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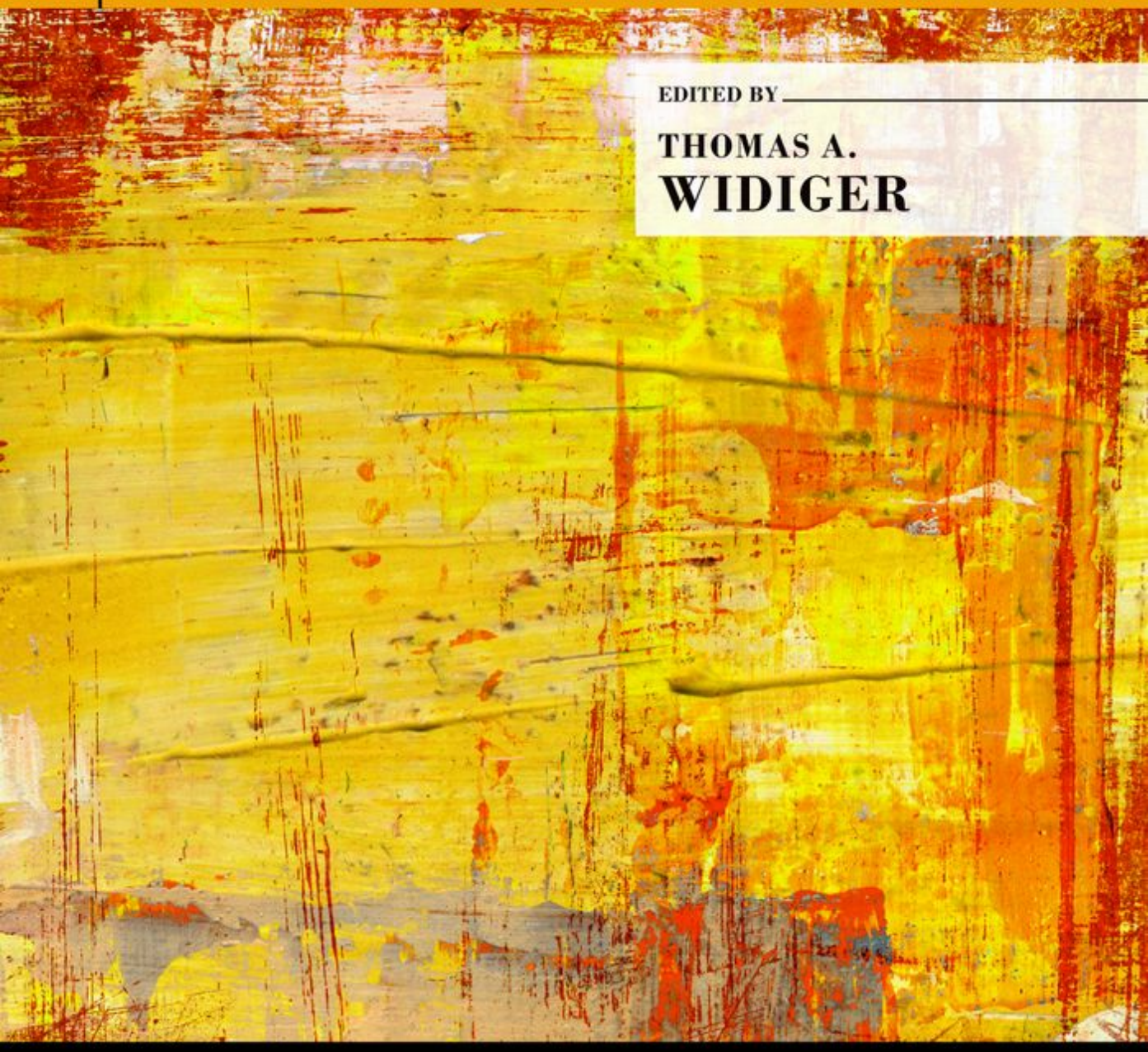

EDITED BY

THOMAS A. WIDIGER

The Oxford Handbook *of* PERSONALITY DISORDERS

The Oxford Handbook of Personality Disorders

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Thomas A. Widiger

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Thomas A. Widiger is the T. Marshall Hahn Professor of Psychology at the University of Kentucky. He has published extensively on the diagnosis, classification, and assessment of personality disorders, including over 400 articles and chapters. He currently serves as associate editor of *Journal of Personality Disorders*, as well as for *Annual Review of Clinical Psychology, Journal of Abnormal Psychology,* and *Journal of Personality Assessment*. He was the research coordinator for *DSM-IV* and co-chair of the *DSM-5* Research Planning Conference on Dimensional Models of Personality Disorder.

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CONTENTS

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CHAPTER

1 Introduction

Thomas A. Widiger

> It was the best of times, it was the worst of times.
> —*Dickens* (1859)

This rather melodramatic hyperbole could be over the top, but it might also be fitting. It is indeed a difficult time. If you are a researcher or a clinician primarily interested in dependent personality disorder, it could be a very poor time, as this disorder is unlikely to be retained (as a distinct diagnostic category) in the next edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; APA, 2011; hereafter the acronym "*DSM*" will be used to refer in general to the diagnostic manual rather than any particular edition). In fact, consideration is even being given to the removal of personality disorders altogether from the diagnostic manual. Of course, in the period of time it takes to get this book into print, the proposals and results for *DSM-5* might in fact be very different than they are now, but this uncertainty also contributes to turmoil and concern.

Yet it is also a very good time, if you are a researcher or clinician interested primarily in personality disorders. The field, as a whole, has never been so productive as it is right now. There are currently three journals devoted to the study and discussion of personality disorders. The flagship journal is, of course, *Journal of Personality Disorders* (*JPD*), founded by Millon and Frances (1987). *JPD* is the official journal of the *International Society for the Study of Personality Disorder*, a society that began in 1988 at the initiative of Niels Strandbygaard and continues to meet every 2 years with strong attendance and worldwide participation. Twenty years after the founding of *JPD*, *Personality and Mental Health* (*PMH*; Davidson, Silk, & Mulder, 2007) arrived. Soon after appeared *Personality Disorders: Theory, Research, and Treatment* (*PDTRT*; Lejuez, 2009), an official journal of the American Psychological Association devoted to the study of personality disorders.

The surge of interest in personality disorders, within both research and clinical practice, owes much, of course, to the third edition of the APA diagnostic manual (APA, 1980), in which personality disorders were placed on a separate axis, essentially requiring that clinicians always consider them, no matter the incoming complaint. As expressed by the editors of *PMH*, "the separation of personality disorders from other mental disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) stimulated interest and research into personality pathology" (Davidson et al., 2007, p. 1). Of course, this may also change with *DSM-5*, with the likely abandonment of the multiaxial system (APA, 2011).

Some of the sections of the APA diagnostic manual are governed largely by one particular theoretical model, or at least some theoretical models of psychopathology have relatively less to offer in understanding etiology, pathology, and/or treatment. It is evident that neurobiological models have predominant influence in the conceptualization, study, and treatment of schizophrenia (albeit, of course, with some minority representation of alternative paradigms), whereas, essentially by definition, neurobiology has relatively little influence to offer (currently) in the conceptualization, study, and treatment of dissociative disorders. Personality disorders, however, is one of the more eclectic areas of clinical research and practice, with strong representation of neurobiological, cognitive, psychodynamic, and interpersonal models.

It was the intention of the editor of this text to attempt to provide a representation of a wide variety

of alternative views and perspectives, with respect to diagnosis, etiology, pathology, and treatment. This is currently a time of major transition for the classification, study, and treatment of personality disorders, and it was the intention of the editor to provide a fair hearing of alternative viewpoints. The timing of this book could be said to be questionable, given the current state of diagnostic turmoil. Yet it also could be said to be timely, given the current state of diagnostic turmoil as the alternative viewpoints are represented within this text.

The book is organized into six sections: (1) introduction and clinical description; (2) construct validity; (3) psychopathology; (4) individual personality disorders; (5) treatment; and (6) conclusions. The intention of each section, along with the chapters contained therein, will be discussed briefly in turn.

Introduction and Clinical Description

This section provides historical background and a discussion of the diagnosis and assessment of personality disorders. The section begins with a chapter by Widiger (2001) concerning the modern history of personality disorder classification, beginning with the first edition of the APA diagnostic manual, proceeding through to the proposals for *DSM-5*, along with a discussion of current issues, including the shifting of psychiatry toward a neurobiological model, the deletion of categorical diagnoses, the proposal to reformulate personality disorders as early onset, chronic variants of Axis I disorders, the shift toward a dimensional model of classification, and the proposed diagnostic criteria.

The next chapter is by Skodol (Chapter 3), chair of the APA *DSM*-5 Personality and Personality Disorders Work Group (Skodol et al., 2011). He discusses in this chapter the diagnosis of personality disorder in general but focuses specifically on the rationale and empirical support for the proposals that have been made for *DSM-5*, including the deletion of diagnoses, a new definition of personality disorder, an assessment of level of functioning, a dimensional trait model, prototype matching, and new criterion sets that combine self and interpersonal dysfunction with maladaptive personality traits.

It is evident from a consideration of the current proposals for *DSM-5* that the APA is shifting its nomenclature toward a dimensional model of classification (Regier, Narrow, Kuhl, & Kupfer, 2011), and this will be particularly evident in the classification of personality disorders. Authors of alternative dimensional models of personality disorder were invited to discuss their particular models within this text, along with the *DSM-5*. Clark (2007), a member of the *DSM-5* Personality and Personality Disorders Work Group, graciously agreed. Ro, Stringer, and Clark (Chapter 4) discuss the conceptualization and assessment of personality disorders from the perspective of the Schedule for Nonadaptive and Adaptive Personality (Clark, 1993), as well as relate this model to the *DSM-5* proposal.

Widiger, Samuel, Mullins-Sweatt, Gore, and Crego (Chapter 5) discuss the conceptualization of personality disorders from the perspective of the Five-Factor Model (Widiger & Trull, 2007). As indicated in the earlier chapters by Skodol (Chapter 3) and Ro and colleagues (Chapter 4), the current proposal for *DSM-5* includes a five-domain dimensional model. Widiger and colleagues suggest that this proposal aligns closely with the Five-Factor Model.

Any discussion of the diagnosis of personality disorders should be tied to a consideration of assessment, and that is no small task for personality disorders, given the substantial number of alternative measures that have been developed. This section ends with a review of the many instruments for the assessment of personality disorder by Miller, Few, and Widiger (Chapter 6). In line with the shift of *DSM-5* toward a dimensional trait model, Miller and colleagues cover not only the traditional self-report and semistructured interview assessments of *DSM-IV-TR* personality disorders, they also cover self-report and semistructured interview assessments of maladaptive personality traits.

Construct Validity

The next section of the text concerns the construct validity support for personality disorders. Covered within this section is research concerning behavior and molecular genetics, childhood antecedents, epidemiology, gender, co-occurrence among the personality disorders, co-occurrence with other mental disorders, universality, and course.

This section begins with a thorough and sophisticated overview of the behavior and molecular genetics of personality disorder by South, Reichborn-Kjennerud, Eaton, and (coeditor of *Journal of Personality Disorders*) Krueger (Chapter 7), including candidate gene analysis, linkage analysis, and genome-wide association studies. The authors focus in particular on the antisocial, borderline, and schizotypal personality disorders, and they also cover normal (adaptive and maladaptive) personality

traits (Krueger & Johnson, 2008), consistent with the shift of the *DSM-5* nomenclature toward a dimensional trait conceptualization. They conclude with a discussion of the implications of the genetic research for the forthcoming *DSM-5*.

De Fruyt and De Clercq (Chapter 8) address the research concerning the childhood antecedents of personality disorder, a largely neglected area of investigation. They focus in particular on the influential and informative Children in the Community Study (CIC; Cohen, Crawford, Johnson, & Kasen, 2005) and cover research concerning risk factors (e.g., abuse and attachment) as well. They also discuss issues concerning the assessment of maladaptive personality traits in children and adolescents, including their own innovative work on an integrative assessment of normal and abnormal personality functioning in children and adolescents (De Clercq & De Fruyt, 2003).

Chapter 9, by Torgersen (2009), concerns the epidemiology of personality disorders. Discussed therein is naturally the research concerning prevalence (including lifetime and specifically within clinical populations). However, Torgersen addresses as well such demographic matters as gender, age, income, education, social class, civil status, urbanicity, and quality of life. He concludes with a brief discussion of the implications of these findings for the validity of individual personality disorders and for their retention or deletion from the APA diagnostic manual.

Oltmanns and Powers (Chapter 10) address the research literature concerning gender and personality disorder. The differential sex ratio of the *DSM* personality disorders has long been controversial (Jane, Oltmanns, South, & Turkheimer, 2007). Oltmanns and Powers address this difficult question through a number of different approaches. They suggest that there might indeed be some gender bias within some respective *DSM-IV-TR* diagnostic criteria, but that the gender differences are generally understandable to the extent that these personality disorders are understood as maladaptive variants of more general personality traits. However, they also go well beyond this issue to consider the differential impact of personality disorder on men and women.

Excessive diagnostic co-occurrence has been another significant issue for the validity of the *DSM-IV-TR* diagnostic categories (Trull & Durrett, 2005), providing a primary rationale for the deletion of at least some of them from the manual (Skodol et al., 2011). Trull, Scheiderer, and Tomko (Chapter 11) summarize and discuss the co-occurrence among the *DSM-IV-TR* personality disorder diagnoses and consider as well the implications of the findings for the proposals that have been generated for *DSM-5*.

As noted earlier, personality disorders were placed on a separate axis in *DSM-III* (APA, 1980) because they were often neglected in routine clinical practice yet could also have a significant impact on course and treatment. Links (past editor of *Journal of Personality Disorders*), Ansari, Fazalullasha, and Shah (Chapter 12) address the relationship of personality disorders with other mental disorders (e.g., anxiety, mood, and substance use) and consider the question of whether a multiaxial distinction (or any distinction) should be continued.

Cross-cultural validity has also been a weakly studied area for the personality disorders. Mulder (coeditor of *Personality and Mental Health*) provides a thoughtful review and discussion of the questionable universality of the concept of personality disorder (Chapter 13), and the APA *DSM* personality disorders in particular. He contrasts this with the empirical support for the structure of higher order domains of general personality, consistent with evolutionary psychology that suggests a fundamental consistency of human interests in status and reproduction. Mulder also discusses in some depth the impact of collectivism versus individualism, immigration, and modernization on the prevalence and conceptualization of personality disorder.

In the final chapter of this section (Chapter 14), Morey (a member of the *DSM-5* Personality and Personality Disorders Work Group) and Meyer provide a thorough and sophisticated discussion of the course of personality disorders. Temporal stability has been another controversial issue with respect to the validity of personality disorder diagnoses. Morey and Meyer focus in particular on the Children in the Community Study (Cohen et al., 2005), the Longitudinal Study of Personality Disorders (Lenzenweger, 1999), the McLean Study of Adult Development (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010), and the Collaborative Longitudinal Personality Disorders Study (Skodol et al., 2005). With respect to the latter project, they discuss in some depth their findings with respect to the stability of categorical diagnoses, dimensional features, functional impairment, and component traits.

Psychopathology

The next section of the text concerns alternative models for the pathology of personality disorders.

Discussed in particular are neurobiological, cognitive, psychodynamic, and interpersonal models.

The section begins with Chapter 15 by Roussos and Siever (a member of the *DSM-5* Personality and Personality Disorders Work Group) concerning neurobiological models for understanding the pathology of personality disorder. They discuss the relevant *DSM* personality disorder research, but it is evident that these authors prefer to conceptualize personality disorder in terms of underlying trait dimensions, such as psychotic-like perceptual distortions, cognitive impairment, deficit symptoms, affective instability, emotional information processing, aggression, impulsivity, anxiety, and compulsivity (Siever & Davis, 1991), more or less consistent with the dimensional trait model proposed for *DSM-5*. They suggest that this endophenotypic approach will provide a better understanding of pathophysiological mechanisms and clarify the underlying candidate genes contributing to them.

