed the self-report measures of personality functioning and had received semi-structured interview assessments of DSM-IV PDs. Approximately 44% of patients in the Berghuis sample and 52% in the Verheul sample met criteria for a DSM-IV PD. Item Response Theory analyses characterized the types of self and interpersonal problems associated with different levels of impairment as represented by the LPFS in DSM-5 Section III (see the following subsection). The results delineated a coherent global dimension of impairment in personality functioning that was related to the likelihood of receiving any PD diagnosis, two or more PD diagnoses, and one of the more severe PDs (e.g., BPD, STPD, ASPD) (Morey et al. 2011).

Impairment in self and interpersonal functioning is consistent with multiple theories of PD and their research bases, including cognitive-behavioral, interpersonal, psychodynamic, attachment, developmental, social-cognitive, and evolutionary theories, and has been viewed as a key aspect of personality pathology in need of clinical attention (e.g., Clarkin and Huprich 2011; Hopwood et al. 2013b; Luyten and Blatt 2011, 2013; Pincus 2011). A factor-analytic study of existing measures of psychosocial functioning found “self-mastery” and “interpersonal and social relationships” to be two of four major factors (Ro and Clark 2009). Furthermore, personality functioning constructs align well with the National Institute of Mental Health Research Domain Criterion of “social processes” (Sanislow et al. 2010), in which “perception and understanding of self” and “perception and understanding of others” are core constructs. The interpersonal dimension of personality pathology has been related to attachment and affiliative systems regulated by neuropeptides (Stanley and Siever 2010), and variation in the encoding of receptors for these neuropeptides may contribute to variation in complex human social behavior and social cognition, such as trust, altruism, social bonding, and the ability to infer the emotional state of others (Donaldson and Young 2008). Neural instantiations of the “self” and of empathy for others also have been linked to the medial prefrontal cortex and other cortical midline structures—the sites of the brain’s so-called “default network” (Fair et al. 2008; Northoff et al. 2006; Preston et al. 2007; Qin and Northoff 2011).

Impairment in personality functioning exists on a continuum, and empirical analyses determined the level at which a “disorder” is diagnosed. Moderate impairment in personality functioning is required by the revised Criterion A. Moderate impairment is indicated by a rating of 2 or greater on the LPFS. Moderate impairment in personality functioning had a sensitivity of 0.85, a specificity of 0.73, and an area under the ROC (receiver operating characteristic) curve of 0.83 for a DSM-IV PD in a study of 337 clinician-rated patients conducted by Morey et al. (2013a). Requiring only mild impairment increased sensitivity (99%) but decreased specificity dramatically (15%). From the clinician’s point of view, therefore, a single-item rating on the LPFS constitutes a highly efficient and effective screen for the possible presence of a PD.
Level of Personality Functioning Scale

Research indicates that generalized severity is the most important single predictor of concurrent and prospective dysfunction in assessing personality psychopathology (Hopwood et al. 2011). Furthermore, PDs are optimally characterized by a generalized personality severity continuum with additional stylistic elements, derived from both PD symptom constellations (e.g., peculiarity) and personality traits. There is wide consensus (e.g., Crawford et al. 2011; Parker et al. 2002; Pulay et al. 2008; Tyrer 2005; Wakefield 1992, 2008) that severity assessment is essential to any dimensional system for personality psychopathology. Moreover, the ICD-11 PD Work Group has proposed severity as the central element of PD (Tyrer et al. 2011). Thus, the DSM-5 P&PD Work Group determined that a personality dysfunction severity scale would be a necessary improvement to PD assessment for DSM-5, and included the LPFS in the Section III model (see the appendix to this textbook).

The LPFS uses each of the elements of personality functioning that are incorporated into Criterion A of the alternative model—identity, self-direction, empathy, and intimacy—to differentiate five levels of impairment on a continuum of severity ranging from little or no impairment (Level 0) to extreme impairment (Level 4). The appendix to this textbook provides the full LPFS with definitions for every level of functioning. In the DSM-5 Academic Center Field Trials, the LPFS was rated with adequate test-retest reliability overall (ICC=0.416) by untrained but experienced clinicians, and rated with higher reliability than a number of other DSM-5 dimensional measures.

With respect to utility, self-interpersonal problems such as insecure attachment and maladaptive schemas have been shown to be associated significantly with PD psychopathology and impairments in psychosocial functioning, as well as to affect clinical outcome (e.g., Bender et al. 1997; Fonagy et al. 1996; Jovev and Jackson 2004; Levy et al. 2006). Self-other dimensions have discriminated different types of PD pathology, predicted various areas of psychosocial functioning, and been shown to be moderators of treatment alliance and outcome (e.g., DeFife et al. 2013; Diguer et al. 2004; Feenstra et al. 2011; Peters et al. 2006; Piper et al. 2004; Verheul et al. 2008).

For example, in a sample of 90 patients in outpatient treatment, a Social Cognitions and Object Relations Scale (SCORS) composite was significantly correlated with psychosocial functioning measured by the Global Assessment of Functioning (GAF), the Global Assessment of Relational Functioning (GARF), and the Social and Occupational Functioning Assessment Scale (SOFAS) (Peters et al. 2006). The correlation was strongest (0.53, large effect) for relational functioning. In a sample of 294 adolescent patients, the composite self-other variables from the SCORS predicted global functioning, school functioning, externalizing behavior, and past hospitalization (DeFife et al. 2013). In this study, the SCORS composite significantly predicted variance in the domains of adaptive functioning above and beyond age and DSM-IV PD diagnosis. In another sample of 378 adolescent patients and 389 community adolescents (Feenstra et al. 2011), the total amount of PD pathology, as represented by the number of diagnostic criteria met, was significantly related to the amount of impairment in the domains of self-control, identity integration, relational capacities, social concordance, and responsibility, as
measured by the SIPP-118. These studies support the clinical significance of measuring severity of impairment in personality functioning on a continuum.

The severity of impairment in self and interpersonal functioning also has predicted empirically important factors such as treatment utilization and treatment course and outcome (e.g., Ackerman et al. 2000; Bateman and Fonagy 2008; Feenstra et al. 2011; Harpaz-Rotem and Blatt 2009; Piper et al. 2004; Verheul et al. 2008; Vermote et al. 2010). The degree of impairment in personality functioning shows short-term stability but is sensitive to change. For example, in a sample of university students, 14- to 21-day test-retest reliabilities of SIPP-118 domains were very good to excellent, with correlations ranging from 0.87 for social concordance to 0.95 for self-control (median=0.93) (Verheul et al. 2008). In 60 patients in that study who were treated for an average of 11+ months as outpatients or in a day hospital and followed-up after 2 years, SIPP-118 domains of self-control, identity integration, and responsibility gradually improved over time, relational capacities improved over the first year, and social concordance improved during the second year. In a subsample of 53 adolescents in the Feenstra et al. (2011) study who were treated as inpatients, 14 of 16 facets of the SIPP-118 showed significant improvement after 1 year, with effect sizes ranging from 0.37 to 1.24, indicating small to very large effects. In a study of interpretative treatment in 72 outpatients, level of the quality of object relations predicted outcome measured by general symptomatic and dysfunction (including self-esteem and interpersonal distress) and by social and sexual maladjustment (Piper et al. 2004). These studies illustrate that the self-other dimension is not subject to brief changes in clinical state but can reflect adaptive change, for example as a result of treatment. Thus, the LPFS provides a useful dimensional severity assessment capability to the DSM PD realm.