In the following chapter, Lobbestael and Arntz (Chapter 16) provide the conceptualization and empirical support for a cognitive model of personality disorder. They focus in particular on the cognitive models of Beck (Beck et al., 2003) and Young (Young, Klosko, & Weishaar, 2003). They provide not only the compelling theoretical rationale for these perspectives but also summarize the considerable body of research that has now accumulated for the cognitive model, including studies from their own very active lab (e.g., Lobbestael, Arntz, & Sieswerda, 2005).

In Chapter 17, Fonagy (2001) and Luyten summarize psychodynamic models for the etiology and pathology of personality disorders, including again a comprehensive summary of the existing empirical support. They also include within their chapter a discussion of psychodynamic models of diagnosis and assessment (e.g., Luyten & Blatt, 2011), as well as psychodynamic approaches to treatment (e.g., transference-focused therapy) not covered in the later chapter by Bateman and Fonagy (Chapter 36).

Pincus and Hopwood (Chapter 18) address the interpersonal model of personality disorder. The interpersonal model distinguishes between the definition of personality pathology and individual differences in the expression of personality disorder (Pincus & Wright, 2010). This facilitates interdisciplinary conceptualizations of functioning and treatment by emphasizing the interpersonal situation as a prominent unit of analysis, organized by the metaconstructs of agency and communion and the interpersonal circumplex (Hopwood, 2010).

Paris (Chapter 19) concludes this section of the text with an integrative perspective. No single theoretical perspective is likely to fully explain the etiology and pathology of personality disorders, which emerge from interactions between biological, psychological, and social forces (Paris, 1998).

Individual Personality Disorders

The next section of this text concerns individual personality disorder types or particular constellations of maladaptive personality traits. Included within this section are all of the types included currently within *DSM-IV-TR* (APA, 2000) and likely to remain in *DSM-5* (e.g., borderline and antisocial). However, one of the criticisms of the APA diagnostic nomenclature is its lack of adequate coverage. Therefore, included within this section are particular types or profiles of maladaptive personality traits recognized within previous editions of the diagnostic manual that may also have considerable clinical utility and empirical support (e.g., passive-aggressive) as well as types that have never achieved official recognition (e.g., depressive, alexithymia, and racism), along with those that are likely to be deleted from *DSM-5* (e.g., dependent and paranoid). Many of the chapters address directly the question of whether the respective type should have official recognition with the diagnostic manual. The section begins, perhaps appropriately, with five of the more heavily researched personality disorders: borderline, schizotypal, psychopathy, dependent, and narcissistic.

Hooley, Cole, and Gironde (Chapter 20) review the empirical literature concerning the etiology and pathology of borderline personality disorder (along with prevalence, demographics, course, and other clinically important correlates). Their chapter was perhaps among the easiest and most difficult to prepare because there is so much research and material concerning this disorder (Hooley & Germain, 2008). Hooley and colleagues provide a unique and sophisticated consideration of borderline personality from the perspective of cognitive science, suggesting how particular genetic dispositions and adversive childhood experiences may interact to create problems with neural circuits that are involved in regulation of affect, behavior, and cognition.

Kwapil and Barrantes-Vidal (Chapter 21) review the comparably vast literature concerning schizotypal personality disorder. As they indicate, schizotypal stands at an important crossroads because it is currently conceptualized as a personality disorder yet it seems likely that it will be classified instead in *DSM-5* as a schizophrenia-spectrum disorder.

Their approach to the disorder is also comparable to that of Hooley et al. (Chapter 20), emphasizing a neurocognitive model for understanding its etiology and pathology (e.g., Barrantes-Vidal, Lewandowski, & Kwapil, 2010; Kaczorowski, Barrantes-Vidal, & Kwapil, 2009), as they review its history and the considerable body of research concerning its epidemiology, course, comorbidity, and multidimensionality.

Hare, Neumann, and Widiger (Chapter 22) review the literature concerning the diagnosis, etiology, and pathology of psychopathy, an alternative formulation of *DSM-IV-TR* antisocial personality disorder. Psychopathy is among the oldest, most heavily researched, and well-validated personality disorders. This chapter considers traditional conceptualizations of psychopathy but emphasizes in particular the influential and heavily researched Psychopathy Checklist-Revised (Hare & Neumann, 2008). Discussed as well is the existing research concerning the epidemiology, etiology, course, treatment, and biological aspects of psychopathy, as well as implications for *DSM-5*.

Bornstein (Chapter 23) reviews the literature concerning dependent personality disorder. Contrary to its likely deletion in *DSM-5*, he suggests there is a considerable body of empirical research supporting its utility and validity (Bornstein, 1992, 2005, 2011). After reviewing its history, Bornstein considers research concerning its epidemiology, differential diagnosis, comorbidity, and assessment. Three contemporary dependent personality disorder treatment approaches (psychodynamic, behavioral, and cognitive) are described, as well as current research and issues concerning gender differences, maladaptive and adaptive expressions, aging, implicit and self-attributed dependency, health consequences of dependency, and the dependency-attachment relationship.

Ronningstam (Chapter 24), current president of the International Society for the Study of Personality Disorders, reviews the literature concerning narcissistic personality disorder. In a manner comparable to Bornstein (Chapter 23), she provides a considerable body of research to support the utility and validity of the *DSM-IV-TR* diagnosis (Ronningstam, 2011). Her approach to the disorder emphasizes the psychodynamic theoretical perspective. She also though acknowledges the relevance of a considerable body of narcissism trait research for understanding the etiology, pathology, and important clinical implications of narcissistic personality disorder (Ronningstam, 2005), much of which is consistent with the psychodynamic perspective (Westen, 1998).

Sanislow, da Cruz, Gianoli, and Reagan (Chapter 25) review the literature concerning avoidant personality disorder. Avoidant was a new addition to *DSM-III* (APA, 1980), due largely to the suggestion of Millon (1981). Its inclusion was somewhat controversial (Gunderson, 1983). Nevertheless, it is one of the personality disorders likely to be retained in *DSM-5*, due perhaps to its inclusion within the Collaborative Longitudinal Studies of Personality Disorder (e.g., Sanislow et al., 2009). Sanislow and colleagues discuss its etiology and pathology, as well as overlap and differentiation from generalized social phobia and its conceptualization as a constellation of maladaptive personality traits.

Samuels and Costa (Chapter 26) review the literature concerning obsessive-compulsive personality disorder. Obsessive-compulsive personality disorder is one of the few personality disorders that is at times curiously associated with relatively high functioning, perhaps related to the trait of workaholism and excessive conscientiousness. Obsessive-compulsive personality disorder is among the *DSM-IV-TR* diagnostic categories that is likely to be retained, although it could be shifted to the anxiety disorders section. Samuels and Costa discuss its comorbidity with obsessive-compulsive anxiety disorder, along with other matters concerning its validity and clinical utility (Costa, Samuels, Bagby, Daffin, & Norton, 2005). They suggest that it is perhaps best understood as a maladaptive variant of more general personality traits.

Hopwood and Thomas (Chapter 27) consider the paranoid and schizoid personality disorders, two diagnoses slated for deletion from the diagnostic manual. For diagnoses with purportedly little empirical support (Blashfield & Intoccia, 2000), they do manage to summarize a substantial body of research concerning their etiology and pathology. Nevertheless, they suggest that this research is insufficient for the retention of the paranoid and schizoid personality disorder diagnoses within the APA manual, at least as distinct clinical syndromes. On the other hand, they also call for further research on their central component traits, such as detachment and paranoid suspiciousness, which they feel have considerable utility and validity (Hopwood, 2011).

Blashfield, Reynolds, and Stennett (Chapter 28) consider the validity of the histrionic personality disorder. This diagnosis has been somewhat controversial throughout its history, particularly with respect to concerns regarding potential gender bias (e.g., Flanagan & Blashfield, 2003; see also Oltmanns and Powers, Chapter 10). Blashfield and colleagues

embrace its demise in *DSM-5*, documenting its failure to attract much systematic research concerned with its etiology, pathology, or treatment (Blashfield & Intoccia, 2000). They also attribute its passing to a steadily increasing dominance of neuroscience models within psychiatry and cognitive-behavioral models within psychology, along with a diminishing influence of the psychoanalytic perspective in both of these fields.

Bagby, Watson, and Ryder (Chapter 29) consider depressive personality disorder, a diagnosis proposed for inclusion within *DSM-III* (APA, 1980) and *DSM-IV* (1994), but each time meeting considerable opposition (particularly from mood disorder researchers). Bagby and colleagues review the history of the construct and the enduring difficulties in differentiating this personality disorder from a mood disorder. Ryder and Bagby (1999) at one time considered depressive personality disorder to be best understood as a mood disorder, but their position has since shifted (Bagby, Ryder, & Schuller, 2003; Ryder, Bagby, & Schuller, 2002). Their review of the personality and mood literature is timely, given the proposal in *DSM-5* to reformulate all personality disorders as early-onset, chronic variants of an Axis I mental disorder (Hyman, 2011)

Taylor and Bagby (Chapter 30) consider the construct of alexithymia, a personality syndrome characterized by difficulties in identifying and describing subjective feelings, a limited imaginal capacity, and an externally oriented cognitive style. They document the existence of a considerable body of research to support the validity and clinical utility of alexithymia (Taylor & Bagby, 2004). Alexithymia is associated with several medical and psychiatric disorders, influences the outcome of insight-oriented psychotherapy, and adversely affects response to some medical treatments. They suggest that it should be included within the APA diagnostic manual, albeit as a dimensional personality trait.

Wetzler and Jose (Chapter 31) discuss the demise of the passive-aggressive personality disorder. However, unlike Blashfield et al. (Chapter 28) with regard to the histrionic, they suggest that its demotion in *DSM-IV* (APA, 1994) might have been in error. They dispute the suggestion that it has not been a useful diagnosis for clinicians, or that it is excessively comorbid with other personality disorders. They further address the question of whether it was defined too narrowly as a situational reaction, particularly within the military context within which it was originally developed (Wetzler & Morey, 1999). They provide an alternative conceptualization of the disorder that warrants a renewed attention and research.

The suggestion that racial, gender, or other forms of prejudicial attitudes represent disorders of personality might be considered somewhat controversial. Nevertheless, Bell and Dunbar (Chapter 32) make a compelling case for considering prejudicial attitudes to reflect, at least in part, personality traits that are maladaptive not only for others within society but also for the person expressing such attitudes. Bell is a member of the *DSM-5* Personality and Personality Disorders Work Group and has long suggested that racism should be recognized as a form of mental disorder (Bell, 1980, 2004). Such a proposal would be an uphill struggle even if the personality disorders were expanding their coverage. It certainly has no chance of approval when the coverage is constricting. On the other hand, as Bell and Dunbar suggest, perhaps prejudicial traits might be recognized within a dimensional model of classification.

Treatment

Part V of the text concerns treatment. The APA has been developing authoritative guidelines for the treatment of the disorders included within the diagnostic manual. However, only one personality disorder has received this attention (i.e., borderline, APA, 2001). Emphasis was given in this section of the text on empirical support for alternative treatment approaches.

Silk (coeditor of *Personality and Mental Health*) and Feurino (Chapter 33) provide an overview of the psychopharmacology of personality disorders. They focus on empirically validated therapies; more specifically, double-blind placebo-controlled pharmacologic studies, most of which were concerned with borderline personality disorder (Silk & Jibson, 2010). As they indicated, while there have been many open-labeled studies, there are less than 30 randomized-controlled trials even for borderline personality disorder. They conclude with suggestions for pharmacologic treatment, including such matters as dosage, lethality, augmentation, and avoiding polypharmacy.

Leahy and McGinn in Chapter 34 overview the empirical support for cognitive-behavioral treatment of personality disorders. As was the case in the chapter by Lobbestael and Arntz concerning cognitive models of pathology (Chapter 16), Leahy and McGinn focus on the treatment approaches advanced by Beck and colleagues (e.g., Beck et al., 2003) and by Young and colleagues (e.g., Young et al. 2003). Their chapter presents research concerning

both theoretical models and outlines similarities and differences between them (Leahy, Beck, & Beck, 2005; McGinn & Young, 1996). They also provide guidelines and suggestions for cognitive therapeutic approaches that will be of direct and immediate benefit to the clinician. As they indicated, the research findings are very encouraging, but further controlled trials are still sorely needed.

In Chapter 35, Markowitz (2005) reviews the research concerning interpersonal approaches to treatment. The interpersonal model has long had a strong, compelling, and influential impact on the conceptualization of personality disorder (see Pincus and Hopwood, Chapter 18), and several interpersonal psychotherapeutic approaches have been proposed for the treatment of personality disorders. However, Markowitz suggests that "the empirical evidence to support their use ranges from nonexistent to fragmentary." He focuses in particular on interpersonal approaches for the treatment of borderline personality disorder, summarizing the research as well as providing suggested guidelines.

There are two approaches to the treatment of borderline personality disorder that have acquired compelling empirical support (APA, 2001): mentalization-based therapy (Bateman & Fonagy, 2009) and dialectical behavior therapy (Lynch, Trost, Salsman, & Linehan, 2007). In Chapter 36, Bateman and Fonagy provide the theoretical conceptualization and empirical support for the mentalization-based approach. Mentalizing concerns the capacity to understand the intentions of oneself and others in terms of mental states that develop in the context of attachment relationships. Treatment requires a focus on mentalizing, and mentalization-based treatment has been developed with the aim of helping patients improve their ability to maintain mentalizing in the face of emotional stimulation in the context of close relationships. As they indicate in their chapter, the treatment has been subjected to a series of well-controlled research trials and shown to be effective in reducing many of the symptoms of borderline personality disorder.

In Chapter 37, Lynch and Cuper provide the theoretical conceptualization and empirical support for the dialectical behavior therapy approach. As they indicate, dialectical behavior therapy is a form of cognitive-behavioral therapy that draws on principles from Zen practice, dialectical philosophy, and behavioral science, and it is based on a biosocial model of borderline personality disorder. The treatment has four components—individual therapy, group skills training, telephone coaching, and therapist consultation team—and it progresses through four stages, depending on the client's level of disorder. As they indicate in their chapter, this form of treatment has also been subjected to a series of well-controlled research trials and shown to be effective in reducing many of the symptoms of borderline personality disorder.

In the final chapter, Widiger (Chapter 38) provides a general overview of the findings, suggestions, and conclusions offered within the prior chapters and speculates about the future conceptualization of personality disorder. This is indeed a time of considerable transition, with some diagnostic categories likely to be removed from the diagnostic manual, others being reformulated as Axis I disorders rather than as a personality disorder, and a shift away from diagnostic categories to a dimensional trait model. The impact of these shifts on the study of the etiology, pathology, and treatment of personality disorders is discussed, as well as proposals for future research.

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PART 1

Introduction and Clinical Description

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CHAPTER

2 Historical Developments and Current Issues

Thomas A. Widiger

Abstract

The purpose of this chapter is to provide an historical understanding of the conceptualization and diagnosis of personality disorders, beginning with the first edition of the American Psychiatric Association's diagnostic manual, and proceeding through each subsequent edition. The chapter concludes with an overview of the issues and concerns with regard to the forthcoming, fifth edition.

Key Words: personality, personality disorder, *DSM*, diagnosis, classification, type, dimension, category

Everybody has a personality, or a characteristic manner of thinking, feeling, behaving, and relating to others (Matthews, Deary, & Whiteman, 2009). Some persons are typically introverted and withdrawn, whereas others are more extraverted and outgoing. Some persons are invariably conscientiousness and efficient, whereas others might be consistently undependable and negligent. Some persons are characteristically anxious and apprehensive, whereas others are typically relaxed and unconcerned. These personality traits are often felt to be integral to each person's sense of self, as they involve what persons value, what they do, how they would describe themselves, and what they are like most every day throughout much of their lives (Millon, 2011).

There was a time in the history of psychology when the concept of personality was under siege, when a segment of psychology questioned the validity of believing that persons actually have personality traits (Mischel, 1968). The argument was basically that a person's behavior was governed largely by situational factors rather than reflecting characteristic tendencies or dispositions internal to the person. "The situationist critique of personality caused a major crisis in the field and led to a reexamination of fundamental postulates and research methods" (Barenbaum & Winter, 2008, p. 16). Those days have long since passed. Personality researchers acknowledge the substantial importance of situational factors in determining what a person will do at any given point in time or place, but the importance of personality for understanding human behavior is now well established (John, Robins, & Pervin, 2008; Matthews et al., 2009). Personality traits are clearly central in predicting a wide array of important life outcomes, such as subjective well-being, social acceptance, relationship conflict, marital status, academic success, criminality, unemployment, physical health, mental health, and job satisfaction (John, Naumann, & Soto, 2008; Lahey, 2009; Ozer & Benet-Martinez, 2006; Roberts, Kuncel, Shiner, Caspi, & Goldberg, 2007), even mortality years into the future (Deary, Weiss, & Batty, 2011).