Pathological Personality Traits

DSM-IV (and DSM-5 Section II) defines personality traits as “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” (American Psychiatric Association 1994, p. 630) and states that it is “only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress [that] they constitute Personality Disorders” (p. 630). For each specific DSM-IV PD, a brief summary of its particular “pattern” (i.e., defining traits) is provided in the criteria “stem,” which is followed by seven to nine specific criteria designed to indicate the pattern. For example, diagnosis of BPD indicates a pattern of “instability of interpersonal relationships, self-image, and affects, and marked impulsivity,” with five or more of nine specific criteria that represent manifestations of this pattern required.

Thus, DSM-IV defines PDs in terms of personality traits. However, there are a number of shortcomings of the DSM-IV implementation of maladaptive personality traits for describing PDs that the DSM-5 Section III model sought to rectify. First, DSM-IV does not provide a comprehensive set of maladaptive personality traits for the criteria of PDs. Instead, 79 specific (adult) PD criteria are provided, which together are an amalgam of traits, behaviors, symptoms, and consequences. Second, for some DSM-IV PDs, there are inconsistencies between
the defining trait(s) (i.e., those in the “stem”) and the specific criteria by which the trait(s) is to be indicated. For example, STPD is defined by two basic traits: 1) discomfort with, and reduced capacity for, close relationships and 2) cognitive or perceptual distortions and eccentricities of behavior. However, because STPD is then indicated by nine criteria—four of which relate to interpersonal discomfort and five of which relate to cognitive distortions and eccentricity—and any five of these nine criteria are sufficient for a diagnosis, it is possible to meet criteria for STPD with no indicators of one of the two presumed principal traits. For some DSM-IV PDs, criteria indicators do not appear to reflect the disorder’s defining trait(s). For example, ASPD is defined in DSM-IV as “disregard for and violation of the rights of others,” but Criterion 3, “impulsivity or failure to plan ahead,” does not necessarily reflect this trait, because impulsivity need not result in the violation of others’ rights.

Furthermore, the DSM-IV PD diagnostic criteria provide a very limited set of indicators for each defining trait. In most cases, there are four or five indicators for a defining trait, which are too few for an internally consistent (reliable) assessment (Clark and Watson 1995). The results of four studies of the internal consistency of DSM criteria sets with a combined sample size of 980 show that no PD had an average alpha coefficient of 0.80; only avoidant and dependent PDs had average alphas ≥0.70, indicating less than optimal reliability (Blais et al. 1998; Clark et al. 2009; Morey 1988; Warren and South 2009). Finally, the specific trait indicators of the DSM-IV PDs have limited applicability across gender, age, culture, or life circumstances. For example, Criterion 7 of PPD, “recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner,” would not apply to a person who has no partner, effectively limiting the number of criteria available for the diagnosis. Criterion 1 of AVPD, “avoids occupational activities that involve significant interpersonal contact,” could not apply to one of the spouses in a single-earner, two-person household, or to a retired person.

To address these shortcomings, the DSM-5 P&P Work Group recommended a number of changes. First, the DSM-5 Section III model provides a set of 25 maladaptive personality trait facets whose empirically based structure reflects that of the well-established five-factor model (FFM) of personality traits. The model is an extension of the FFM of personality that specifically delineates and encompasses the more extreme and maladaptive personality variants necessary to capture the maladaptive personality dispositions of individuals with PDs (Costa and Widiger 2002). The model includes five broad, higher-order personality trait domains—Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism—each comprised of three to nine lower-order, more specific trait facets that are representative of the domains (e.g., manipulativeness and callousness are two of the seven specific facets in the Antagonism domain) (Krueger and Eaton 2010; Krueger et al. 2011a, 2011b, 2012; Wright et al. 2012b). Trait domains and facets can be rated by clinicians on 4-point dimensional scales of descriptiveness, and patient-report and lay informant-report forms have also been developed. The structural validity of an original 37-trait model was tested in a three-wave community survey (Krueger et al. 2011b, 2012), and the model was subsequently revised to yield the five-domain, 25-trait model on which the DSM-5 Section III diagnostic criteria for PDs are based.
There is extensive evidence that the FFM represents a universal structure of personality traits that encompasses both the normal and abnormal range of traits in both self and observer ratings, as well as across age groups and diverse cultures (McCrae and Costa 1997). For example, Yamagata et al. (2006) found high congruence for the FFM across descriptive, genetic, and environmental factors in three countries (Canada, Germany, and Japan) in a sample of 1,209 monozygotic and 701 dizygotic twin pairs, and De Fruyt et al. (2009) found a universal structure in observer ratings of over 5,000 adolescents in 24 countries. The initial set of 37 recommended traits was refined empirically using representative population samples (including treatment-seeking samples), as described by Krueger et al. (2012). The appendix to this textbook lists the definitions of the five PD trait domains and 25 facets of DSM-5. (Further explanation on how to evaluate and rate traits can be found in Chapter 7, “Manifestations, Assessment, and Differential Diagnosis,” in this volume.)

Next, the DSM-5 Section III GCPD requires that there be one or more pathological traits to diagnose PD. This requirement provides continuity with the DSM-IV definition of PD (as maladaptive personality traits) and with DSM-IV PD diagnoses. Then, rather than providing a limited set of indicators for the traits of each PD, the DSM-5 Section III model includes the traits themselves to comprise the B criteria. Using traits as indicators solves the current problems of the lack of correspondence between the defining traits of the PDs and the specific indicators and allows for variation in the expression of traits, depending on an individual’s circumstances and personal characteristics (e.g., age).

From a psychometric perspective, personality traits can be assessed reliably. For example, the personality trait domains all had very good test-retest reliability in the DSM-5 Academic Centers Field Trials, as measured by a 36-item self-report Patient Rated Personality Scale (ICCs ranged from 0.84 for Negative Affectivity to 0.77 for Antagonism and averaged 0.81). Structured interviews for personality traits also show strong psychometric properties: Stepp et al. (2005) reported ICCs > 0.90 for all domains and facets of the Structured Interview for the Five-Factor Model (SIFM) in clinical and nonclinical samples.

The DSM-5 Section III model lists the component traits for six specific PDs (see section “Translation of Six DSM-IV Personality Disorders” later in this chapter). For PD-TS, the clinician is directed simply to note the patient’s prominent maladaptive personality traits, whichever they may be. To maximize continuity with the DSM-IV PDs and also to create a tighter connection between the hallmark features of PDs and the criteria required to make a diagnosis, threshold algorithms for diagnoses are provided for the specific DSM-5 Section III PDs. For example, ASPD is defined by four specific trait facets of the higher-order trait domain of Antagonism and three specific trait facets of the higher-order trait domain of Disinhibition. As determined by empirical methods (Morey and Skodol 2013), a total of six of these seven trait facets are required for diagnosis, thus ensuring that there are at least two trait facets from each of the broad domains that comprise the trait set of ASPD (see also later subsection “Diagnostic Thresholds”).

The 25 facet-level Personality Inventory for DSM-5 (PID-5) scales have been shown to be reliable (alphas reported by
Krueger et al. [2012] ranged from 0.72 to 0.96 in the normative U.S. population sample, with a median of 0.86. Domain-level scales of the PID-5 are also highly reliable because they consist of empirically based combinations of facet-level scales (range=0.84–0.96). (The PID-5, available in several versions, can be accessed online at http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures.)