Not surprisingly, many of these important life outcomes predicted by personality traits are undesirable, to say the least. Personality traits can be substantially maladaptive, resulting in significant distress, social impairment, and/or occupational impairment. In fact, it is "when personality traits

are inflexible and maladaptive and cause significant functional impairment or subjective distress [that] they constitute Personality Disorders" (American Psychiatric Association 2000, p. 686). The American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*; APA, 2000) includes 10 different forms of personality disorder. Two additional possibilities are also placed within an appendix to *DSM-IV-TR* for further study (i.e., passive-aggressive and depressive).

The purpose of this chapter is to provide a brief history of personality disorder (Widiger, 2001a), as well as to discuss some of the basic concepts and current issues, particularly with respect to the forthcoming fifth edition of the APA diagnostic manual. The history of the personality disorders provided within this chapter will be relatively brief, but for a thoroughly comprehensive and insightful history of personality disorder prior to *DSM-I* (APA, 1952), there is no better source than Millon (2011; see also Millon, 2012, for an abbreviated summary).

Efforts to Develop a Nomenclature

Persons (including clinicians, researchers, theorists, and scientists) think within their language or, at least, it can be difficult to think otherwise. The official language of modern psychiatry within the United States is *DSM-IV-TR* (APA, 2000) and within the rest of the world it is the World Health Organization's (WHO) *International Classification of Diseases* (*ICD-10*; WHO, 1992). As such, these nomenclatures have a substantial impact on how clinicians conceptualize, and researchers study, personality disorders (Hyman, 2010).

The impetus for the development of an official, authoritative classification was the crippling confusion provided by its absence (Widiger, 2001a, in press). Psychology can proceed without a governing body informing the field as to the authoritative dimensions of general personality structure. In fact, any such official nomenclature sponsored by the American Psychological Association would likely be perceived as heavy handed and premature. The optimal approach is to allow any such nomenclature to emerge naturally through the process of continued scientific research and debate.

However, this is not practical for psychiatry, or at least for the practice of medicine. It is highly problematic for clinicians to be using a wide variety of alternative diagnoses (Widiger, 2001a). "For a long time confusion reigned. Every self-respecting alienist [the 19th-century term for a psychiatrist], and certainly every professor, had his own classification" (Kendell, 1975, p. 87). Prior to the first edition of the *DSM*, each country, and to some extent each state and medical center within the United States, had developed its own nomenclature. It was suggested that the production of a new system for classifying psychopathology became a right of passage for the young, aspiring psychiatrist.

> To produce a well-ordered classification almost seems to have become the unspoken ambition of every psychiatrist of industry and promise, as it is the ambition of a good tenor to strike a high C. This classificatory ambition was so conspicuous that the composer Berlioz was prompted to remark that after their studies have been completed a rhetorician writes a tragedy and a psychiatrist a classification. (*Zilboorg*, 1941, p. 450)

Initial efforts to develop a uniform language did not meet with much success. The Statistical Committee of the British Royal Medico-Psychological Association produced a classification in 1892, and they conducted formal revisions in 1904, 1905, and 1906. However, "the Association finally accepted the unpalatable fact that most of its members were not prepared to restrict themselves to diagnoses listed in any official nomenclature" (Kendell, 1975, p. 88). The Association of Medical Superintendents of American Institutions for the Insane (a forerunner to the American Psychiatric Association) adopted a slightly modified version of the British nomenclature, but it was not any more successful in getting its membership to use it.

The American Bureau of the Census struggled to obtain national statistics in the absence of an officially recognized nomenclature (Grob, 1991). In 1908, the Bureau asked the American Medico-Psychological Association (which changed its name to the American Psychiatric Association in 1921) to appoint a Committee on Nomenclature of Diseases to develop a standard nosology. In 1917 this committee affirmed the need for a uniform system.

> The importance and need of some system whereby uniformity in reports would be secured have been repeatedly emphasized by officers and members of this Association, by statisticians of the United States Census Bureau, by editors of psychiatric journals …. The present condition with respect to the classification of mental diseases is chaotic. Some states use no well-defined classification. In others the classifications used are similar in many respects but differ enough to prevent accurate comparisons. Some

> states have adopted a uniform system, while others leave the matter entirely to the individual hospitals. This condition of affairs discredits the science of psychiatry.
> (*Salmon, Copp, May, Abbot, & Cotton,* 1917, pp. 255–256)

The American Medico-Psychological Association, in collaboration with the National Committee for Mental Hygiene, issued a nosology in 1918, titled the *Statistical Manual for the Use of Institutions for the Insane* (Grob, 1991; Menninger, 1963). The National Committee for Mental Hygiene published and distributed this nosology. This nomenclature was of use to the census, but many hospitals failed to adopt the system for clinical practice, in part because of its narrow representation. There were only 22 diagnostic categories and they were confined largely to psychoses with a presumably neurochemical pathology (the closest to personality disorders were conditions within the category of "not insane," which included drug addiction without psychosis and constitutional psychopathic inferiority without psychosis; Salmon et al., 1917). Confusion continued to be the norm. "In the late twenties, each large teaching center employed a system of its own origination, no one of which met more than the immediate needs of the local institution …. There resulted a polyglot of diagnostic labels and systems, effectively blocking communication" (APA, 1952, p. v).

A conference was held at the New York Academy of Medicine in 1928 with representatives from various government agencies and professional associations. A trial edition of a proposed nomenclature (modeled after the Statistical Manual) was distributed to hospitals in 1932 within the American Medical Association's Standard Classified Nomenclature of Disease. Most hospitals and teaching centers used this system, or at least a modified version that was more compatible with the perspectives of the clinicians at that particular center. However, the Standard Nomenclature proved to be grossly inadequate when the attention of mental health clinicians expanded beyond the severe "organic" psychopathologies that had been the predominant concern of inpatient hospitals.

ICD-6 and *DSM-I*

Two medical statisticians, William Farr in London and Jacques Bertillon in Paris, had convinced the International Statistical Congress in 1853 of the value of producing a uniform classification of causes of death (Widiger, 2001a; see also Blashfield, Reynolds, and Stennett, Chapter 28). A classification system was eventually developed by Farr, Bertillon, and Marc d'Espine (of Geneva). The Bertillon Classification of Causes of Death became of substantial benefit and interest to many governments and public health agencies. In 1889, the International Statistical Institute urged that the task of sponsoring and revising the nomenclature be accepted by a more official governing body. The French government therefore convened a series of international conferences in Paris in 1900, 1920, 1929, and 1938, producing successive revisions of the International List of Causes of Death.

The WHO accepted the authority to produce the sixth edition of the International List, renamed in 1948 as the *International Statistical Classification of Diseases, Injuries, and Causes of Death* (Kendell, 1975). It is at times stated that this sixth edition was the first to include mental disorders. However, mental disorders had been included within the 1938 fifth edition within the section for "Diseases of the Nervous System and Sense Organs" (Kramer, Sartorius, Jablensky, & Gulbinat, 1979). Within this section were four subcategories: mental deficiency, dementia praecox, manic-depressive psychosis, and other mental disorders. Several other mental disorders (e.g., alcoholism), however, were included within other sections of the manual. *ICD-6* was the first edition to include a specific (and greatly expanded) section devoted to the diagnosis of mental disorders (Kendell, 1975; Kramer et al., 1979). Nevertheless, the "mental disorders section [of ICD-6] failed to gain acceptance and eleven years later was found to be in official use only in Finland, New Zealand, Peru, Thailand, and the United Kingdom" (Kendell, 1975, p. 91).

"In the United States, [the mental disorders section] of the ICD was ignored completely, in spite of the fact that American psychiatrists had taken a prominent part in drafting it" (Kendell, 1975, p. 92). American psychiatrists, however, were not any happier with the Standard Nomenclature because its neurochemical emphasis was not helpful in addressing the many casualties of the world war that dominated the attention and concern of mental health practitioners in the 1940s (Grob, 1991). "Military psychiatrists, induction station psychiatrists, and Veterans Administration psychiatrists, found themselves operating within the limits of a nomenclature specifically not designed for 90% of the cases handled" (APA, 1952, p. vi). Of particular importance was the inadequate coverage of somatoform, stress reaction, and, of interest to this text, personality disorders. As a result, the Navy, the Army, the Veterans Administration, and the Armed

Forces each developed their own nomenclatures during World War II.

It should be noted, however, that the *ICD-6* had attempted to be responsive to the needs of the war veterans. As acknowledged by the APA (1952), the *ICD-6* "categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature" (p. vii). The Standard Manual, the Bureau of the Census Statistics, and the *ICD* were largely compatible (Menninger, 1963) and had expanded by the early 1940s to include psychoneurotic and behavior disorders, although not in the manner or extent desired by many of the mental health clinicians of World War II (Grob, 1991). One specific absence from the *ICD-6*, for example, was a diagnosis for passive-aggressive personality disorder, which, curiously, might have even been the most frequently diagnosed personality disorder by American psychiatrists during the war, accounting for 6% of all admissions to Army hospitals (Malinow, 1981; see also Wetzler and Jose, Chapter 31).

The US Public Health Service commissioned a committee, chaired by George Raines, with representation from a variety of professional and public health associations, to develop a variant of *ICD-6* for use within the United States. This nomenclature was coordinated with *ICD-6*, but it resembled more closely the Veterans Administration system developed by William Menninger. Responsibility for publishing and distributing the nosology was provided to the American Psychiatric Association (1952) under the title *Diagnostic and Statistical Manual. Mental Disorders* (hereafter referred to as *DSM-I*).

DSM-I was more successful in obtaining acceptance across a wide variety of clinical settings than the previously published Standard Nomenclature. This was due in large part to its inclusion of the many diagnoses of considerable interest to practicing clinicians. Table 2.1 provides a list of the personality disorder diagnoses included within *DSM-I*.

The personality disorders section of *DSM-I* included three subsections: personality pattern disturbances, personality trait disturbances, and sociopathic personality disturbances. Personality pattern disturbances (i.e., inadequate, schizoid, cyclothymic, and paranoid) were "considered deep seated disturbances" (APA, 1952, p. 34). "Their functioning may be improved by prolonged therapy, but basic change is seldom accomplished" (p. 35). Personality trait disturbances (i.e., emotionally unstable, passive-aggressive, and compulsive) were said to be "unable to maintain their emotional equilibrium and independence under minor or major stress because of disturbance in emotion development" (APA, 1952, p. 36). Sociopathic personality disturbance (i.e., antisocial reaction, dyssocial reaction, sexual deviation, and addiction), "are ill primarily in terms of society and of conformity" (APA, 1952, p. 38) but do nevertheless involve "severe underlying personality disorder" (p. 38). It is, of course, notable, that some of the personality disorder diagnoses of *DSM-I* were subsequently reclassified as Axis I disorders (i.e., cyclothymic, sexual deviation, and addiction).

DSM-I was largely successful in providing a common, authoritative nomenclature for American psychiatry (Grob, 1991; Kendell, 1975). However, fundamental objections and criticisms regarding the reliability and validity of *DSM-I* psychiatric diagnoses were being raised, and much of this objection was directed at inadequacies of the diagnostic manual (e.g., Zigler & Phillips, 1961). A widely cited reliability study by Ward, Beck, Mendelson, Mock, and Erbaugh (1962) concluded that most of the poor agreement among psychiatrists' diagnoses was due largely to inadequacies of *DSM-I* rather than to idiosyncracies of the clinical interview or inconsistent patient reporting. "Two thirds of the disagreements were charged to inadequacies of the nosological system itself" (Ward et al., 1962, p. 205). The largest single disagreement was determining "whether the neurotic symptomatology or the characterological pathology is more extensive or 'basic'" (Ward et al., 1962, p. 202). Ward et al. criticized the *DSM-I* requirement that the clinician choose between a neurotic condition versus a personality disorder when both appeared to be present. The second most frequent cause of disagreement was unclear diagnostic criteria.

The WHO was also concerned with the failure of its member countries to adopt the mental disorders section of *ICD-6* and therefore commissioned a review by the English psychiatrist Erwin Stengel. Stengel (1959) reiterated the importance of establishing an official diagnostic nomenclature.

> A . . . serious obstacle to progress in psychiatry is difficulty of communication. Everybody who has followed the literature and listened to discussions concerning mental illness soon discovers that psychiatrists, even those apparently sharing the same basic orientation, often do not speak the same language. They either use different terms for the same concepts, or the same term for different concepts, usually without being aware of it.
> (*Stengel,* 1959, p. 601)

Table 2.1 Personality Disorder Diagnoses in Each Edition of the American Psychiatric Association's Diagnostic Manual

DSM-I	DSM-II	DSM-III	DSM-III-R	DSM-IV(-TR)	DSM-5 Proposals
Personality					
Pattern Disturbance:					
Inadequate	Inadequate				
Schizoid	Schizoid	Schizoid	Schizoid	Schizoid	
Cyclothymic	Cyclothymic				
Paranoid	Paranoid	Paranoid	Paranoid	Paranoid	
		Schizotypal	Schizotypal	Schizotypal	(Schizotypal)[a]
Personality					
Trait Disturbance:					
Emotionally Unstable	Hysterical	Histrionic	Histrionic	Histrionic	
		Borderline	Borderline	Borderline	Borderline
Compulsive	Obsessive-Compulsive	Compulsive	Obsessive-Compulsive	Obsessive-Compulsive	Obsessive-Compulsive
Passive-Aggressive:					
Passive-Depressive subtype		Dependent	Dependent	Dependent	
Passive-Aggressive subtype	Passive-Aggressive	Passive-Aggressive	Passive-Aggressive		
Aggressive subtype					
	Explosive				
	Aesthenic				
		Avoidant	Avoidant	Avoidant	Avoidant
		Narcissistic	Narcissistic	Narcissistic	Narcissistic[b]
Sociopathic Personality					
Disturbance:					
Antisocial reaction	Antisocial	Antisocial	Antisocial	Antisocial	Antisocial-Psychopathic
Dyssocial reaction					
Sexual deviation					
Addiction					
			Appendix:	*Appendix*:	*Appendix:*
			Self-Defeating	Negativistic	Dependent
			Sadistic	Depressive	Histrionic
					Paranoid
					Schizoid
					Negativistic
					Depressive

[a]Not actually to be classified as a personality disorder; classified instead as a form of schizophrenia-spectrum disorder.
[b]Originally proposed for deletion; status remains unclear for *DSM-5*.

Stengel recommended that future nomenclatures be shorn of their theoretical and etiological assumptions and provide instead behaviorally specific descriptions.

ICD-8 and *DSM-II*

Work began on *ICD-8* soon after Stengel's (1959) report (*ICD-6* had been revised to *ICD-7* in 1955, but there were no revisions to the mental disorders section). The first meeting of the Subcommittee on Classification of Diseases of the WHO Expert Committee on Health Statistics was held in Geneva in 1961. Considerable effort was extended to develop a system that would be usable by all countries. The United States collaborated with the United Kingdom in developing a common, unified proposal; additional proposals were submitted by Australia, Czechoslovakia, the Federal Republic of Germany, France, Norway, Poland, and the Soviet Union. These alternative proposals were considered within a joint meeting in 1963. The most controversial points of disagreement concerned mental retardation with psychosocial deprivation, reactive psychoses, and antisocial personality disorder (Kendell, 1975). The final edition of *ICD-8* was approved by the WHO in 1966 and became effective in 1968. A companion glossary, in the spirit of Stengel's (1959) recommendations, was to be published conjointly, but work did not begin on the glossary until 1967 and it was not completed until 1972. "This delay greatly reduced [its] usefulness, and also [its] authority" (Kendell, 1975, p. 95).

In 1965, the American Psychiatric Association appointed the Committee on Nomenclature and Statistics, chaired by Ernest M. Gruenberg, to revise *DSM-I* to be compatible with *ICD-8* and yet also be suitable for use within the United States (a technical consultant to *DSM-II* was the young psychiatrist Dr. Robert Spitzer). A draft was circulated in 1967 to 120 psychiatrists with a special interest in diagnosis, and the final version was approved in 1967, with publication in 1968.