Comprehensive Coverage of DSM-IV Personality Disorders

An initial investigation of the link between the DSM-5 facets and DSM-IV PDs was provided by Hopwood et al. (2012). DSM-IV PDs were assessed with the Personality Diagnostic Questionnaire–4 (PDQ-4; Hyler 1994), a 99-item self-report instrument that assesses each of the diagnostic criteria for the 10 DSM-IV PDs. Traits proposed for DSM-5 PD types (see Table 24–2), as assessed by the PID-5, explained substantial variance in DSM-IV PDs as assessed by the PDQ-4, and trait indicators for the six PDs were mostly specific for those disorders. Traits and an indicator of general personality pathology severity also provided incremental information about PDs in this study, further supporting the validity of the hybrid personality functioning–trait model.

An empirically structured set of traits helps make the observed comorbidity between PDs comprehensible. Some PDs share traits in common. For example, BPD and AVPD are both characterized by the trait facet anxiousness, which “builds in” a certain degree of overlap or comorbidity. Similarly, BPD and ASPD may be expected to overlap even more frequently because they have three facets in common: hostility, impulsivity, and risk taking. Importantly, defining PDs by an empirically structured set of trait facets also explains overlap between some disorders that do not have any facets in common because of the hierarchical structure of personality traits. Specifically, PDs that are characterized by facets from the same domain can be expected to overlap more than those whose facets are from different domains, because trait facets within a domain are more strongly intercorrelated than trait facets across distinct domains. Thus, even though ASPD and NPD share no specific trait facets, they may be expected to co-occur with some frequency because traits in the Antagonism domain characterize both types. Thus, although the DSM-5 formulation does not eliminate the comorbidity built into the DSM-IV system, the observed empirical overlap is now well explained via shared traits within the hierarchical empirical structure of personality trait variation, and by the core components of the LPFS (see also Chapter 3, “Articulating a Core Dimension of Personality Pathology,” in this volume).

Convergence With the Empirical Structure of Personality

In addition to providing reproductions of DSM-IV PDs, the DSM-5 trait set provides a synthetic bridge between DSM-IV PDs and the empirical structure of human personality, thus creating a pathway for moving systematically not only from DSM-IV to DSM-5, but also from DSM-5 to an even better system grounded in data that will be collected using the proposed structured set of trait facets. This synthetic bridge can be seen by examining the joint structure of the DSM-5 facets and established markers of the five major domains of personality variation. That is, an extensive literature shows that personality constructs are organized empirically into five broad domains (Costa and Widiger 2002; Widiger...
These domains of-often are labeled Neuroticism (tense, anx-
ious), Agreeableness (oriented toward getting along with other people), Extra-
version (outgoing, friendly), Openness (to unusual and novel experiences), and
Conscientiousness (orderly, planful). These domains have been shown to or-
ganize both normal- and abnormal-range personality constructs (Markon et al. 2005). This organizational continuity emerges because abnormal- and nor-

<table>
<thead>
<tr>
<th>Trait domains/facets</th>
<th>Personality disorders</th>
</tr>
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<tbody>
<tr>
<td><strong>Negative Affectivity</strong></td>
<td>ASPD AVPD BPD NPD OCPD STPD</td>
</tr>
<tr>
<td>(vs. Emotional Stability)</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>Emotional lability</td>
<td>X</td>
</tr>
<tr>
<td>Anxiousness</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>Separation insecurity</td>
<td>X</td>
</tr>
<tr>
<td>Perseveration</td>
<td>X X</td>
</tr>
<tr>
<td>Depressivity</td>
<td>X X</td>
</tr>
<tr>
<td><strong>Detachment (vs. Extraversion)</strong></td>
<td>ASPD AVPD BPD NPD OCPD STPD</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>Intimacy avoidance</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>Anhedonia</td>
<td>X X</td>
</tr>
<tr>
<td>Restricted affectivity</td>
<td>X X</td>
</tr>
<tr>
<td>Suspiciousness</td>
<td>X X</td>
</tr>
<tr>
<td><strong>Antagonism (vs. Agreeableness)</strong></td>
<td>ASPD AVPD BPD NPD OCPD STPD</td>
</tr>
<tr>
<td>Manipulativeness</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>Deceitfulness</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>Grandiosity</td>
<td>X X</td>
</tr>
<tr>
<td>Attention seeking</td>
<td>X X</td>
</tr>
<tr>
<td>Callousness</td>
<td>X X</td>
</tr>
<tr>
<td>Hostility</td>
<td>X X</td>
</tr>
<tr>
<td><strong>Disinhibition (vs. Conscientiousness)</strong></td>
<td>ASPD AVPD BPD NPD OCPD STPD</td>
</tr>
<tr>
<td>Irresponsibility</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>X X</td>
</tr>
<tr>
<td>Risk taking</td>
<td>X X</td>
</tr>
<tr>
<td>Rigid perfectionism (lack of)</td>
<td>X X</td>
</tr>
<tr>
<td><strong>Psychoticism (vs. Lucidity)</strong></td>
<td>ASPD AVPD BPD NPD OCPD STPD</td>
</tr>
<tr>
<td>Unusual beliefs and experiences</td>
<td>X X</td>
</tr>
<tr>
<td>Eccentricity</td>
<td>X X</td>
</tr>
<tr>
<td>Cognitive and perceptual dysregulation</td>
<td>X X</td>
</tr>
</tbody>
</table>

**Note.** Underlining indicates common facets.

ASPD = antisocial personality disorder; AVPD = avoidant personality disorder; BPD = borderline personality disorder; NPD = narcissistic personality disorder; OCPD = obsessive-compulsive personality disorder; STPD = schizotypal personality disorder.
mal-range variation are continuous with each other, a fact for which there is considerable and compelling evidence and, contrariwise, no compelling evidence that abnormal personality is different in kind, as opposed to being different in degree, from normal-range personality (Eaton et al. 2011; Haslam et al. 2012).

Recent studies have validated the relationship of the DSM-5 trait model to existing measures of the FFM and its variants. Thomas et al. (2013) conjointly factor analyzed data on 808 participants from a nonpatient sample collected using the PID-5 and the Five Factor Model Rating Form (FFMRF) and found a factor structure that reflected the domains of the FFM. Wright et al. (2012b) examined the hierarchical structure of DSM-5 traits measured by the PID-5 in 2,461 students. Exploratory factor analysis replicated the five-factor structure initially reported by the work group (Krueger et al. 2011a). The two-, three-, and four-factor solutions bore a close resemblance to existing models of common mental disorders, temperament, and personality pathology. In another student sample in Belgium, the five-factor structure from the U.S. derivation sample was also confirmed and the joint structure of the DSM-5 pathological traits and general personality traits as measured by the NEO Personality Inventory–3 (NEO-PI-3) resembled the major dimensions of FFM and the Personality Psychopathology Five (PSY-5) (De Fruyt et al. 2013). Anderson et al. (2013) examined the convergence of PID-5 domains and facets and the PSY-5 domains as measured by the Minnesota Multiphasic Personality Inventory–2 Restructured Form (MMPI-2-RF). Correspondence between PSY-5 scales and their PID-5 counterpart domains was high, and a joint factor analysis indicated the five-factor structure shared by the two approaches. Finally, in the only sample of clinician ratings of patients on the DSM-5 pathological personality trait system, Morey et al. (2013b) found the same five-factor structure as proposed and replicated in the above-mentioned studies which used self-report measures and nonpatient samples.

Revision of DSM-IV
General Criteria for PD for DSM-5 Section III

Relatively minor changes have been made to DSM-IV GCPD Criteria B through F for the DSM-5 Section III alternative model. A brief discussion of each of these criteria follows. (Some criteria letters differ in the two DSM editions, as clarified in the following text.)

GCPD Criterion B

DSM-IV Criterion B stated, “The enduring pattern is inflexible and pervasive across a broad range of personal and social situations” (American Psychiatric Association 1994, p. 633). The DSM-5 Section III model includes a revised GCPD Criterion C: “The impairments in personality functioning and the individual’s personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations” (American Psychiatric Association 2013, p. 761). The key elements of Criteria A and B (i.e., impairments in personality functioning and the individual’s personality trait expression) are repeated in this criterion, as well as all subsequent GCPD, to keep the focus on these key elements, which the other GCPD modify or elaborate. The insertion of “relatively” before “inflexible and pervasive” is intended to dispel the mistaken belief that personality characteristics are cast in stone, and to convey
that PD features are not absolutely and completely unresponsive to any and all environmental circumstances.

GCPD Criterion C

Criterion C of DSM-IV stated, “The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association 1994, p. 633). This criterion has been deleted from the DSM-5 Section III model because it is redundant with the proposed Criterion A for impairment in personality functioning, which includes social functioning. Furthermore, the DSM-5 Impairment and Disability Assessment Study Group recommended that DSM-5 criteria should describe signs, symptoms, and manifestations of disorders, and not their consequences, neither internal (i.e., distress) nor external (e.g., occupational).

GCPD Criterion D

DSM-IV Criterion D referred to the longitudinal course of PDs as follows: “The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood” (American Psychiatric Association 1994, p. 633). Criterion D in DSM-5 Section III describes this pattern similarly: “The impairments in personality functioning and the individual’s personality trait expression are relatively [italics added] stable across time, with onsets that can be traced back to at least adolescence or early adulthood” (American Psychiatric Association 2013, p. 761).

The notion of PDs as stable disorders to be distinguished from the more episodic mental disorders, such as mood disorders, has persisted despite a large number of one-time follow-up studies in the DSM-III and DSM-III-R (American Psychiatric Association 1987) eras that showed that less than 50% of patients diagnosed with PDs retained these diagnoses over time (Skodol 2008, 2013). The results of three methodologically rigorous, large-scale studies of the naturalistic course of PDs—The Collaborative Longitudinal Personality Disorders Study (CLPS) (Gunderson et al. 2000; Skodol et al. 2005c), The McLean Study of Adult Development (MSAD) (Zanarini et al. 2005), and The Children in the Community Study (CICS) (Cohen et al. 2005), conducted on patient (CLPS and MSAD) and community (CICS) populations—confirm that the longitudinal course of PD psychopathology is much more waxing and waning than stable. In addition, personality traits show clear temperamental antecedents (Shiner 2005) such that by school age, children’s personality structure is similar to adults’ structure (Shiner 2009; Tackett et al. 2009). As early as age 3 years, personality traits are moderately stable, but their stability increases across the lifespan until at least age 50 (Roberts and DelVecchio 2000). The insertion of “relatively” to modify “stable” in the revised Criterion D reflects this large body of empirical evidence. The redefinition of PDs in terms of personality functioning and pathological traits is expected to increase the stability of PD diagnoses, because both the functional impairments (Skodol et al. 2005b) and the trait manifestations (Hopwood et al. 2013a) of PDs have been found to be more stable than the symptomatic manifestations (McGlashan et al. 2005). A more detailed discussion of the longitudinal course of PDs can be found in Chapter 8, “Course and Outcome,” in this volume.

GCPD Criterion E

DSM-IV Criterion E stated, “The enduring pattern is not better accounted for as a manifestation or consequence of an-
other mental disorder” (American Psychiatric Association 1994, p. 633). The revised criteria adopt the “standard” DSM-5 language for Criterion E: “The impairments in personality functioning and the individual’s personality trait expression are not better explained by another mental disorder” (American Psychiatric Association 2013, p. 761).

**GCPD Criterion F**

Criterion F was meant to rule out substances and other medical conditions as a cause of personality psychopathology: “The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma)” American Psychiatric Association 1994, p. 633). The revised criteria again reflect the “standard” DSM-5 language for this criterion: “The impairments in personality functioning and the individual’s personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma)” (American Psychiatric Association 2013, p. 761). Mental disorders in DSM-5 are considered medical conditions.

**GCPD Criterion G**

Criterion G has been added to the DSM-5 Section III model for the GCPD and the individual PDs. It states, “The impairments in personality functioning and the individual’s personality trait expression are not better understood as normal for an individual’s developmental stage or sociocultural environment” (American Psychiatric Association 2013, p. 761). In DSM-IV, GCPD Criterion A includes the stipulation that the “enduring pattern” must deviate “markedly from the expectations of the individual’s culture.” In the DSM-5 alternative model, this concept is incorporated into a separate criterion, and developmental considerations are added. This change is consistent with the intention of DSM-5 to be widely applicable in different cultures and developmental age groups.

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**Translation of Six DSM-IV Personality Disorders**

Criteria for individual PDs in DSM-IV were amalgams of traits, cognitions about self and others, behaviors, emotions, signs, symptoms, and interpersonal consequences of maladaptive personality functioning. Many of the individual criteria for the DSM-IV PDs reflect disturbances in sense of self and interpersonal functioning. Also, DSM-IV acknowledges the importance of personality traits in its description of a PD when it says, “Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Personality Disorders” (American Psychiatric Association 1994, p. 630). Most of the criterion “stems” or lead-ins to the specific PD manifestations in DSM-IV rely heavily on self-interpersonal or trait language. For example, the criteria for NPD begin with “A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy…” (American Psychiatric Association 1994, p. 661), and the criteria for AVPD begin with “A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation…” (American Psychiatric Association 1994, p. 664). Many criteria for individual disorders vary from those that are directly trait-based (e.g., ASPD’s “deceitfulness,” “impulsivity,” “irrita-
bility and aggressiveness,” “reckless disregard for safety,” and “irresponsibility”; American Psychiatric Association 1994, p. 650) to those that are more specific manifestations of traits (e.g., STPD’s “ideas of reference,” “odd beliefs or magical thinking,” “unusual perceptual experiences,” and “odd thinking and speech” [American Psychiatric Association 1994, p. 645], which are all manifestations of various facets of the broad trait domain of Psychoticism).

One result of the extreme variation in the ways PDs are characterized is their low convergent validity when operationalized in different measures. In an early study, the average kappa across specific PDs between an unstructured clinical interview and the Personality Disorder Questionnaire—Revised (Hyler and Rieder 1987) was an abysmal 0.08 (Hyler et al. 1989). A study comparing the LEAD (Longitudinal Evaluation using All Data; Spitzer 1983) standard to two different structured assessments yielded an average kappa of 0.25 for any PD—that is, simply whether individuals did or did not have a PD (Pilkonis et al. 1991). Importantly, these are not isolated examples. Meta-analytic convergence between structured interviews and between structured interviews and personality questionnaires, respectively, yielded kappas of 0.27 for specific PDs and 0.29 for any PD (Clark et al. 1997).