Spitzer and Wilson (1968) summarized the changes to *DSM-I*. For example, shifted out of the section for personality disorders were substance dependencies and sexual deviations that were closely associated with maladaptive personality traits but were not themselves necessarily disorders of personality (see Table 2.1). Deleted as well was the passive-dependent variant of the passive-aggressive personality trait disturbance (see also Wetzler and Jose, Chapter 31). New additions to the personality disorders section were the explosive, hysterical, and asthenic personality disorders. Spitzer and Wilson (1975) subsequently criticized the absence of a diagnosis for depressive personality disorder (see also Bagby, Watson, and Ryder, Chapter 29), noting the inclusion of a cyclothymic personality disorder within *DSM-II* and an affective personality disorder within *ICD-8*. "No adequate classification is furnished for the much larger number of characterologically depressed patients" (Spitzer & Wilson, 1975, p. 842). Spitzer and Wilson (1975), however, also objected to some of the personality disorder diagnoses that were included. "In the absence of clear criteria and follow-up studies, the wisdom of including such categories as explosive personality, asthenic personality, and inadequate personality may be questioned" (p. 842).

The time period in which *DSM-II* and *ICD-8* were published was also highly controversial for mental disorder diagnoses in general (e.g., Rosenhan, 1973; Szasz, 1961). A fundamental problem continued to be the absence of empirical support for the reliability, let alone the validity, of these diagnoses (e.g., Blashfield & Draguns, 1976). Spitzer and Fleiss (1974) reviewed nine major studies of interrater diagnostic reliability. Kappa values for the diagnosis of a personality disorder ranged from a low of .11 to .56, with a mean of only .29. *DSM-II* (APA, 1968) was blamed for much of this poor reliability, although a proportion was also attributed to idiosyncratic clinical interviewing (Spitzer, Endicott, & Robins, 1975).

Many researchers had by now taken to heart the recommendations of Stengel (1959), developing more specific and explicit diagnostic criteria to increase the likelihood that they would be able to conduct replicable research (Blashfield, 1984). The most influential of these efforts was provided by a group of Washington University psychiatrists and psychologists, the results of which were eventually published by Feighner et al. (1972). Feighner et al. developed criteria for 15 conditions, one of which was antisocial personality disorder. The inclusion of antisocial personality disorder within this influential project was due in large part to the interest and foresight of Robins (1966). Her criterion set was based in large part on the clinical research of Cleckley (1941), but she modified Cleckley's criteria for psychopathy to increase the likelihood of obtaining reliable diagnoses. Many other researchers followed the lead of Feighner et al. and, together, they indicated empirically that mental disorders could be diagnosed reliably and could provide valid information regarding etiology, pathology, course,

and treatment (Blashfield, 1984; Klerman, 1986; Nathan & Langenbucher, 1999).

ICD-9 and *DSM-III*

By the time Feighner et al. (1972) was published, work was nearing completion on the ninth edition of the *ICD*. Representatives from the American Psychiatric Association were again involved, particularly Henry Brill, Chairman of the Task Force on Nomenclature, and Jack Ewalt, past president of the American Psychiatric Association (Kramer et al., 1979). A series of international meetings were held, each of which focused on a specific problem area (the 1971 meeting in Tokyo focused on personality disorders and drug addictions). It was decided that *ICD-9* would include a narrative glossary describing each of the conditions, but it was apparent that *ICD-9* would not include the more specific and explicit criterion sets being developed by many researchers (Kendell, 1975).

In 1974, the APA appointed a Task Force on Nomenclature and Statistics to revise *DSM-II* in a manner that would be compatible with *ICD-9* but would also incorporate many of the current innovations in diagnosis. By the time this Task Force was appointed, *ICD-9* was largely completed (the initial draft of *ICD-9* was published in 1973). Spitzer and Williams (1985) described the mission of the *DSM-III* Task Force more with respect to developing an alternative to *ICD-9* than with developing a manual that was well coordinated with *ICD-9*.

> As the mental disorders chapter of the ninth revision of the International Classification of Diseases (ICD-9) was being developed, the American Psychiatric Association's Committee on Nomenclature and Statistics reviewed it to assess its adequacy for use in the United States… There was some concern that it had not made sufficient use of recent methodological developments, such as specified diagnostic criteria and multiaxial diagnosis, and that, in many specific areas of the classification, there was insufficient subtyping for clinical and research use …. For those reasons, the American Psychiatric Association in June 1974 appointed Robert L. Spitzer to chair a Task Force on Nomenclature and Statistics to develop a new diagnostic manual…. The mandate given to the task force was to develop a classification that would, as much as possible, reflect the current state of knowledge regarding mental disorders and maximize its usefulness for both clinical practice and research studies. Secondarily, the classification was to be, as much as possible, compatible with ICD-9.
> (*Spitzer & Williams,* 1985, p. 604)

DSM-III was published by the APA in 1980 and did indeed include many innovations (Spitzer, Williams, & Skodol, 1980). Four of the personality disorders that had been included in *DSM-II* were deleted (i.e., aesthenic, cyclothymic, inadequate, and explosive) and four new diagnoses were added (i.e., avoidant, dependent, borderline, and narcissistic) (Frances, 1980; Spitzer et al., 1980; see also Table 2.1). Equally important, each of the personality disorders was now provided with relatively specific and explicit diagnostic criteria, with the hope that they would then be diagnosed reliably in general clinical practice.

Field trials were conducted that indicated that the diagnostic criteria sets of *DSM-III* were indeed helpful in improving reliability (e.g., Spitzer, Forman, & Nee, 1979; Williams & Spitzer, 1980). "In the DSM-III field trials over 450 clinicians participated in the largest reliability study ever done, involving independent evaluations of nearly 800 patients.… For most of the diagnostic classes the reliability was quite good, and in general it was much higher than that previously achieved with DSM-I and DSM-II" (Spitzer et al., 1980, p. 154). However, there was less success with the personality disorders. For example, Spitzer et al. (1979) reported a kappa of only .61 for the agreement regarding the presence of any personality disorder for jointly conducted interviews. "Although Personality Disorder as a class is evaluated more reliably than previously, with the exception of Antisocial Personality Disorder… the kappas for the specific Personality Disorders are quite low and range from .26 to .75" (Williams & Spitzer, 1980, p. 468).

Mellsop, Varghese, Joshua, and Hicks (1982) reported the agreement for individual *DSM-III* personality disorders in general clinical practice, with kappa ranging in value from a low of .01 (schizoid) to a high of .49 (antisocial). The relative "success" obtained for the antisocial diagnosis was attributed to the greater specificity of its diagnostic criteria, a finding that has been replicated many times thereafter (Widiger & Boyd, 2009). In addition, the lack of reliability for the other diagnoses was attributed by Mellsop et al. to idiosyncratic biases among the clinicians rather than to inadequate criterion sets. They noted how one clinician diagnosed 59% of patients as borderline, whereas another diagnosed 50% as antisocial. Mellsop et al. concluded that "Axis II of DSM-III represents a significant step forward in increasing the reliability of the diagnosis of personality disorders in everyday clinical practice" (p. 1361). They suggested that even further

specification of the diagnostic criteria would be helpful in increasing reliability, but they emphasized the development of more standardized and structured interviewing techniques to address idiosyncratic clinical interviewing.

Another innovation of *DSM-III* was the placement of the personality and specific developmental disorders on a separate "axis" (i.e., Axis II) to ensure that they would not be overlooked by clinicians whose attention might be drawn to a more florid and immediate condition and to emphasize that a diagnosis of a personality disorder was not mutually exclusive with the diagnosis of an anxiety, mood, or other mental disorder (Frances, 1980; Spitzer et al., 1980). The effect of this placement was indeed a boon to the diagnosis of personality disorders, dramatically increasing the frequency of their diagnosis and research interest (Blashfield & Intoccia, 2000). Loranger (1990), for example, compared the frequency of personality disorder diagnoses in the last 5 years of *DSM-II* with the first 5 years of *DSM-III* at a large medical center. In a total sample of over 10,000 patients, the percent receiving a personality disorder diagnoses went from 19% with *DSM-II* to 49% with *DSM-III.*

DSM-III-R

A difficulty in the development of *DSM-III* was the absence of enough research to guide the construction of all of the diagnostic criterion sets, including the personality disorders (with the exception of antisocial and perhaps borderline). Some were developed in the absence of any systematic research, and a number of problems and evident errors were identified soon after the manual was completed. "Criteria were not entirely clear, were inconsistent across categories, or were even contradictory" (APA, 1987, p. xvii). The APA therefore authorized the development of a revision to *DSM-III* to correct these errors, as well as to provide a few additional refinements and clarifications. A more fundamental revision was to be tabled until work began on *ICD-10*. The manual was only to be revised "for consistency, clarity, and conceptual accuracy, and revised when necessary" (APA, 1987, p. xvii). However, it was perhaps unrealistic to expect the authors of *DSM-III-R* to confine their efforts to simply refinement and clarification, given the impact, success, and importance of *DSM-III* (Frances & Widiger, 2012).

> The impact of DSM-III has been remarkable. Soon after its publication, it became widely accepted in the United States as the common language of mental health clinicians and researchers for communicating about the disorders for which they have professional responsibility. Recent major textbooks of psychiatry and other textbooks that discuss psychopathology have either made extensive reference to DSM-III or largely adopted its terminology and concepts. In the seven years since the publication of DSM-III, over two thousand articles that directly address some aspect of it have appeared in the scientific literature. (*American Psychiatric Association,* 1987, p. xviii)

It was not difficult to find persons who wanted to be involved in the development of *DSM-III-R*, and most persons who were (or were not) involved wanted to make a significant impact. Oddly, there were more persons involved in making the corrections to *DSM-III* than had been involved in its original construction. The *DSM-III* personality disorders committee consisted of 10 persons, whereas the *DSM-III-R* committee swelled to 38 and, not surprisingly, there were many proposals for significant revisions and even additions, despite the fact that the mandate had been only to make corrections. Two new diagnoses, sadistic and self-defeating, were proposed by the Personality Disorders Advisory Committee and approved by the *DSM-III-R* Work Group (the central committee was titled Work Group rather than Task Force, consistent with its limited mandate). However, this decision was eventually overturned by the APA Board of Trustees due to their controversial nature and questionable empirical support (Widiger, 1995; Widiger, Frances, Spitzer, & Williams, 1988).

ICD-10 and *DSM-IV*

By the time work was completed on *DSM-III-R*, work had already begun on *ICD-10.* In May of 1988 the APA Board of Trustees appointed a *DSM-IV* Task Force, chaired by Allen Frances. Mandates for this Task Force were to revise *DSM-III-R* in a manner that would be more compatible with *ICD-10*, that would be more user friendly to the practicing clinician, and that would be more explicitly empirically based (Frances, Widiger, & Pincus, 1989). Each of these concerns will be discussed in turn.

Compatibility with ICD-10

The decision of the authors of *DSM-III* to develop an alternative to *ICD-9* was instrumental in developing a highly innovative manual (Kendell, 1991; Spitzer & Williams, 1985; Spitzer et al., 1980). However, this was also at the cost of decreasing

compatibility with the nomenclature used throughout the rest of the world, which is problematic to the stated purpose of having a common language of communication. Representatives of *DSM-IV* and *ICD-10* met to work together to develop more congruent personality disorder nomenclatures.

Table 2.2 provides the personality disorder diagnoses of *ICD-10* (WHO, 1992) and *DSM-IV* (APA, 1994). A borderline subtype was added to the *ICD-10* emotionally unstable personality disorder that was closely compatible with *DSM-IV* borderline personality disorder. The *DSM-IV* Personality Disorders Work Group recommended that a diagnosis for the *ICD-10* personality change after catastrophic experience be included in *DSM-IV* (Shea, 1996), but this recommendation was not approved by the *DSM-IV* Task Force (Gunderson, 1998). Many revisions to *DSM-III-R* criterion sets were implemented to increase the congruency of respective diagnoses from the two nomenclatures (Widiger, Mangine, Corbitt, Ellis, & Thomas, 1995). For example, the *DSM-IV* obsessive-compulsive criterion of rigidity and stubbornness and many of the *DSM-IV* criteria for schizoid personality disorder were obtained from the *ICD-10* research criteria. An initial draft of *ICD-10* included passive-aggressive personality disorder, largely in the spirit of compatibility with *DSM-IV*, but the authors of *DSM-IV* were recommending at the same time that this diagnosis be considered for removal. The authors of *ICD-10* chose not to include a narcissistic personality disorder diagnosis, feeling, at that time, that interest in this diagnosis was confined largely to the United States.

Clinical Utility

A difficulty shared by the authors of *DSM-IV* and *ICD-10* was the development of criterion sets that would maximize reliability without being overly

Table 2.2 Personality Disorders of *ICD-10* and *DSM-IV*

ICD-10	DSM-IV[a]
Paranoid	Paranoid
Schizoid	Schizoid
Schizotypal[b]	Schizotypal
Dyssocial	Antisocial
Emotionally Unstable, Borderline Type	Borderline
Emotionally Unstable, Impulsive Type	
Histrionic	Histrionic
	Narcissistic
Anxious	Avoidant
Dependent	Dependent
Anankastic	Obsessive-Compulsive
Enduring Personality Change After Catastrophic Experience	
Enduring Personality Change After Psychiatric Illness	
Organic Personality Disorder[c]	Personality Change Due to General Medical Condition[d]
Other Specific Personality Disorders and Mixed & Other Personality Disorders	Personality Disorder Not Otherwise Specified

[a]Included within an appendix to *DSM-IV* are proposed criteria sets for Passive-Aggressive (Negativistic) Personality Disorder and Depressive Personality Disorder.
[b]*ICD-10* Schizotypal Disorder is consistent with *DSM-IV* Schizotypal Personality Disorder but included within the section for Schizophrenia, Schizotypal, and Delusional Disorders.
[c]Included within section for Organic Mental Disorders.
[d]Included within section for Mental Disorders Due to a General Medical Condition Not Elsewhere Classified.

cumbersome for clinical practice. Maximizing the utility of the diagnostic criteria for the practicing clinician had been an important concern for the authors of *DSM-III* and *DSM-III-R*, but it did appear that more emphasis was at times given to the needs of the researcher (First et al., 2004; Frances et al., 1990). This was particularly evident in the lengthy and complex criterion sets (e.g., see *DSM-III-R* conduct disorder and antisocial personality disorder; APA, 1987). Researchers can devote more than 2 hours to assess the personality disorder diagnostic criteria, but this is unrealistic for the general practitioner (Mullins-Sweatt & Widiger, 2009). The WHO, therefore, provided separate versions of *ICD-10* for the researcher and the clinician (Sartorius, 1988; Sartorius et al., 1993). The researcher's version included relatively specific and explicit criteria sets, whereas the clinician's version included only narrative descriptions. The *DSM-IV* Task Force considered this option but decided that it would complicate the generalization of research findings to clinical practice and vice versa (Frances et al., 1990). The *DSM-IV* Task Force also questioned the implication of providing more detailed, reliable criterion sets for researchers, and simpler, less reliable criterion sets for clinical decisions, as if diagnoses in clinical practice do not need to be as reliable or valid as the diagnoses obtained for research. The *DSM-IV* Task Force decided instead to try to simplify the most cumbersome and lengthy *DSM-III-R* criterion sets, the best example of which for the personality disorders was the shortening of the criterion set for antisocial personality disorder (Widiger et al., 1996; Widiger & Corbitt, 1995).

In addition, because the personality disorder *DSM-IV* criterion sets were still relatively long for general clinical practice, most of the criteria were presented in a descending order of diagnostic value (Widiger et al., 1995). Clinicians could then economically focus their attention primarily on the most fruitful and informative criteria if they were unable to systematically assess all of them. Research has suggested that clinicians do not systematically assess each diagnostic criterion (time constraints do not permit this). Therefore, if clinicians are focusing on just a subset of features, it would then be useful to provide them a rank order of the diagnostic efficiency of each criterion within a respective list. Not all of the diagnostic criteria need to be assessed, and some diagnostic criteria are considerably more informative than others (Chorpita & Nakamura, 2008; Frick et al., 1994; Widiger, Hurt, Frances, Clarkin, & Gilmore, 1984). However, the descending order of diagnostic value was never acknowledged within the manual in part because there were a few notable exceptions (e.g., new diagnostic criteria were placed at the end of the list due to the absence of sufficient data for their ranking) and in part because the basis for the descending order was not always applied consistently (e.g., the first borderline criterion was selected because of its central theoretical importance, not because it was the most diagnostic empirically).