The P&PD Work Group was charged by the DSM-5 Task Force with developing a standard approach to diagnostic criterion sets that would be consistent with core personality functioning and trait dimensional constructs. Therefore, revised diagnostic criteria are included in DSM-5 Section III for six specific PDs: ASPD, AVPD, BPD, NPD, OCPD, and STPD. Each PD is translated into typical impairments in personality functioning (Criterion A) and particular sets of pathological personality traits (Criterion B). The other DSM-IV PDs (paranoid, schizoid, histrionic, and dependent), DSM-IV Appendix B PDs (depressive, passive-aggressive), and the residual category of PDNOS are diagnosed by the DSM-5 Section III model with PD-TS (Skodol 2012), which is represented by moderate or greater impairment in personality functioning, combined with specification by pathological personality traits based on individuals’ most prominent descriptive trait features.

Specific Personality Disorders

The PDs with the most extensive empirical evidence of validity and clinical utility are BPD, ASPD, and STPD (Blashfield and Intoccia 2000; Morey and Stagner 2012). In contrast, there are very few empirical studies focused explicitly on paranoid, schizoid, or histrionic PDs. The rationales for retaining six of the 10 DSM-IV PDs (Skodol et al. 2011a) in DSM-5 Section III were based on their prevalence (and its consistency) in community and clinical populations, associated functional impairment, treatment and prognostic significance, and (where information was available) neurobiological and genetic studies. Moreover, the DSM-IV PDs for which the P&PD Work Group elected not to provide full descriptions in DSM-5 were characterized by the relative simplicity of their trait composition, such that they are easily represented. A recent study in a very large outpatient population revealed that 84% of PD diagnoses fell into one of the six specific PDs included in DSM-5 Section III (Zimmerman et al. 2012).

In both epidemiological (Torgersen 2009) and clinical (Stuart et al. 1998; Zimmerman et al. 2005) samples, AVPD and OCPD are consistently among the most
common PDs. BPD has a moderate prevalence in community studies but is one of the most common in clinical settings. STPD has relatively low prevalence in both populations but is highly impairing. ASPD is less common but has considerable individual and collective impact on society and related relevance in forensic settings. NPD is among the less common PDs, but constructs of narcissism have utility in treatment planning.

All DSM-IV PDs have moderate heritability (Coolidge et al. 2001; Kendler et al. 2006; Reichborn-Kjennerud et al. 2007; Torgersen et al. 2000, 2008); however, estimates are inconsistent across samples. Behavioral genetics evidence supports at least five of the six PD types retained for DSM-5 (the exception being NPD). STPD has been found to have the strongest loadings on genetic and environmental risk factors among DSM-IV Cluster A PDs (Kendler et al. 2006); ASPD and BPD have a second genetic and non-shared environmental factor over and above the genetic factor influencing all Cluster B disorders (Torgersen et al. 2008); and of the Cluster C PDs, AVPD has been found to be more heritable than dependent PD, and OCPD has disorder-specific genetic influence not found for the other two PDs (Reichborn-Kjennerud et al. 2007). The retained PD types also have been associated with increased rate of various types of abuse and neglect in both prospective (e.g., Johnson et al. 1999; Widom 1989) and retrospective (e.g., Battle et al. 2004; Zanarini et al. 2002b) studies. The retained PDs are associated with high and persistent degrees of functional impairment (Skodol et al. 2002, 2005a, 2005b), and BPD is associated with an increased risk for suicidal behavior (Oldham 2006). The retained specific PDs also are associated with poorer outcomes of a range of mood, anxiety, and substance use disorders (Ansell et al. 2011; Fenton et al. 2012; Grilo et al. 2005, 2010; Hasin et al. 2011; Skodol et al. 2011b).

Criteria Assignment

Initially, assignment of the specific A criteria to the six individual PD types was made by inspection of the related DSM-IV criteria involving self and interpersonal functioning, by consideration of the definitions of the proposed core components of personality functioning, and by clinical judgment; the proposed criteria were then examined in a survey of 337 clinician ratings of patients, hereafter referred to as “the Morey survey.” Item-total correlations for the 24 A criteria (four for each of the six PDs) with the entire DSM-5 PD criterion set ranged from 0.70 (ASPD empathy) to 0.25 (OCPD empathy), with an overall mean of 0.48. The item-total correlation range was from 0.64 (ASPD) to 0.38 (OCPD).

Self functioning (identity, self-direction) criteria had a mean item-total correlation across the six PDs of 0.45, and interpersonal functioning (empathy, intimacy) criteria had a mean of 0.51 (L.C. Morey, “Developing and Evaluating a DSM-5 Model for Personality Disorder Diagnosis: Data From a National Clinician Sample,” unpublished manuscript, August 2012).

Saulsman and Page (2004) conducted a meta-analysis of 15 independent samples on relationships between the DSM-IV PDs and the broad, higher-order trait domains of the FFM as measured by the self-report NEO-PI-R (Costa and McCrae 1992). Samuel and Widiger (2008) conducted a non-overlapping meta-analysis of 18 independent samples, first replicating Saulsman and Page’s (2004) domain-level findings and then further examining relationships between the DSM-IV PDs and the more specific,
lower-order trait facets of the FFM. In addition to the NEO-PI-R, Samuel and Widiger also examined studies that used either the SIFFM (Trull et al. 1998) or the FFM Rating Form (Mullins-Sweatt et al. 2006). The results of the two domain-level meta-analyses showed a high degree of similarity, indicating the robustness of the relations. The results of the FFM facet-level meta-analysis were used for the preliminary assignment of pathological personality traits to the B criteria for PDs, as represented in DSM-5 Section III.

These assignments then were examined by Hopwood et al. (2012) and by Morey et al. (L.C. Morey, “Developing and Evaluating a DSM-5 Model for Personality Disorder Diagnosis: Data From a National Clinician Sample,” unpublished manuscript, August 2012). In the Morey survey, each of the 25 traits from the pathological trait model proposed for DSM-5 was correlated to the criterion count for DSM-IV PDs to examine the fidelity of the rendering of DSM-IV criteria by trait terms. For ASPD, each of the seven assigned traits had higher correlations with a DSM-IV diagnosis of ASPD than any of the other 18 traits (range 0.49 for hostility to 0.73 for irresponsibility; mean=0.65). The same was true for the six criteria for STPD. For OCPD, both of the assigned traits had the highest correlations, and two additional traits with significant correlations consistent with rationale-theoretical considerations were added; for AVPD, three of the four assigned traits had the highest correlations; and for BPD, five of seven had the highest correlations. Using Cohen’s metric, half the correlations indicated a large effect size, 47% a medium effect size, and only one a small effect size; in all cases, the correlations were statistically significant ($P<0.01$). For NPD, grandiosity had the highest correlation (0.77), but several other traits including callousness, deceitfulness, and manipulativeness had higher correlations than attention seeking (0.54). These results paralleled the findings for NPD in the Hopwood et al. (2012) study. However, adding these traits to NPD increased overlap with ASPD considerably, so rather than being added to the NPD criterion set, they are mentioned as common “trait specifiers” for NPD, to modify the diagnosis and capture the concept of “malignant narcissism.” After comparing the results from the Morey survey and the Hopwood et al. study, a change was made to the assigned traits of only one PD: intimacy avoidance and restricted affectivity were added to OCPD.

The new criteria for BPD were rated with moderately good reliability in the DSM-5 field trials (pooled interclass kappa=0.54), despite a monothetic B criterion set used at the time requiring seven of seven traits for a diagnosis (Regier et al. 2013). Subsequent analyses of the field trial data suggested that a polythetic rule for the B criterion set requiring four or five or greater of the trait facets would improve reliability and increase correspondence with the DSM-IV diagnosis. It is important to recognize that the DSM-5 Section III model provides a scientifically based framework (of impairment in personality functioning and maladaptive personality traits) in which DSM-IV PD concepts can be faithfully represented, meaning that validated aspects of these concepts will have continuity under the new system. As a demonstration, in the Morey survey comparing patients on all DSM-IV and DSM-5 specific PD criteria and dimensions, the correlations between rated criterion counts of DSM-IV and DSM-5 diagnostic concepts from the 337 patients are as follows: BPD, 0.80; ASPD, 0.80; AVPD, 0.77; NPD, 0.74; STPD, 0.63;
and OCPD, 0.57 (Morey and Skodol 2013). In most instances, these values are comparable to the established joint interview reliabilities of these diagnoses under DSM-IV, suggesting that the agreement between DSM-IV and DSM-5 Section III PD diagnoses is likely to be as high as the agreement between two diagnosticians on DSM-IV (and now DSM-5 Section II) diagnoses. However, an important difference is that in DSM-5, a coherent framework for representing the potential underlying endophenotypic structure of the PDs is provided, in contrast to the mixed collection of signs, symptoms, traits, and behaviors that make up the DSM-5 Section II diagnostic criteria.

**Diagnostic Thresholds**

Three scoring rules were compared for the A criteria for each PD using the data from the Morey survey: one or more each from self and from interpersonal functioning, any single A criterion, and any two A criteria. Maximizing sensitivity and specificity for the corresponding DSM-IV PDs were used as the outcomes. Sensitivity values are of particular importance relative to specificity for the A criteria, because all DSM-5 PDs are presumed to have core impairments in personality functioning and specificity will likely further result from pathological traits (B criteria). Over all six PDs, any two A criteria resulted in the best combination of strong sensitivities and adequate specificities (Morey et al. 2013a).

Originally, all specified PD traits were required for the diagnosis of a given PD. As mentioned in the previous subsection, these monothetic scoring rules were tested in the DSM-5 field trials. Although monothetic scoring reduces heterogeneity, it also reduces prevalence and reliability, so polythetic decision rules were investigated in the Morey survey. As an example, based on the DSM-5 field trial result that requiring either four or five of seven traits for BPD equally increased the test-retest reliability of the diagnosis, a threshold of any four B criteria was compared to any five using the Morey survey data. A threshold of any four criteria, compared to any five criteria, was associated with a higher kappa of agreement with a DSM-IV diagnosis (0.64 vs. 0.57), a prevalence more closely approximating the DSM-IV prevalence of 40.2% (40.1% vs. 28.7%), better discrimination from four of the five other DSM-5 PDs, and a stronger correlation to functioning (–0.30 vs. –0.25). Requiring only four criteria, however, means that a patient could be diagnosed with BPD with only the four criteria listed under the Negative Affectivity domain and, therefore, without any evidence of Disinhibition or Antagonism. Therefore, “any four criteria” was compared to an algorithm requiring four criteria and also requiring that one criterion be from either the Disinhibition domain (i.e., impulsivity or risk taking) or the Antagonism domain (hostility). This algorithm produced an equivalent kappa to the any four rule with DSM-IV BPD of 0.64, little change in prevalence (38.9%), and slightly more overlap with other PDs, but a slightly stronger relationship to functioning (–0.32). Thus, the final algorithm requires four or more Criterion B traits, one of which must be a trait from either the Disinhibition or the Antagonism domains (Morey and Skodol 2013).

A similar iterative process was followed for selecting the diagnostic thresholds for the B criteria for the other five specified PDs proposed for DSM-5. Balancing consideration of agreement with DSM-IV diagnosis (kappa) and prevalence, minimizing overlap with other PDs (i.e., discriminant validity), and maximizing the correlation to the composite of psychosocial functioning (so-
cial, occupational, leisure) in the Morey survey, the decision rules for the B criteria have been set as listed in Table 24–3.

<table>
<thead>
<tr>
<th>Personality disorder</th>
<th>Trait domains (facet Ns)</th>
<th>Proposed algorithm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial</td>
<td>Antagonism (4) Detriment (3)</td>
<td>6 or more of 7</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Detachment (3) Negative Affectivity (1)</td>
<td>3 or more of 4, and 1 must be anxiousness</td>
</tr>
<tr>
<td>Borderline</td>
<td>Negative Affectivity (4) Disinhibition (2) Antagonism (1)</td>
<td>4 or more of 7, and 1 must be impulsivity, risk taking, or hostility</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Antagonism (2)</td>
<td>Both</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>Conscientiousness (1) Negative Affectivity (1) Detriment (2)</td>
<td>3 or more of 4, and 1 must be rigid perfectionism</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>Psychoticism (3) Detriment (3)</td>
<td>4 or more of 6</td>
</tr>
</tbody>
</table>

Elimination of Childhood Conduct Disorder as a Requirement for Antisocial PD

In previous DSM editions, ASPD could be diagnosed only if childhood conduct disorder (CCD), with onset before age 15 years, was also present in the developmental history of the patient. In DSM-5 Section III, ASPD can be diagnosed in the absence of CCD. This significant change was made for several reasons.

First, the ASPD diagnosis in previous editions of DSM involved retrospective recall and/or review of records to establish that the CCD requirement was met. Retrospective recall has well-known shortcomings: not all patients are accurate reporters of their own history (Moffitt et al. 2010); in addition, historical records with sufficient information content and detail to establish or rule out a CCD diagnosis are not always available for adult patients or may be inaccessible to the clinician for legal reasons (e.g., juvenile criminal records are often inaccessible). Thus, the ASPD diagnosis in Section III is based solely on contemporary assessment data, pertaining to a person’s personality, and consistent with all other PDs.

Second, the requirement of CCD for the diagnosis of ASPD implies that adult antisocial behavior (AAB) can only present in persons who met criteria for CCD. This is not empirically accurate. AAB can also present in the absence of CCD. Also, the majority (more than 50%) of children with conduct disorder do not go on to develop ASPD (Zocciolillo et al. 1992). For example, Silberg et al. (2007) studied CCD and AAB in a sample of male twins and reported a correlation of 0.46 between CCD and AAB, indicating both continuity and discontinuity in the development of antisocial behavior that is not recognized by the CCD requirement for ASPD. Moreover, AAB was associated with novel genetic effects that were not overlapping with genetic effects on CCD, indicating etiological distinctiveness between antisocial behavior.
syndromes occurring in different developmental periods. By removing the CCD requirement from ASPD, both conduct disorder and ASPD can be diagnosed as appropriate, recognizing the fact that people can and do change in their antisocial propensities over the life course. Children with conduct disorder are also at risk for developing other externalizing and internalizing mental disorders, not only for ASPD (e.g., Kim-Cohen et al. 2003). Moreover, other childhood disorders, in addition to conduct disorder, increase the risk of ASPD (e.g., Kasen et al. 2001).

Third, AAB (ASPD in the DSM-5 Section III) has been studied in both clinical and epidemiological samples and has been found to be both prevalent and consequential. Goldstein and Grant (2011) provided an extensive review of literature on the validity of AAB versus ASPD, focusing on both psychiatric and medical correlates of these syndromes, and concluded as follows: “Findings concerning the similarities between AAB and ASPD indicate the clinical and public health importance of AAB, calling into question the requirement under DSM criteria of CCD for the diagnosis of clinically serious antisociality in adults” (p. 52). They noted also that the prevalence of AAB is greater than the prevalence of ASPD, in spite of both syndromes having similar validity evidence. By removing the CCD requirement from ASPD, the proposed DSM-5 ASPD recognizes the substantial social costs of antisocial behavior in adulthood that is not necessarily accompanied by antisocial behavior in a developmentally earlier period.