Empirical Support

One of the more common concerns regarding *DSM-III* and *DSM-III-R* was the extent of its empirical support. It was often suggested that the decisions were more consistent with the theoretical perspectives of the members of the Work Group or Advisory Committee than with the published research. "For most of the personality disorder categories there was either no empirical base (e.g., avoidant, dependent, passive-aggressive, narcissistic) or no clinical tradition (e.g., avoidant, dependent, schizotypal); thus their disposition was much more subject to the convictions of individual Advisory Committee members" (Gunderson, 1983, p. 30). Millon (1981) criticized the *DSM-III* criteria for antisocial personality disorder for being too heavily influenced by Robins (1966), a member of the *DSM-III* Personality Disorders Advisory Commitee. Gunderson (1983) and Kernberg (1984), on the other hand, criticized the inclusion of avoidant personality disorder as being too heavily influenced by Millon (1981), another member of the same committee. The authors of *DSM-III-R* approved for inclusion four diagnoses that were eventually vetoed by the APA Board of Trustees because there was insufficient research to support their validity and to address concerns of harmful use (e.g., paraphiliac rapism and premenstrual dysphoric disorder). Two of these diagnoses were to be included within the personality disorders section (i.e., sadistic and self-defeating personality disorders; Widiger, 1995).

The primary authors of *DSM-IV* suggested that "the major innovation of DSM-IV will not be in its having surprising new content but rather will reside in the systematic and explicit method by which DSM-IV will be constructed and documented" (Frances et al., 1989, p. 375). The development of *DSM-IV* proceeded through three stages of review of empirical data, including systematic and comprehensive reviews of the research literature, reanalyses of multiple data sets, and field trials, all of which were published in a series of archival texts (Frances

et al., 1990; Nathan, 1994). Importantly, the intention and focus of the literature reviews could not be simply to make the best case for a respective proposal (Widiger, Frances, Pincus, Davis, & First, 1991). The authors were required to acknowledge and address findings inconsistent with their proposals (Frances & Widiger, 2012). An explicit method of literature search was required to maximize the likelihood that it would be objective and systematic (or at least maximize the ease with which biases and errors could be identified). Each review was also submitted for critical review by persons likely to oppose any suggested proposals so that biases and gaps in coverage would be identified. Similarly, the field trials had to address specific concerns and objections that had been raised with respect to a given proposal, rather than simply address whether a criterion set was feasible or acceptable. For example, the field trial concerning antisocial personality disorder (Widiger et al., 1996) focused specifically on the alternative diagnostic criterion set developed by Hare (Hare & Neumann, 2008; see also Hare, Neumann, and Widiger, Chapter 22), including sites that involved opposing theoretical perspectives (e.g., both Lee Robins and Robert Hare participated).

The approach taken in *DSM-IV* was more conservative than it had been for *DSM-III* and *DSM-III-R* (Frances & Widiger, 2012). Nevertheless, *DSM-IV* did include many substantive revisions. Only 10 of the 93 *DSM-III-R* personality disorder diagnostic criteria were left unchanged, 21 received minor revisions, 10 were deleted, 9 were added, and 52 received a significant revision (Widiger et al., 1995). The personality disorder that was the most frequently diagnosed by clinicians during World War II (passive-aggressive) was downgraded to an appendix (Wetzler & Morey, 1999; see also Wetzler and Jose, Chapter 31). A new diagnosis, depressive, was also added to this appendix (Ryder & Bagby, 1999; see also Bagby, Watson, and Ryder, Chapter 29). The self-defeating and sadistic personality disorders, approved for inclusion by the *DSM-III-R* Advisory Committee, were deleted entirely from the manual (Widiger, 1995).

ICD-11 and *DSM-5*

No substantive changes were made to the personality disorders section of *DSM-IV-TR* (APA, 2000). The *DSM-IV-TR* revisions were confined simply to updating of text (First & Pincus, 2002). Work is now under way for *DSM-5* and *ICD-11*, with the *DSM-5* Personality and Personality Disorders Work Group (PPDWG) chaired by Andrew Skodol, and the *ICD-11* Working Group for the Revision of Classification of Personality Disorders chaired by Peter Tyrer.

Proposed revisions throughout *DSM-5* have been controversial, to say the least (Frances & Widiger, 2012; Widiger, in press), including the deletion of the multiaxial system, which had addressed, successfully, the tendency of clinicians to ignore personality disorders in the context of more vivid and immediate incoming patient concerns (Spitzer et al., 1980; Ward et al., 1962). The rationale for its deletion has not been provided, let alone discussed.

The proposed revisions for the personality disorders in particular are among the more controversial of the diagnostic manual, given the extent of the proposed change. As indicated by Skodol (2010), "the work group recommends a major reconceptualization of personality psychopathology" ("Reformulation of personality disorders in DSM-5," para. 1; see also Skodol, Chapter 3). The proposals for *ICD-11* are comparably substantial, at least with respect to the deletion of diagnoses (Tyrer, Crawford, & Mulder, 2011). Not surprisingly, these proposals have also generated considerable controversy (see Skodol, Chapter 3, for an excellent summary of the responses to the proposals). Discussed herein will be such concerns as the shift toward a neurobiological orientation, the deletion of diagnoses, the reformulation of personality disorders as early onset, chronic variants of Axis I disorders, the shift toward a dimensional trait model, and the abandonment of the *DSM-IV* diagnostic criterion sets. It should be emphasized, however, that the final decisions have not yet been made (see Skodol, Chapter 3). Initial proposals were posted February 10, 2010 (Skodol, 2010), but these were substantially revised in a second posting, June 21, 2011 (APA, 2011). It would not be surprising if there was further significant revision before the final decision is made.

Neurobiological Shift

DSM-I (APA, 1952) and *DSM-II* (APA, 1968) were slanted toward a psychodynamic model. Spitzer et al. (1980) attempted to have *DSM-III* (APA, 1980) be more theoretically neutral. The *DSM* is used by clinicians and researchers from a wide variety of theoretical perspectives, including (but not limited to) neurobiological, psychodynamic, interpersonal, cognitive, behavioral, humanistic, and interpersonal systems (Widiger, in press; Widiger & Mullins-Sweatt, 2008). An important

function of the manual is to provide a common and neutral means for conducting research and clinical practice among persons with alternative and at times competing theoretical orientations (Frances et al., 1989). A language that purposely favored one particular perspective would not provide an equal playing field and would have an insidious, cumulative effect on subsequent scientific research and discourse (Wakefield, 1998). It is unlikely that one could create a diagnostic manual that is entirely neutral or atheoretical. In fact, if a diagnostic manual is to be guided by the existing empirical support (Frances et al., 1989), the manual would inevitably favor the theoretical perspective that has obtained the greatest empirical support. Nevertheless, the diagnostic manual should probably at least attempt to remain above the competitive fray rather than embrace any one particular theoretical perspective.

However, it is apparent that the APA, and the profession of psychiatry more generally, is shifting to a neurobiological orientation (Paris, 2011). A reading of the table of contents of any issue of the two leading journals of psychiatry (i.e., *American Journal of Psychiatry* and *Archives of General Psychiatry*) will clearly suggest a strong neurobiological emphasis. The head of the National Institute of Mental Health (NIMH) has indicated that priority for funding in the future will be given to studies that formally adopt a "clinical neuroscience" perspective that contributes to an understanding of mental disorders as "developmental brain disorders" (Insel, 2009, p. 132). Insel and Quirion (2005) suggested that psychiatry should rejoin neurology and redefine itself as a clinical application of neuroscience, embracing the position that mental disorders are fundamentally abnormalities in neuronal or synaptic functioning. This shift in NIMH is being accomplished in part through the development of research domain criteria (RDoC) diagnoses with an explicit neurobiological orientation: "a strong focus on biological processes, and emphasis on neural circuits" (Sanislow et al., 2010, p. 633). "The RDoC framework conceptualizes mental illnesses as brain disorders" (Garvey et al., 2010, p. 749).

DSM-IV included a new section within the text devoted to laboratory and physical exam findings (Frances et al., 1989). All of the laboratory tests included therein were concerned with neurobiological findings, with no reference to any laboratory test that would be of particular relevance to a cognitive, psychodynamic, or interpersonal-systems clinician. The definition of mental disorder in *DSM-5* will refer to a "psychobiological dysfunction" in recognition that mental disorders ultimately reflect a dysfunction of the brain (Stein et al., 2010). Kupfer and Regier (2011), the chair and vice chair of *DSM-5* (respectively), explicitly embrace the shift toward a neurobiological orientation for the *DSM.*

Whether and how this shift within psychiatry and the *DSM* is affecting the conceptualization and diagnosis of personality disorders is unclear. The dimensional trait models of personality disorder are compatible with a psychodynamic orientation (Mullins-Sweatt & Widiger, 2007; Stone, 2002) and, in turn, an interest in discovering neurobiological endophenotypes is not inconsistent with a categorical model (Paris, 2011). Nevertheless, the increasing emphasis throughout *DSM-5* on dimensional models of psychopathology is driven in part by the interest in shifting psychiatry toward biologically based endophenotypes (Goldberg, Krueger, Andrews, & Hobbs, 2009; Paris, 2011), and it is perhaps no coincidence that opposition to the trait model has been expressed by persons who have generally favored a psychodynamic perspective (e.g., Shedler et al., 2010).

The prototype narratives initially proposed for *DSM-5* (Skodol, 2010) favored a psychodynamic perspective (Shedler, 2002; Skodol et al., 2011). In addition, the proposed changes to the definition of personal disorder and diagnostic criterion sets to include attachment and self pathology have a clear psychodynamic orientation (Fonagy and Luyten, Chapter 17; Skodol et al., 2011). It is possible that these shifts in the diagnosis of personality disorder have been and will be met with some resistance by other members of psychiatry who favor a more neurobiological orientation (Hyman, 2010; Insel, 2009; Kupfer & Regier, 2011).

Deletion of Diagnoses

The *DSM-5* PPDWG initially proposed to delete half of the diagnoses: histrionic, narcissistic, dependent, paranoid, and schizoid (Skodol et al., 2011; see also Skodol, Chapter 3). The rationale for their deletion was not that dependent, histrionic, and narcissistic traits (for instance) do not exist. On the contrary, the traits of the diagnoses being deleted would be retained within the dimensional trait model (discussed later). For example, included within the dimensional trait model will likely be submissiveness (a dependent trait), attention seeking (a histrionic trait), anhedonia (a schizoid trait), and grandiosity (a narcissistic trait).

The rationale provided for the deletion of diagnostic categories was to reduce the problematic

diagnostic co-occurrence (Skodol, 2010). Diagnostic co-occurrence has been a significant problem (Clark, 2007; Trull & Durrett, 2005; Widiger & Trull, 2007) but sacrificing fully half of them to address this problem might be somewhat of a draconian solution (Widiger, 2011b). Lack of adequate coverage has also been a problem of comparable magnitude to diagnostic co-occurrence (Verheul & Widiger, 2004). Persons will still have dependent, schizoid, paranoid, and histrionic personality traits (and these will be assessed by the dimensional trait model) despite their categorical diagnoses being deleted. Lack of coverage will be magnified substantially in *DSM-5*. For example, with the removal of the histrionic and dependent personality disorders, almost half of the interpersonal circumplex will no longer be represented within the personality disorder nomenclature (Widiger, 2010; see also Pincus and Hopwood, Chapter 18, Figure 18.3). The credibility of the field of personality disorder could also very well suffer from the fact that the *DSM-5* PPDWG decided that literally half of the disorders that have been recognized, discussed, and treated over the past 30 years lack sufficient utility or validity to remain within the diagnostic manual (Pilkonis, Hallquist, Morse, & Stepp, 2011; Widiger, 2011b).

Concerns have also been raised with respect to the decision of which specific diagnoses to delete and which to retain (Mullins-Sweatt, Bernstein, & Widiger, in press). Skodol et al. (2011) suggested that the narcissistic, dependent, histrionic, schizoid, and paranoid diagnoses have less empirical support for their validity and/or clinical utility than the avoidant, obsessive-compulsive, borderline, schizotypal, and antisocial (see also Skodol, Chapter 3). Tyrer (Tyrer et al., 2011), chair of the *ICD-11* Working Group, indicated that they also intend to delete at least five diagnoses, but surprisingly not necessarily the same five (i.e., they proposed retaining schizoid, but deleting borderline). Tyrer (1999, 2009) has long opposed the borderline personality disorder diagnosis.

There does appear to be much less research on the histrionic, paranoid, and schizoid personality disorders than (for instance) research concerning the borderline, antisocial, and schizotypal (Blashfield & Intoccia, 2000; Boschen, & Warner, 2009; see also Blashfield, Reynolds, and Stennett, Chapter 28, and Hopwood and Thomas, Chapter 27). However, Shedler et al. (2010) argued that "absence of evidence is not evidence of absence" (p. 1027). A dearth of research can reflect a failure of personality disorder researchers rather than an absence of the clinical importance of a respective personality disorder. In addition, it is not the case that the existing research indicates a lack of validity or utility for the five personality disorders originally proposed for deletion; it may just indicate relatively less research is being conducted concerning the paranoid, histrionic, and schizoid personality disorders. Nevertheless, it is at least evident that the histrionic, paranoid, and schizoid personality disorders have not been generating much interest of researchers (Blashfield & Intoccia, 2000; see also Blashfield, Reynolds, and Stennett, Chapter 28).

The proposals to delete the dependent and narcissistic personality disorders, however, are more difficult to defend (Bornstein, 2011; Gore & Pincus, in press; Ronningstam, 2011; Widiger, 2011b; see also Bornstein, Chapter 23, and Ronningstam, Chapter 24). There might in fact be as much, if not more, research to support the validity and utility of the dependent and narcissistic personality disorders as there is to support the validity of the avoidant and obsessive-compulsive (Miller, Widiger, & Campbell, 2010; Mullins-Sweatt et al., in press; Widiger, 2011b). As expressed by even one of the *DSM-5* PPDWG members, "Well-studied conditions that represent important clinical presentations, such as dependent and narcissistic PDs, are slated for elimination, whereas obsessive-compulsive PD, which is often associated with less serious pathology, will be retained" (Livesley, 2010, p. 309). As suggested by Livesley (2010), "the criteria for deciding which PD diagnoses to delete are not explicit and the final selection appears arbitrary" (p. 309).

Bornstein (2011) suggested that the decision of which diagnoses to retain and delete was biased in favor of the personality disorders studied within the heavily funded and widely published Collaborative Longitudinal Study of Personality Disorders (CLPS; Skodol et al., 2005), perhaps thereby providing a distinct advantage to a particular subset of the diagnoses. The CLPS project was confined largely to the avoidant, schizotypal, obsessive-compulsive, and borderline. There are strong research programs focused on the study of dependency (Bornstein, 2011) and narcissism (Campbell & Miller, 2011; Ronningstam, 2011), but findings from the CLPS do appear to be heavily weighted in the *DSM-5* deliberations (Skodol et al., 2011). Zimmerman (in press) suggests further that the *DSM-5* PPDWG may have even felt obligated to retain the avoidant and obsessive-compulsive personality disorders because they were the focus of CLPS. It would have been difficult to delete from the diagnostic manual

the disorders that were the focus of over 10 years of NIMH-funded research.

In response to critical reviews of the proposal to delete narcissistic personality disorder (e.g., Miller et al., 2010; Ronningstam, 2011; Widiger, 2011b), the proposal to delete this diagnosis was withdrawn (APA, 2011). Dependent personality disorder, however, still appears to be slated for deletion. In addition, it has also been proposed to remove the schizotypal and antisocial personality disorders from the personality disorders section (Siever, 2011). The rationale for this proposal will be discussed in the following section.