Redefinition of PDNOS as PD-TS

DSM-IV states that PDNOS “is a category provided for two situations: 1) the individual’s personality pattern meets the general criteria for a Personality Disorder and traits of several different Personality Disorders are present, but the criteria for any specific Personality Disorder are not met; or 2) the individual’s personality pattern meets the general criteria for a Personality Disorder, but the individual is considered to have a Personality Disorder that is not included in the Classification (e.g., passive-aggressive personality disorder)” (American Psychiatric Association 1994, p. 629). DSM-5 Section III includes the more useful category personality disorder-trait specified (PD-TS) to replace PDNOS.

This new diagnosis in DSM-5 Section III allows clinicians to turn the residual PDNOS category into a clinically more useful one by selecting from the set of maladaptive traits those that are most characteristic of an individual and assigning an appropriate specific level of impairment in personality functioning. This can be done in both the instances described in DSM-IV—that is, 1) when an individual meets the GCPD but not the specific criteria for one of the specifically named disorders and 2) when an individual has a PD not included in DSM-5, whether it is a disorder from the DSM-IV appendix (i.e., depressive, passive-aggressive) or one that was rendered as a specific disorder in DSM-IV but is not specifically included in DSM-5 Section III (i.e., paranoid, schizoid, histrionic, dependent). For example, an individual meeting all the criteria for DSMIV-TR depressive PD might be characterized by depressivity (e.g., “is pessimistic”), anxiousness (e.g., “is brooding and given to worry”), anhedonia (e.g., “usual mood is dominated by dejection, gloominess, cheerlessness, joylessness, unhappiness”), and hostility (e.g., “is negativistic, critical, and judgmental toward others”) (American Psychiatric Association 1994, p. 733).
PD-TS also can be used as the diagnosis when patients have such extensive personality pathology that they meet criteria for several of the specific PD, with or without additional traits. In such a case, it may be clinically more useful to state, for example, that the individual has extreme and extensive Negative Affectivity, Detachment, and Disinhibition, with manipulativeness and eccentricity, than to list the several diagnoses met (e.g., STPD, BPD, and AVPD plus manipulativeness), because it provides a more precise picture of the individual’s specific pattern of trait psychopathology.

Use of Level of Personality Functioning and Pathological Traits as Specifiers

DSM-IV lacked a PD-specific severity specifier. In DSM-IV, neither the general severity specifiers nor the Axis V GAF Scale had sufficient specificity for personality psychopathology to be useful in measuring its severity. The LPFS, therefore, functions as a PD-specific severity measure in the alternative DSM-5 Section III model.

Both the severity level of personality functioning and the trait specifiers may be used to record additional personality features that may be present in a PD but are not required for the diagnosis. For example, although moderate or greater impairment in personality functioning is required for the diagnosis of BPD (Criterion A), the severity of impairment in personality functioning can vary between patients and thus can also be specified, if it is more severe and/or if it improves over time. In addition, traits of Psychoticism (e.g., cognitive and perceptual dysregulation) are not diagnostic criteria for BPD but can be specified if present. The provision of 25 pathological personality traits permits more systematic use of personality information to inform clinical case formulation and treatment planning than was possible in DSM-IV.

Traits to Augment the Description of Personality Disorders

DSM-IV states that when an individual meets criteria for more than one PD, both should be diagnosed. This is true in DSM-5 Section III PDs as well; however, in addition, if an individual meets criteria for a specific PD and has several prominent personality traits besides those needed to diagnose a specific PD, the additional traits may be listed to provide valuable personality information for use in treatment planning.

Traits of Clinical Significance in Patients Who Do Not Have a Personality Disorder

DSM-IV also states that specific maladaptive personality traits that do not meet the threshold for a PD may be listed. This is unchanged in DSM-5 Section III, except for the important difference that DSM-5 Section III provides a set of 25 specific trait facets for clinicians to use in describing the personality difficulties of their clients and in treatment planning. Given that personality has been shown to be an important modifier of a wide range of clinical phenomena and a source of dysfunction (e.g., Lahey 2009; Rapee 2002; Roberts et al. 2007), and is associated with economic costs exceeding those of many mental disorders themselves (Cuijpers et al. 2010), a dimensional trait model will strengthen DSM-5 Section III–based assessments, in general.
Clinical Utility of a Hybrid Model of Personality Disorder

In addition to the independent utility of measures of personality functioning and of pathological personality traits in identifying and describing personality pathology and in planning and predicting the outcome of treatment, a number of recent studies support a model of personality psychopathology that specifically combines ratings of disorder and trait constructs. Each has been shown to add incremental value to the other in predicting important antecedent (e.g., family history, history of child abuse), concurrent (e.g., functional impairment, medication use), and predictive (e.g., functioning, hospitalization, suicide attempts) variables (Hopwood and Zanarini 2010; Morey and Zanarini 2000; Morey et al. 2007, 2012).

Morey and Zanarini (2000) found that FFM personality domains captured substantial variance in the diagnosis of BPD with respect to its differentiation from non-borderline PDs, but also that residual variance not explained by the FFM was related significantly 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, dimensional representations of DSM-IV PD diagnoses (i.e., criterion counts) predicted concurrent functional impairment, but their predictive power diminished over time (Morey et al. 2007). In contrast, the FFM (assessed with the NEO-PI-R) provided less information about current behavior and functioning, but was more stable over time and more predictive of future outcomes. The model used in the Schedule for Non-adaptive and Adaptive Personality (SNAP; Clark 1993) and its second edition (SNAP-2; Clark et al. 2009) performed the best, both at baseline and prospectively, because it combines the strengths of a pathological disorder diagnosis and more normal-range personality traits by assessing personality traits across the normal-to-abnormal spectrum and by including clinically important trait dimensions (e.g., self-harm, dependency) that are not included in measures of normal-range personality. In fact, a model combining FFM and DSM-IV PD constructs performed much like the SNAP model. The results indicated that models of personality pathology that incorporate stable trait dispositions and dynamic, maladaptive manifestations are most clinically informative.

Hopwood and Zanarini (2010) 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 had incremental effects over FFM traits. They concluded that both BPD symptoms and personality traits are important long-term predictors of clinical functioning and supported the integration of traits and disorder in DSM-5. Morey et al. (2012) extended their earlier findings comparing the FFM, SNAP, and DSM-IV PDs in a 10-year follow-up of CLPS patients. Baseline data were used to predict long-term outcomes, including functioning, Axis I psychopathology, and medication use. Each model was significantly valid, predicting a host of important clinical outcomes. Overall, approaches that integrate normative traits and personality pathology proved to be most predictive: the SNAP generally showed the largest validity coefficients overall, and...
the DSM-IV PD syndromes and FFM traits tended to provide substantial incremental information relative to one another (Morey et al. 2012). The results again indicated that DSM-5 PD assessment ideally would involve an integration of characteristic PD features and personality traits, to maximize clinical utility. Such a hybrid model is presented in DSM-5 Section III.

Perceived Clinical Utility

In the DSM-5 field trials, clinicians were asked to rate the usefulness of tested diagnostic criteria for all disorders. In both the academic centers and the routine clinical practice field trials (Kraemer et al. 2010), the Section III PD model was rated as “moderately,” “very,” or “extremely” useful by over 80% of clinicians. In the academic centers trial, the Section III model was rated as “very” or “extremely” useful compared to DSM-IV by more clinicians than all disorders except somatic symptom disorders and feeding and eating disorders. In the routine clinical practice trial, the Section III model was rated as “very” or “extremely” useful compared to DSM-IV by more clinicians than all disorders except neurocognitive disorders and substance use and addictive disorders. The Morey survey asked clinicians to rate the perceived utility of the proposed DSM-5 rendering of personality pathology compared with DSM-IV. Questions addressed ease of use and usefulness for communication, description, and treatment planning. Although the clinicians were much more familiar with DSM-IV PDs, they rated all DSM-5 components to be generally “as useful” or “more useful” than DSM-IV for clinical description and treatment planning (L.C. Morey, “Developing and Evaluating a DSM-5 Model for Personality Disorder Diagnosis: Data From a National Clinician Sample,” unpublished manuscript, August 2012).

Relationships to Clinical Judgments

The Morey survey investigated the relationships of DSM-IV PDs and DSM-5 PDs and their components to important clinical validators including psychosocial functioning; risk for self-harm, violence, and criminality; optimal level of treatment intensity; and prognosis (Morey et al., unpublished data). DSM-5 components together and individually (personality functioning level and traits) had appreciably stronger unadjusted and corrected correlations with these concurrent validators than DSM-IV disorders in 11 of 12 comparisons. The only exception was for level of personality functioning and the composite risk prediction, which was more associated with DSM-IV PDs (L.C. Morey, “Developing and Evaluating a DSM-5 Model for Personality Disorder Diagnosis: Data From a National Clinician Sample,” unpublished manuscript, August 2012).

The incremental validity of the DSM-IV and DSM-5 PD systems—that is, the associations between each of the two PD systems and the four validators while controlling for the effects of the other—was also examined. The partial multiple correlations (and corresponding PRESS (Predicted Residual Sums of Squares)—corrected—for different numbers of variables—correlations) show that DSM-5 PD renderings significantly added to DSM-IV in predicting all four clinical judgments, while DSM-IV did not provide any validity information above and beyond that provided by DSM-5. Thus, virtually all valid variance in DSM-IV PD diagnoses was captured by DSM-5, but the converse was not true. The DSM-5 formulation accounted for sig-
An Alternative Model for Personality Disorders

Conclusion and Future Directions

A new alternative model of PD psychopathology is included in DSM-5 Section III, based on dimensional assessments of impairment in personality (self/interpersonal) functioning and of pathological personality traits. Each of these aspects of personality pathology has an extensive empirical basis. Six DSM-IV PDs were translated into consistent criteria sets defined by typical impairments in personality functioning and specific pathological personality traits for DSM-5 Section III. The PDs selected to be represented as specific PDs are those with the greatest research bases and clinical utility. Assignments of revised criteria were based on careful consideration of continuity with DSM-IV, literature reviews, and empirical data. Diagnostic thresholds were set for the first time for all of the PD diagnoses using rational, empirical methods. The alternative model represents DSM-IV (and DSM-5 Section II) PDs with high fidelity, thereby reducing concerns about potentially disruptive effects of the changes on clinical practice or research. The new hybrid model is expected to increase the clinical utility of personality assessment over the 10-category DSM-IV PD classification, based on prior research. Data comparing the DSM-IV classification and the proposed DSM-5 PD model reveals that the revised formulations are viewed by clinicians as equally or more useful than DSM-IV and have considerably greater ability to predict important clinical correlates, including functioning, risks, treatment needs, and prognosis.

More research in diverse settings and populations is obviously desired. First et al. (2002) outlined ideal steps for validating a new model for the PDs in A Research Agenda for DSM-V. Specifically, they suggested that alternatives should 1) better account for existing behavioral, neurobiological, genetic, and epidemiological data and adequately represent all clinically important aspects of a PD; 2) be more reliable, specific, and clinically informative; 3) be more effectively guide treatment decisions; 4) have adequate levels of temporal stability in clinical settings; 5) relate to motivational and cognitive systems of the brain; 6) provide a better understanding of the interaction between temperaments and environment that result in PD; and 7) explicate the mechanisms by which maladaptive and adaptive personality traits impact physical disease and health. Although prior research on which the Section III alternative model is based suggests affirmative answers to many of these questions, only extensive research could address them with certainty.

At the beginning of the deliberations of the DSM-5 work groups, a “paradigm shift” was deemed necessary for DSM-5 because of the shortcomings of the “neo-Kraepelinian model” of mental disorders. The P&PD Work Group persisted in the pursuit of a hybrid dimensional-categorical model for PDs for which the PD field was eager (Bernstein et al. 2007; Clark 2007; Trull and Widiger 2008; Widiger and Trull 2007) and which the DSM-5 research agenda embraced. A set of criteria for change were proposed for DSM-5 to be applied across all categories, which focused on traditional measures of validity (antecedent, concurrent, and predictive) for making changes. It is ironic that the motivation for DSM-5 was that existing categories of mental disorders could not be validated using tradi-
tional (e.g., Robins and Guze 1970) criteria, but new options for these disorders seem intended to meet these standards. Furthermore, different validators (e.g., familiality vs. consistent longitudinal course) are known to support different definitions of disorder, and which is prioritized depends on the specific purpose of the diagnosis (e.g., to study heritability vs. to predict prognosis).

The guidelines for change in DSM-5 stated that the magnitude of a suggested change should be supported by a proportional amount and quality of evidence in support of the change. In the PD field, the problems with the existing 10-category system for diagnosing PDs were deemed so severe that a reduced threshold for change seemed warranted. Furthermore, the relationship of empirical literature and clinical utility is not entirely clear. Should the recommended changes in the classification reflect and promote progress on understanding pathophysiology and etiology, or should they assist clinicians in doing their essential tasks? When these goals are in conflict, on what basis, by what process, and by whom should decisions be made (Skodol 2011)?

In addition, clinical utility should not be limited to user friendliness, feasibility, and clinician acceptability of diagnostic approaches; rather, their usefulness in communication between clinicians or between clinicians and patients, or their ability to guide treatment decisions or estimates of prognosis should be considered (First et al. 2004). According to strict definitions of validity (e.g., Kendell and Jablensky 2003), few psychiatric diagnoses can be said to be valid, because few “zones of rarity” (p. 4) in the manifestations of disorders have been found, and few disorders have been identified to have specific mechanisms of pathophysiology or etiology. According to Kendell and Jablensky (2003), however, a diagnosis possesses utility “if it provides nontrivial information about prognosis and likely treatment outcomes, and/or testable propositions about biological and social correlates....Diagnostic categories provide invaluable information about the likelihood of future recovery, relapse, deterioration, and social handicap; they guide decisions about treatment; and they provide a wealth of information about similar patients encountered in clinical populations or community surveys throughout the world...” (p. 9). Therefore, in addition to the structural, genetic, and neurobiological validity of personality pathology, it is the belief of many of the clinicians and researchers on the P&P Work Group that attention should be paid to the clinical utilities for which diagnostic assessments are used.

DSM-5, as a whole, is intended to be a “living document,” with the potential for partial revision in an ongoing process, as research advances in a particular area warrant (Regier et al. 2009). Thus, the edition published in 2013 technically should have been called DSM-5.0, with future revisions called 5.1, 5.2, and so on. Whether the notion of a continuing process of revision will be acceptable and can be implemented by the American Psychiatric Association, or will be too disruptive to practice and research, is also a matter for the future.

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