Reformulating Personality Disorders as Axis I Disorders

At the first meeting of the *DSM-5* Research Planning Conference in 2001, chaired by Drs. Darrel Regier (now vice chair of *DSM-5*) and Steve Hyman (now chair of the *DSM-5* Spectrum Study Group), it was suggested that the personality disorders section be removed from the diagnostic manual (due in part to a perceived psychodynamic orientation, as well as a perceived lack of empirical support) albeit have some of them (e.g., antisocial, borderline, and schizotypal) be converted into early-onset, chronic variants of various Axis I disorders. Dr. Bruce Cuthbert was given the responsibility for developing this proposal, the results of which were provided within First et al. (2002). As Skodol (Chapter 3) indicates, an agreement between a representative from the PPDWG and the Schizophrenia Work Group was reached such that schizotypal personality disorder is likely to be shifted out of the personality disorders section and into a schizophrenia-spectrum disorders section with (at best) only a secondary coding (for historical purposes) as a personality disorder. As Skodol (Chapter 3) and Siever (2011) further indicate, consideration is also being given to shifting antisocial out of the personality disorders section into a new class of disorders, called Disruptive, Impulse Control, and Conduct Disorders. Finally, in line with the original proposal at the initial *DSM-5* Research Planning Conference, there is a further proposal to remove the personality disorders section entirely, folding some of them into existing Axis I diagnoses (e.g., avoidant personality disorder becoming generalized social phobia) and deleting any of the others (e.g., narcissistic) that cannot be redefined (Andrews et al., 2009; Hyman, 2011a, 2011b; see also South, Reichborn-Kjennerud, Eaton, and Krueger, Chapter 7).

Concerns have been raised for some time about the possibility that the personality disorders might be subsumed within existing Axis I disorders (Widiger, 2001b, 2003). This proposal is not without some support. There is indeed a lack of empirical support for a qualitative distinction between some Axis I disorders and some personality disorders (Krueger, 2005; Siever & Davis, 1991; Tyrer, 2009). For example, there is clearly substantial overlap of avoidant personality disorder with generalized social phobia (Widiger, 2001b). Antisocial personality disorder could be considered to be an adult variant of Axis I conduct disorder (APA, 2000). Schizotypal personality disorder is already classified as a form of schizophrenia in *ICD-10* (WHO, 1992). Borderline personality disorder is to a significant extent a disorder of mood dysregulation (Tyrer, 2009). It might then seem straightforward for some to simply redefine these personality disorders as early-onset, chronic variants of the existing Axis I disorder (Andrews et al., 2009; Hyman, 2011b). This reformulation would also be consistent with the shift of psychiatry toward a neurobiological model (Goldberg et al., 2009; Krueger, Eaton, Derringer, et al., 2011; Siever & Davis, 1991), as well as perhaps help with treatment funding (i.e., the placement on Axis II might be contributing to a stigma of being untreatable).

Nevertheless, the empirical support for this reformulation might not really be that compelling, even for schizotypal personality disorder (see also Chapter 29 by Bagby, Watson, and Ryder, and Chapter 21 by Kwapil and Barrantes-Vidal). The fact that schizotypal personality disorder shares features with schizophrenia does not necessarily suggest that this disorder is best understood as a form of schizophrenia rather than as a personality disorder (Raine, 2006). Scientific support for conceptualizing schizotypal personality disorder as a form of schizophrenia is that it is genetically related to schizophrenia, most of its neurobiological risk factors and psychophysiological correlates are shared with schizophrenia (e.g., eye tracking, orienting, startle blink, and neurodevelopmental abnormalities), and the treatments that are effective in ameliorating schizotypal symptoms overlap with treatments used for persons with Axis I schizophrenia (Krueger, 2005; Lenzenweger, 2006; see also Roussos and Siever, Chapter 15). Nevertheless, inconsistent with the *ICD-10* classification of schizotypal personality disorder as a form of schizophrenia is that schizotypal is far more comorbid with other personality disorders than it is with psychotic disorders, persons

with schizotypal personality disorder rarely go on to develop schizophrenia, and schizotypal symptomatology is seen in quite a number of persons who lack a genetic association with schizophrenia and would not be at all well described as being schizophrenic (Raine, 2006).

It should hardly need mentioning that persons do have personality traits (John, Robins, & Pervin, 2008; Matthews et al., 2009) and that these traits can result in significant problems in living that warrant professional assessment, intervention, and treatment (Deary et al., 2011; John et al., 2008; Lahey, 2009; Ozer & Benet-Martinez, 2006; Roberts et al., 2007). In addition, these personality traits will often predate and effect the onset, course, and treatment of other mental disorders (Dolan-Sewell, Krueger, & Shea, 2001; Widiger & Smith, 2008), supporting the utility of providing them with a unique recognition on a distinct axis. Prior to *DSM-III*, personality disorders were often overlooked as the attention of clinicians was focused on their patient's immediate complaint (Frances, 1980; Spitzer et al., 1980). The placement of the personality disorders on a separate axis has contributed well to their increased recognition and appreciation (Blashfield & Intoccia, 2000; Loranger, 1990).

Reformulating the personality disorders into Axis I disorders would represent quite a fundamental shift of the APA diagnostic nomenclature. It would be essentially suggesting that there was no such thing as personality or, alternatively, that personality traits are never so maladaptive or impairing that they would warrant conceptualization as a disorder. Of course, these traits would still be recognized, but they would now be conceptualized as disorders of mood, anxiety, impulsive dyscontrol, disruptive behavior, and/or schizophrenia spectrum. However, this would likely create more problems than it solves. Persons have constellations of maladaptive (and adaptive) personality traits (John et al., 2008; Matthews et al., 2009). These traits are currently not well described by just one or even multiple personality disorder diagnoses (Clark, 2007; Widiger & Trull, 2007). They will be even less well described by multiple Axis I diagnoses across broad classes of anxiety, mood, impulsive dyscontrol, disruptive behavior, and schizophrenic disorders, each of them on a continuum with normal personality functioning (Widiger & Smith, 2008).

It is possible that the dimensional trait model would still be included within *DSM-5* even if all of the categories are reformulated as early-onset, chronic Axis I disorders. This is consistent with the current proposal for schizotypal personality traits. The categorical diagnosis is likely to be reformulated as a schizophrenia-spectrum disorder, removed from the personality disorders section, but the traits of perceptual dysregulation, unusual beliefs, and eccentricity are still being included within the dimensional trait model of the personality disorders section (Skodol, Chapter 3). This provides a continued recognition of these traits as reflecting personality dysfunction, but it also provides the manual with an odd overlap and inconsistency to have the same behaviors included in different sections of the manual. Of course, it is also possible that if all of the personality disorder types are removed, the dimensional trait model will be removed as well.

Personality disorders are perhaps under siege today in a manner analogous to the 1960s situationist critiques. Prominent psychologists at that time suggested that personality traits do not exist, that the apparent behavior patterns were due largely to the situations in which the persons were in rather than the persons themselves (Mischel, 1968). Similarly, prominent psychologists and psychiatrists now suggest that personality disorders do not really exist, or at least are better understood as chronic variants of respective Axis I disorders (Hyman, 2011b; Krueger, 2005; Krueger, Eaton, Derringer, et al., 2011; Siever & Davis, 1991).

Shifting to a Dimensional Trait Model

It is evident that the APA and WHO personality disorder nomenclatures are shifting to a dimensional trait model of classification (Skodol, 2010; Tyrer et al., 2011; Widiger & Simonsen, 2005b). The *ICD-11* dimensional proposal is currently limited to just a gross level of severity of dysfunction (Tyrer et al., 2011), but consideration is also being given to replacing all of the traditional personality disorder types (e.g., borderline) with a coding for four or five fundamental dimensions of maladaptive personality (e.g., emotional instability). In *DSM-5*, the 25 traits within the current dimensional trait proposal can be used as an independent means for describing the individual patient, and they will be the sole basis for recovering the diagnostic categories being deleted (e.g., the dimensional trait model will include the histrionic trait of attention seeking) and for any particular case of PDNOS (renamed as personality trait, specified). In addition, in the current proposal, the 25 traits will also provide the primary basis for the diagnosis of each personality disorder type (along with indicators of self and interpersonal dysfunction; see Skodol, Chapter 3). In sum,

in *DSM-5*, as currently proposed, the dimensional trait model will play a central and fundamental role in the conceptualization and diagnosis of personality disorders (Trull & Widiger, in press).

The initial *DSM-5* dimensional trait proposal was to include six broad factors (i.e., negative emotionality, introversion, antagonism, disinhibition, compulsivity, and schizotypy), with each domain including 37 more specific traits (e.g., within negative emotionality was suspiciousness, dependency, emotional lability, anxiousness, separation insecurity, pessimism, depressivity, low self-esteem, guilt/shame, and self-harm). This proposal was subsequently revised to a five-factor model, consisting of emotional dysregulation, detachment, antagonism, disinhibition, and peculiarity-psychoticism, with 25 underlying traits (see Ro, Stringer, and Clark, Chapter 4, and Skodol, Chapter 3).

In a survey of members of the International Society for the Study of Personality Disorders and the Association for Research on Personality Disorders, 80% of respondents indicated that "personality disorders are better understood as variants of normal personality than as categorical disease entities" (Bernstein, Iscan, & Maser, 2007, p. 542). Nevertheless, there is a vocal opposition to any such shift to a dimensional trait model (e.g., Gunderson, 2010a; Shedler et al., 2010; see also Skodol, Chapter 3). It would not be surprising for this opposition to lead to another significant change to the *DSM-5* proposal.

Gunderson (2010b), Bornstein (2011), and Ronningstam (2011), for example, question whether the *DSM-5* trait model will adequately represent the borderline, dependent, and narcissistic personality disorders, respectively. This concern is understandable. The basis for the selection of the original set of 37 traits is unclear (Samuel, Lynam, Widiger, & Ball, 2012; Simms et al., 2011; Widiger, 2011a). Krueger (2011) indicated that they were largely the nominations of PPDWG members. There did not seem to be an explicit or systematic effort to ensure an adequate coverage of the existing personality disorders (Samuel et al., 2012; Simms et al., 2011). Therefore, it would not be surprising to find that some of the personality disorders (deleted or retained) are not adequately represented. For instance, it is not really clear that submissiveness, anxiousness, and insecure attachment will provide an adequate representation of the pathology of dependent personality disorder (Bornstein, 2011; see also Bornstein, Chapter 23). Missing from the *DSM-5* description would be the additional traits of low competence and low self-discipline (Miller & Lynam, 2008), as well as gullibility, selfless self-sacrifice, and meekness (Gore & Pincus, in press; Lowe, Edmundson, & Widiger, 2009; Samuel & Widiger, 2008).

Similar concerns can be raised for other diagnostic types. If the current proposal is approved, narcissistic personality disorder would be diagnosed by just the two traits of grandiosity and attention seeking, failing to include such additional traits as authoritarianism, acclaim seeking, and lack of empathy evident in grandiose narcissism. There are virtually no traits, such as shame or need for admiration, to represent vulnerable narcissism (Ronningstam, 2011; see also Ronningstam, Chapter 24). Passive-aggressive (or negativistic) personality disorder would be assessed by simply depressivity and hostility (Hopwood & Wright, in press; see Wetzler and Jose, Chapter 31). Obsessive-compulsive personality disorder would be diagnosed by just rigid perfectionism and perseveration, failing to include such traits as workaholism, ruminative deliberation, or risk aversion.

Shedler et al. (2010) criticize the trait model in being constructed by academic psychologists without an adequate appreciation of clinical interests and concerns. This criticism is somewhat ad hominem, but the construction of the trait model does appear to have emphasized factor structure over clinical relevance. One limitation of factor analysis is that any one particular factor solution can be highly sensitive to shifts in variable submission and sample characteristics (Millon, 2011), and this instability is evident in the history of the proposal. Clark and Watson (2008) long advocated a three-dimensional model (i.e., negative affectivity, positive affectivity, and constraint), but Markon, Krueger, and Watson (2005) advocated the five-factor model on the basis of a joint factor analysis of measures of normal and abnormal personality functioning. On the basis of a subsequent factor analysis that overloaded the domain of openness, Watson, Clark, and Chmielewski (2008) argued for a six-factor model, consisting of neuroticism, introversion, antagonism, conscientiousness, openness, and oddity. On the basis of a factor analysis of the 37 traits nominated by *DSM-5* PPDWG members, Clark and Krueger (2010) and Krueger, Eaton, Clark et al. (2011) advocated a very different six-factor model, consisting of negative emotionality, introversion, antagonism, disinhibition, compulsivity, and schizotypy. On the basis of a subsequent factor analysis, Krueger, Eaton, Derringer, et al. (2011) shifted

back to a five-factor model, consisting of emotional dysregulation, detachment, antagonism, disinhibition, and peculiarity (also called psychoticism). It would not be surprising if the model shifted once again prior to the final decision on the basis of a new factor analysis.

Nevertheless, the current five-factor model does align well with the original integrative proposal of Widiger and Simonsen (2005a), consisting of emotional dysregulation (*DSM-5* emotional dysregulation), introversion (*DSM-5* detachment), antagonism (*DSM-5* antagonism), impulsivity (*DSM-5* disinhibition), and unconventionality (*DSM-5* psychoticism), which in turn is aligned well with the five-factor model of Widiger and Costa (1994). As such, the *DSM-5* proposal would have a considerable body of empirical support in accounting for the *DSM-IV-TR* personality disorder symptomatology (Widiger & Costa, 2012). The empirical support for the alignment with the five-factor model is provided by Trull (2012), Widiger (2011a), and Widiger, Samuel, Mullins-Sweatt, Gore, and Crego (Chapter 5), albeit Krueger, Eaton, Clark, et al. (2011) and Skodol (Chapter 3) might disagree.

Diagnostic Criteria

Prior to *DSM-III* (APA, 1980), mental disorder diagnosis was notoriously unreliable as it was based on clinicians providing their subjective judgments in matching what they knew about a patient to a narrative, paragraph description of a prototypic case. Clinicians were free to focus on any particular part of the narrative description. No specific or explicit guidelines were provided as to which features were necessary or even how many to consider (Spitzer et al., 1980). As noted earlier, the reliability of personality disorder diagnosis was rather poor (Spitzer & Fleiss, 1974; Spitzer et al., 1975).

One of the major innovations of *DSM-III* (APA, 1980) was the inclusion of specific and explicit criterion sets (Spitzer et al., 1980; Zimmerman, 1994) following the influential lead of Feighner et al. (1972). As suggested by Spitzer in a 1997 monograph devoted to the importance and impact of the Feighner et al. approach to mental disorder diagnosis, "the basic concept that specified diagnostic criteria are necessary to promote [reliable and valid] communication among investigators cannot be challenged" (Spitzer, 1997, p. 12). As expressed recently by Kendler, Munoz, and Murphy (2010), "the renewed interest in diagnostic reliability in the early 1970s—substantially influenced by the Feighner criteria—proved to be a critical corrective and was instrumental in the renaissance of psychiatric research witnessed in the subsequent decades" (p. 141). One of the benefits of this renaissance was the highly published CLPS, which used as its primary measure a semistructured interview that systematically assessed the *DSM-IV-TR* personality disorders' specific and explicit criterion sets (Skodol et al., 2005).

Nevertheless, the *DSM-5* PPDWG initially proposed to abandon specific and explicit criterion sets in favor of returning to prototype matching (Skodol, 2010; Skodol et al., 2011; see as well Skodol, Chapter 3). There is certainly support among personality disorder clinicians and researchers for making this shift (First & Westen, 2007; Huprich, Bornstein, & Schmitt, 2011; Shedler et al., 2010). However, only two studies had been published that provided empirical support for the reliability and/or validity of the narrative prototype matching proposed for *DSM-5* (i.e., Westen, DeFife, Bradley, & Hilsenroth, 2010; Westen, Shedler, & Bradley, 2006) and concerns about the validity of these studies have been raised (Widiger, 2011b; Zimmerman, 2011). For example, for the reliability study (Westen et al., 2010), the ratings were supported by a 2.5 hour interview with questionable independence of the two sets of ratings. For the validity study (Westen et al., 2006), the person who provided the prototype diagnoses already knew the patient very well. In addition, the same person who provided the prototype ratings had also provided the criterion diagnoses. In addition, the narratives proposed for *DSM-5* would probably have been even less reliable than those for *DSM-II* (APA, 1968) as they were considerably longer and more complex (each consisting of 10–17 sentences), allowing for even more variation in the selection of which features to consider and emphasize. In response to the critical review (Livesley, 2010; Pilkonis et al., 2011; Widiger, 2011b; Zimmerman, 2011), the proposal was abandoned (APA, 2011).

The narrative paragraphs were replaced with new criterion sets consisting of a combination of the self-interpersonal dysfunction with maladaptive personality traits (APA, 2011; see Skodol, Chapter 3). A criticism of many of the *DSM-5* PPDWG proposals is that they appear to have emerged de novo from work group member deliberations (Gunderson, 2010b). However, the inclusion of maladaptive traits within the criterion sets is consistent with the proposal of Miller, Bagby, Pilkonis, Reynolds, and Lynam (2005) for five-factor model personality

disorder diagnosis. Miller (2011) provides the empirical support for this proposal (see also Chapter 6). Nevertheless, it is unclear how this new method of personality disorder diagnosis will compare to the criterion sets of *DSM-IV-TR*, which do have a considerable amount of empirical support (Gunderson, 2010a). They are unlikely to be well received by some personality disorder clinicians and researchers (Shedler et al., 2010). It will be useful to compare empirically these proposed criterion sets with the existing criterion sets (APA, 2000) for potential change in coverage (Frances & Widiger, 2012) but as well for convergent and discriminant validity. Even small changes to a diagnostic criterion set can have surprisingly dramatic changes to prevalence rates (Blashfield, Blum, & Pfohl, 1992), and the changes being made for the criterion sets of *DSM-5* are certainly not small. Hopefully the *DSM-5* field trial will be providing this information, as was the case in the field trial for *DSM-IV* (Widiger et al., 1996).

Conclusions

The conceptualization and diagnosis of personality disorder within the APA's diagnostic manual is undergoing a major, fundamental revision. It is not even certain whether there will in fact be a section for personality disorders in *DSM-5*, let alone what it will contain. This could be a time of tremendous progress and growth, or a time of demise and downfall. Of course, how one interprets and perceives these changes depends tremendously on one's own theoretical perspective. In any case, if one is not satisfied with *DSM-5*, it is useful to recognize that it will also not be the last word, as someday there will be a *DSM-6*.

Author's Note

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CHAPTER

3 Diagnosis and *DSM-5*: Work in Progress

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Abstract

A new hybrid dimensional-categorical model for personality and personality disorder assessment and diagnosis has been proposed for *DSM-5* field testing. The justifications for the proposed modifications in approach to diagnosing personality disorders include lack of specificity in the *DSM-IV-TR* definition of personality disorder, inadequate representation of personality disorder severity and arbitrary thresholds for diagnosis, excessive comorbidity among personality disorders, limited validity for some existing types, heterogeneity within types, and instability of current personality disorder criteria sets. This chapter reviews the development of the revised personality assessment model, including summaries of literature reviews, experiences in workshops, comments from the field, and published critiques. The next major step in the development of the *DSM-5* personality assessment and diagnosis model will be the *DSM-5* field trials. Further revisions are anticipated.

Key Words: diagnosis, *DSM-5*, personality disorders, personality, personality functioning

Preparations for *DSM-5* began in 1999, when a *DSM-V* Research Planning Conference was held (initial references to *DSM-5* used the Roman numeral, but this was eventually changed to the Arabic numeral). As a result of that conference, 12 *DSM-V* Research Planning Work Groups were constituted; most of which met and produced "white papers" on the research needed to inform the revision process. In 2002, *A Research Agenda for DSM-V* was published (Kupfer, First, & Regier, 2002), which contained the first series of these papers. In this book, Kupfer and colleagues argued that the categorical approach to the diagnosis of mental disorders in general, and of personality disorders specifically, needed reexamination. No laboratory marker had been found to be specific for any *DSM*-defined Axis II (personality disorders and mental retardation) or Axis I (all other mental disorders) syndrome. Epidemiologic and clinical studies showed high rates of comorbidity within and across axes, and short-term diagnostic instability. A lack of treatment specificity for individual disorders has been the rule rather than the exception. Thus, the question of whether mental disorders, including personality disorders, should be represented by sets of dimensions of psychopathology and other features, rather than by multiple categories, was identified as one of seven basic nomenclature issues needing clarification for *DSM-5*.

In *A Research Agenda for DSM-V*, Rounsaville and colleagues (Rounsaville et al., 2002) elaborated: "There is a clear need for dimensional models to be developed and their utility compared with that of existing typologies in one or more limited fields, such as personality. If a dimensional system performs well and is acceptable to clinicians, it might be appropriate to explore dimensional approaches in other domains (e.g., psychotic or mood disorders)" (p. 13). Thus, personality disorders became a

"test case" for the return to a dimensional approach to the diagnosis of mental disorders in *DSM-5*.[1]

A *DSM-V* Research Planning Conference was held in 2004 on "Dimensional Models of Personality Disorder: Etiology, Pathology, Phenomenology, and Treatment." Two special issues of the *Journal of Personality Disorders* were published in 2005, containing the review papers prepared for this conference. Topics reviewed included alternative dimensional models of personality disorders, behavioral and molecular genetic contributions to a dimensional classification, neurobiological dimensional models of personality, developmental perspectives and childhood antecedents, cultural perspectives, the continuity of Axes I and II, coverage and cutoffs for dimensional models, clinical utility, and the problem of severity in personality disorder classification (Widiger & Simonsen, 2005a, 2005b). These issues guided early deliberations of the *DSM-5* Personality and Personality Disorders Work Group.

Dimensional Versus Categorical Models

Considerable research has shown excessive co-occurrence among personality disorders diagnosed using the categorical system of the *DSM* (Oldham, Skodol, Kellman, Hyler, & Rosnick, 1992; Zimmerman, Rothchild, & Chelminski, 2005). In fact, most patients diagnosed with personality disorders meet criteria for more than one. In addition, use of the polythetic criteria of *DSM*, in which a minimum number (e.g., five) from a list of criteria (e.g., nine) are required, but no single one is necessary, results in extreme heterogeneity among patients receiving the same diagnosis. For example, there are 256 possible ways to meet criteria for borderline personality disorder in *DSM-IV-TR* (Johansen, Karterud, Pedersen, Gude, & Falkum, 2004).[2]

Furthermore, all of the personality disorder categories have arbitrary diagnostic thresholds (i.e., the number of criteria necessary for a diagnosis). There are no empirical rationales for setting the boundaries between pathological and "normal" personality functioning. Finally despite having criteria for 10 different personality disorder types, the *DSM* system may still not cover the domain of personality psychopathology adequately. This has been suggested by the observation that the most frequently used personality disorder diagnosis is personality disorder not otherwise specified (PDNOS) (Verheul, Bartak, & Widiger, 2007), a residual category for evaluations indicating that a patient is considered to have a personality disorder but does not meet full criteria for any one of the *DSM-IV-TR* types, or he or she is judged to have a personality disorder not included in the classification (e.g., depressive, passive-aggressive, or self-defeating personality disorders).

Dimensional models of personality psychopathology make the co-occurrence of personality disorders and their heterogeneity more rational, because they include multiple dimensions that are continua on all of which people can vary. The configurations of dimensional ratings describe each person's profile of personality functioning, so many different multidimensional configurations are possible. Trait dimensional models were developed to describe the full range of personality functioning, so it should be possible to describe any one.

Dimensional models, however, are unfamiliar to clinicians trained in the medical model of diagnosis, in which a single diagnostic concept is used to communicate a large amount of important clinical information about a patient's problems, the treatment needed, and the likely prognosis (First, 2005). Dimensional models are also more difficult to use: 30 dimensions (e.g., the five-factor model) or more (e.g., the originally proposed *DSM-5* trait model) may be necessary to fully describe a person's personality. Finally, there is little empirical information on the treatment or other clinical implications of dimensional scale elevations and, in particular, where to set cut points on dimensional scales to maximize their clinical utility. Thus, the advantages of both categorical and dimensional approaches are reciprocals of the other model's disadvantages. Proponents of dimensional models point out how extremes of some clinical phenomena in medicine that have continuous distributions, such as blood pressure, lead to meaningful categorical diagnoses (i.e., hypertension), once cut points with significance for morbidity and a need for treatment are established. And, as an example from the realm of psychiatry, meaningful cut points based on progressive degrees of functional impairment have been established for extreme (low) values of intelligence.

Widiger and Simonsen (2005c) reviewed 18 alternative proposals for dimensional models of personality disorders. The proposals included (1) dimensional representations of existing personality disorder constructs; (2) dimensional reorganizations of diagnostic criteria; (3) integration of Axes II and I via common psychopathological spectra; and (4) integration of Axis II with dimensional models of general personality structure.

An example of dimensional representations of existing constructs was proposed by Oldham

and Skodol (2000). This proposal converted each *DSM-IV-TR* personality disorder into a 6-point scale ranging from absent traits to prototypic disorder. Significant personality traits and subthreshold disorders could be noted, in addition to full diagnoses. This schema has been shown to be significantly associated with functional impairment of patients with personality disorders when seeking treatment, outperforming *DSM* categories and other dimensional systems based on diagnostic criteria or on general personality traits (Skodol, Oldham, et al., 2005). Another example of this type of "person-centered" dimensional system is the prototype matching approach described by Shedler and Westen (Shedler & Westen, 2004; Westen, Shedler, & Bradley, 2006). In this system, a patient is compared to a description of a prototypic patient with each disorder and the "match" is rated on a 5-point scale from "very good match" to "little or no match."

An example of a dimensional system in which criteria for personality disorders are arranged by trait dimensions instead of by categories is the assessment model of the Schedule for Nonadaptive and Adaptive Personality (SNAP) (Clark, 1993). This model has three higher order factors similar to Tellegen's (Tellegen & Waller, 1987) model: negative temperament (or affectivity), positive temperament (or affectivity), and disinhibition (or constraint). In addition, there are 12 lower order trait scales measuring traits such as dependency, aggression, and impulsivity. Another example of this approach is Livesley's (Livesley & Jackson, 2000) Dimensional Assessment of Personality Pathology (DAPP), with broad domains of emotional dysregulation, dissocial behavior, inhibition, and compulsivity, as well as 28 lower order, primary traits.

Models designed to integrate Axis II and Axis I disorders based on shared spectra of psychopathology have been developed. Siever and Davis's (1991) model, for example, hypothesizes fundamental dimensions of cognitive/perceptual disturbance, affective instability, impulsivity, and anxiety that link related disorders across the *DSM* axes. Thus, schizophrenia and related psychotic disorders and schizotypal personality disorder (STPD) are on a spectrum of cognitive/perceptual disturbance, sharing some fundamental genetic and neurobiological processes but also having differences that account for flagrant psychotic episodes in schizophrenic disorders and only psychotic-like symptoms in STPD (Siever & Davis, 2004). Another integrative model has been proposed that hypothesizes only two fundamental dimensions: internalization and externalization (Krueger, 2005; Krueger, McGue, & Iocono, 2001). Internalizing disorders include mood and anxiety disorders on Axis I and avoidant and dependent personality disorders on Axis II. Externalizing disorders include substance use disorders, for example, on Axis I and antisocial personality disorder (ASPD) on Axis II. Differences between Axis I and II disorders are a function of the extensiveness of the psychopathology, with personality disorders being more extensive and Axis I disorders more circumscribed.

Finally, the fourth group of alternatives hypothesizes that personality disorders are on a continuum of general personality functioning—extremes of normal personality traits. Three- and five-factor models have a long history. Three-factor models (Eysenck, 1987; Tellegen & Waller, 1987) usually include neuroticism, extroversion, and psychoticism (or disinhibition vs. constraint) as higher order factors and the Five-Factor Model (FFM) includes neuroticism, extroversion, agreeableness, openness, and conscientiousness (Costa & McCrae, 1992). Each of the FFM factors is composed of six trait dimensions or "facets." Another model is the Temperament and Character Model (Cloninger, 2000) that consists of four dimensions of temperament (novelty seeking, harm avoidance, reward dependence, and persistence), originally hypothesized as genetic, and three dimensions of character (self-directedness, cooperation, and self-transcendence) that were believed to result from the environment, learning, or life experience.

Theoretical and empirical work has been done to describe personality disorders in terms of dimensional models (Trull, 2005). For example, according to the FFM, personality disorders, in general, would be characterized by high neuroticism. A specific personality disorder, such as borderline personality disorder, would also be characterized by low agreeableness and low cooperativeness. According to the Temperament Character Model, personality disorders would be characterized by low self-directedness and low cooperativeness. Personality disorders in Cluster B (i.e., borderline, antisocial, narcissistic, and histrionic) would also show high novelty seeking; those in Cluster C (i.e., avoidant, dependent, and obsessive-compulsive), high harm avoidance; and those in Cluster A (paranoid, schizoid, and schizotypal), low reward dependence. Some research has suggested that it is easier to distinguish personality disorders from normality using these models than to distinguish specific personality disorders from each other (Morey et al., 2002).

With so many models from which to choose, attempts have been made to synthesize them into an overarching dimensional model. One such synthesis (Widiger & Simonsen, 2005c) proposed that the alternative models could be integrated over four levels of specificity. In this scheme, at the highest level, personality psychopathology is divided by the dimensions of internalization and externalization. Below these are 3–5 broad domains of personality functioning: extroversion versus introversion, antagonism versus compliance, impulsivity versus constraint, emotional dysregulation versus emotional stability, and unconventionality versus closed to experience. Below these are a number (25–30) of lower order traits, each with behaviorally specific diagnostic criteria.

Despite this integration, questions remain. What is the evidence that personality psychopathology is best represented by categorical entities or by dimensions (Widiger & Samuel, 2005)? If by dimensions, should these be abnormal constructs or are extremes of normal variation sufficient? Should personality psychopathology be described by the few (3–5) higher order broad factors, or does the specificity of lower order, more narrowly defined traits add to clinical utility? Finally, should personality psychopathology be conceptualized as static phenotypes or as dynamic processes?

Developing a Hybrid Model of Personality Disorders

Recent longitudinal research in patient (Skodol, Gunderson et al., 2005; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005), nonpatient (Lenzenweger, 2006), and general population samples (Cohen, Crawford, Johnson, & Kasen, 2005) indicates that personality disorders show consistency as syndromes over time but rates of improvement that are inconsistent with their *DSM-IV-TR* definitions. Functional impairment in personality disorders is more stable than personality psychopathology itself (Skodol, Pagano et al., 2005). Some personality disorder criteria are more stable than others (McGlashan et al., 2005) and, in fact, personality traits are more stable than personality disorders, predict stability and change in personality disorders, and are associated with outcomes over time. Personality disorders, therefore, may be best conceptualized as "hybrids" of more stable personality traits and less stable symptomatic behaviors.

The implications of hybrid models are several. First, defining the core features of personality disorders, as distinct from personality traits or styles, is a high priority. One potential hybrid model would have a generic personality disorder diagnosis on Axis I, with the types represented by dimensional trait structures or prototypes on Axis II. Other types of psychopathology, such as depression, anxiety, substance abuse, or suicidality that might become manifest secondary to stress or other life circumstances would be noted separately. Functional impairment could continue to be rated on a separate Axis, if a multiaxial system persisted in *DSM-5*, or by independent notations similar to those for psychopathology.

One initial attempt at redefining the core features of personality disorder was made by Krueger and colleagues (Krueger, Skodol, Livesley, Shrout, & Huang, 2007). According to this conceptualization, personality disorder is characterized by a persistent inability to accomplish one or more of the basic tasks of adult life: (1) the establishment of coherent and adaptive working models of self and others (e.g., is capable of formulating a clear and consistent sense of his or her goals in life and preserves other people as coherent entities); (2) establishment of intimate relationships and activities (e.g., is able to form long-term relationships that involve mutual emotional support); and (3) establishment of occupational relationships and activities (e.g., is able to maintain employment that provides a stable, independent source of income). A generic, unitary personality disorder diagnosis could be listed at the same level ("axis") as other mental disorders in *DSM-5* and be diagnosed either alone or in combination with other psychopathology.

Borderline personality disorder is a classic example of a disturbance of self-other representations (Bender & Skodol, 2007). Borderline psychopathology emanates from impairment in the ability to maintain and use benign and integrated internal images of self and others, which leads to associated unstable interpersonal relationships, affective instability, and impulsivity. The centrality of self-other representational disturbance to borderline personality disorder is recognized across a wide theoretical spectrum spanning psychodynamic, interpersonal, cognitive-behavioral, and trait models.

An example of a trait-based description of borderline personality disorder features was also proposed by Krueger and colleagues (Krueger et al., 2007). Based on the traits derived by Livesley, Jang, and Vernon (1998) from twin studies using the DAPP, the prototypic descriptive features of borderline personality disorder are the following: anxiousness, emotional reactivity, emotional intensity, attachment

need, cognitive dysregulation, impulsivity, insecure attachment, pessimistic anhedonia, self-harming acts, and self-harming ideas. To meet the criteria for borderline personality disorder according to this type of hybrid model, a patient would need to meet the generic criteria for a personality disorder and to have extreme levels on a number of prototypic traits. The minimum number of extreme traits would need to be determined empirically. Extreme might be defined on a dimensional scale for traits characteristic of the patient ranging from highly characteristic to highly uncharacteristic. Other trait-based models of personality (e.g., the FFM or a three-factor model) with empirical support and clinical utility might substitute for the DAPP model in describing personality. Ratings of descriptive prototypes of personality styles and disorders are alternatives to trait-based descriptions (Westen et al., 2006). Prototypes have been found to be "user friendly" and to receive high approval ratings from clinicians (Spitzer, First, Shedler, Westen, & Skodol, 2008).

A number of recent studies support a hybrid model of personality psychopathology consisting of ratings of both disorder and trait constructs. Morey and Zanarini (2000) found that FFM domains captured substantial variance in the borderline diagnosis with respect to its differentiation from non–borderline personality disorders, but that residual variance not explained by the FFM was significantly related to important clinical correlates of borderline personality disorder, such as childhood abuse history, family history of mood and substance use disorders, concurrent (especially impulsive) symptoms, and 2- and 4-year outcomes. In the CLPS, dimensionalized *DSM-IV-TR* personality disorder diagnoses predicted concurrent functional impairment, but this diminished over time (Morey et al., 2007). In contrast, the FFM provided less information about current behavior and functioning but was more stable over time and more predictive in the future. The SNAP model performed the best, both at baseline and prospectively, because it combines the strengths of a pathological disorder diagnosis and normal range personality functioning. In fact, a hybrid model combination of FFM and *DSM-IV-TR* constructs performed much like the SNAP. The results indicated that models of personality pathology that represent stable trait dispositions and dynamic, maladaptive manifestations are most clinically informative. Hopwood and Zanarini (2010) found that FFM extraversion and agreeableness were incrementally predictive (over a borderline personality diagnosis) of psychosocial functioning over a 10-year period and that borderline cognitive and impulse action features incremented FFM traits. They concluded that both borderline personality disorder symptoms and personality traits are important long-term indicators of clinical functioning and supported the integration of traits and disorder in *DSM-5*.

DSM-5 Personality Disorder Model Proposed for Field Testing

The development of a hybrid dimensional-categorical model for personality and personality disorder assessment and diagnosis has been a consistent goal of the *DSM-5* Personality and Personality Disorders Work Group. The model has evolved through several iterations. The original model posted on the American Psychiatric Association's *DSM-5* Web site (see http://www.dsm5.org) consisted of four parts: a severity rating of levels of impairment in personality functioning, narrative prototypes for five personality disorder types, a six-domain/thirty-seven-facet trait rating system (with certain characteristic traits rated in the context of the prototypes), and a revised definition and general criteria for personality disorder. Since its original posting, the model has been revised twice. In its first revision, ratings from the first three assessments mentioned earlier were combined to comprise the essential criteria for a personality disorder: a rating of mild impairment or greater on the Levels of Personality Functioning (criterion A), associated with a "good match" or "very good match" to a Personality Disorder Type *or* with a rating of "quite a bit" or "extremely" descriptive on one or more Personality Trait Domains (criterion B). The criteria also included relative stability across time and consistency across situations and excluded culturally normative personality features and those due to the direct physiological effects of a substance or a general medical condition (see Table 3.1). The approach to levels of impairment, types, and traits was unchanged (except that traits were no longer linked to the types), although some simplifications were made in the levels and the types, based on feedback received (see later discussion). Most recently, a second revision has proposed diagnostic criteria for six specific personality disorder types to replace the narrative prototypes, and for a category of personality disorder trait specified, consisting of core impairments in personality functioning and pathological personality traits. The various parts of the model were further integrated, simplified, and streamlined. Each of these later two revisions

Table 3.1 General Diagnostic Criteria for Personality Disorder (First Revision)

The essential features of a personality disorder are impairments in **identity and sense of self** and in the capacity for effective **interpersonal functioning.** To diagnose a personality disorder, the impairments must meet *all* of the following criteria:

A. A rating of mild impairment or greater in **self** and **interpersonal** functioning on the Levels of Personality Functioning.
B. Associated with a "good match" or "very good match" to a **personality disorder type** *or* with a rating of "quite a bit" or "extremely" descriptive on one or more personality **trait domains**.
C. Relatively stable across time and consistent across situations.
D. Not better understood as a norm within an individual's dominant culture.
E. Not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

has been or is being tested in field trials (see later discussion).

The levels of personality functioning are based on the severity of disturbances in self and interpersonal functioning (see Table 3.2). Disturbances in thinking about the self are reflected in dimensions of *identity* and *self-directedness*. Interpersonal disturbances consist of impairments in the capacities for *empathy* and for *intimacy*. The five originally proposed disorder types (e.g., borderline, obsessive compulsive) were narrative combinations of core personality pathology, personality traits, and behaviors. The six currently proposed types reintroduce narcissistic personality disorder and are defined by personality functioning and trait-based criteria. Six broad personality trait domains (e.g., disinhibition and compulsivity) were originally defined, as well as component trait facets (e.g., impulsivity and perfectionism). These have subsequently been reduced to five domains. Levels of personality functioning, the degree of correspondence between a patient's personality (disorder) and a narrative type, and personality trait domains and facets were all dimensional ratings. The criteria-based categories combine dimensional ratings of personality functioning and pathological traits to arrive at a diagnosis. The personality domain in *DSM-5* is intended to describe the personality characteristics of all patients, regardless of whether they have a personality disorder. The assessment "telescopes" the clinician's attention from a global rating of the overall severity of impairment in personality functioning through increasing degrees of detail and specificity

Table 3.2 Levels of Personality Functioning (First Revision)

Self

1. **Identity**: Experience of oneself as unique, with boundaries between self and others; coherent sense of time and personal history; stability and accuracy of self-appraisal and self-esteem; capacity for a range of emotional experience and its regulation
2. **Self-direction**: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to productively self-reflect

Interpersonal

1. **Empathy**: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding of social causality
2. **Intimacy**: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior

In applying these dimensions, self and interpersonal difficulties should not be better understood as a norm within an individual's dominant culture.

Self and Interpersonal Functioning Continuum

Please indicate the level that most closely characterizes the patient's functioning in the self and interpersonal realms:

_____ No Impairment
_____ Mild Impairment
_____ Moderate Impairment
_____ Serious Impairment
_____ Extreme Impairment

in describing personality psychopathology that can be pursued depending on constraints of time and information and on expertise.

Rationales for Proposed Changes

The justifications for the proposed modifications in approach to diagnosing personality disorders include lack of specificity in the *DSM-IV-TR* definition of personality disorder, inadequate representation of personality disorder severity and arbitrary thresholds for diagnosis, excessive comorbidity among personality disorders, limited validity for some existing types, heterogeneity within types, and instability of current personality disorder criteria sets (Skodol, Clark et al., 2011). The current *DSM-IV-TR* general criteria for personality disorder were not empirically based and are not sufficiently specific to personality pathology, so they may apply equally well to other types of mental disorders. All of the personality disorder categories have arbitrary diagnostic thresholds (i.e., the number of criteria necessary for a diagnosis), while severity of personality disorder rather than categorical diagnosis has more clinical salience. Considerable research has shown excessive co-occurrence among personality disorders diagnosed using the categorical system of the *DSM*. Some *DSM-IV-TR* personality disorders that rarely occur in the absence of other Axis I and II disorders also have little evidence of validity. Specific personality disorders may be very heterogeneous, such that persons receiving the same diagnosis may share few features in common. Finally, personality disorder diagnoses have been shown in longitudinal follow-along studies to be significantly less stable over time than their definition in *DSM-IV-TR* implies.

The requirement of core impairments in self and interpersonal functioning in the general criteria for personality disorder helps to distinguish personality pathology from other disorders and forms the basis for a rating of disorder-specific severity. The use of dimensional ratings of impairment in personality functioning and traits recognizes that personality psychopathology occurs on continua. A reduction in the number of types is expected to reduce comorbid personality disorder diagnoses by eliminating less valid types. The use of traits in conjunction with core impairments in personality functioning to diagnose "personality disorder trait-specified" reduces the need for PDNOS. The addition of traits to personality disorder criteria is anticipated to increase diagnostic stability, and trait assessment facilitates the description of heterogeneity within types.

Severity of Impairment in Personality Functioning

Research suggests that generalized severity may be the most important single predictor of concurrent and prospective dysfunction in assessing personality psychopathology and that personality disorders are optimally characterized by a generalized personality severity continuum with additional specification of stylistic elements, derived from personality disorder symptom constellations and personality traits (Hopwood et al., 2011). A number of experts (e.g., Parker et al., 2002; Tyrer, 2005) have asserted that severity level is essential to any dimensional system for assessing personality psychopathology. Neither the *DSM-IV-TR* general severity specifiers nor the *DSM-IV-TR* Axis V Global Assessment of Functioning (GAF) Scale (APA, 2000) has sufficient specificity for personality psychopathology to be useful in measuring its severity.

Literature reviewed by Bender, Morey, and Skodol (2011) demonstrates that personality disorders are associated with distorted thinking about self and others and that maladaptive patterns of mentally representing self and others serve as substrates for personality psychopathology. A number of reliable and valid measures that assess personality functioning and psychopathology demonstrate that a self-other dimensional perspective has an empirical basis and significant clinical utility (Bender, Morey, & Skodol, 2011). Reliable ratings can be made on a broad range of self-other constructs, such as identity and identity integration, self-other differentiation, agency, self-control, sense of relatedness, capacity for emotional investment in others, responsibility and social concordance, maturity of relationships with others, and understanding social causality. Numerous studies using the measures designed to assess these and other related self-other capacities have shown that a self-other approach is informative in determining type and severity of personality psychopathology, in planning treatment interventions, and in anticipating treatment course and outcome (Skodol, Clark et al., 2011).

A continuum of impairment in self and interpersonal functioning was developed based on theory and existing research (see Bender et al., 2011) and then validated using IRT analyses on over 2,200 psychiatric patients and community members evaluated for *DSM-IV-TR* personality disorders with semistructured diagnostic interviews (Morey et al., 2011). Scores indicating greater impairment in personality functioning predicted the presence of a personality disorder, of more severe personality

disorder diagnoses, and of personality disorder comorbidity. Typical impairments in personality functioning are incorporated into the proposed criteria for the personality disorder types for *DSM-5*, but the proposed severity dimension captures variability, not only across but also within personality disorder types.

Personality Disorder Types

The original proposal for the specified personality disorder types in *DSM-5* had three main features: (1) a reduction in the number of specified types from ten to five; (2) description of the types in a narrative format that combines typical deficits in self and interpersonal functioning and particular configurations of traits and behaviors; and (3) a dimensional rating of the degree to which a patient matches each type (see Table 3.3). Five specific personality disorders were recommended for retention in *DSM-5*: antisocial/psychopathic, borderline, schizotypal, avoidant, and obsessive-compulsive. In response to feedback and further consideration, the proposal was modified to also retain narcissistic. Each *DSM-IV-TR* personality disorder was the subject of a literature review performed by Work Group members and advisors. Antisocial/psychopathic, borderline, and schizotypal personality disorders have the most extensive empirical evidence of validity and clinical utility. In contrast, there are almost no empirical studies focused explicitly on paranoid, schizoid, or histrionic personality disorders. The *DSM-IV-TR* personality disorders not represented by a specific type (now paranoid, schizoid, histrionic, and dependent), the Appendix personality disorders (depressive and negativistic), and the residual category of PDNOS will be diagnosed as personality disorder trait-specified (PDTS) and will be represented by significant impairment on the Levels of Personality Functioning continuum, combined with descriptive specification of patients' unique pathological personality trait profiles. See Skodol, Bender, Morey et al. (2011) for a summary of the rationales for retention versus deletion of specific personality disorders.

There are no clinical or empirical justifications for the number of criteria needed to make a personality disorder diagnosis according to *DSM-IV-TR*. In all cases, more than half of the polythetic criteria set are required. Although some studies consider patients who fall even one criterion below threshold to no longer "have" the categorical diagnosis, most clinicians and researchers know that this convention is a fiction. There are a number of ways to "dimensionalize" personality disorder diagnoses. Some focus on "variables," such as personality traits; others focus on people. A "person-centered" dimensional approach

Table 3.3 Borderline Personality Disorder Type (First Revision)

Individuals who resemble this personality disorder type have an impoverished and/or unstable self-structure and difficulty maintaining enduring and fulfilling intimate relationships. Self-concept is easily disrupted under stress, and it is often associated with the experience of a lack of identity or chronic feelings of emptiness. Self-appraisal is filled with loathing, excessive criticism, and despondency. There is sensitivity to perceived interpersonal slights, loss, or disappointments, linked with reactive, rapidly changing, intense, and unpredictable emotions. Anxiety and depression are common. Anger is a typical reaction to feeling misunderstood, mistreated, or victimized, which may lead to acts of aggression toward self and others. Intense distress and characteristic impulsivity may also prompt other risky behaviors, including substance misuse, reckless driving, binge eating, or dangerous sexual encounters.

Relationships are often based on excessive dependency, a fear of rejection and/or abandonment, and urgent need for contact with significant others when upset. Behavior may sometimes be highly submissive or subservient. At the same time, intimate involvement with another person may induce fear of loss of identity as an individual—psychological and emotional engulfment. Thus, interpersonal relationships are commonly unstable and alternate between excessive dependency and flight from involvement. Empathy for others is significantly compromised, or selectively accurate but biased toward negative elements or vulnerabilities. Cognitive functioning may become impaired at times of interpersonal stress, leading to concrete, black-and white, all-or-nothing thinking, and sometimes to quasi-psychotic reactions, including paranoia and dissociation.

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

5 Very Good Match: patient *exemplifies* this type
4 Good Match: patient *significantly* resembles this type
3 Moderate Match: patient has *prominent features* of this type
2 Slight Match: patient has *minor features* of this type
1 No Match: description does not apply

was originally proposed for *DSM-5* personality disorder types. According to this approach, types can be represented by paragraph-length narrative descriptions of disorders (see Table 3.3) and the use of a rating of degree of "fit." Using this system, a clinician compares a patient to the description of the prototypic patient with each disorder and the "match" is rated on a 5-point scale from 5 = "very good match" to 1 = "little or no match." For the purpose of making a categorical diagnosis, a rating of 4 = "good match" or better was proposed. Prototype matching ratings have been shown to have good interrater reliability (Heumann & Morey, 1990; Westen, Defife, Bradley, & Hilsenroth, 2010), to reduce comorbidity (Westen et al., 2006), to predict external validators as well as *DSM-IV* personality disorder diagnoses (Westen et al., 2006), and to be rated higher by clinicians on measures of clinical utility than categorical, criteria count, or trait dimensional approaches (Spitzer et al., 2008). A recent study also found that clinicians made fewer correct diagnoses of personality disorders and more incorrect diagnoses when given ratings of patients on a list of traits of normal-range personality than when given prototype personality disorder descriptions (Rottman, Ahn, Sanislow, & Kim, 2009). These findings suggest that personality traits in the absence of clinical context are too ambiguous for clinicians to interpret.

In response to feedback and further consideration, however, the method of diagnosing a personality disorder type in *DSM-5* was modified to combine the assessment of level of functioning and of maladaptive personality traits into sets of diagnostic criteria. A number of recent studies cited earlier support a hybrid model of personality psychopathology consisting of both disorder and trait constructs, in that each accounts for variance in etiological, functional, and longitudinal outcome variables not accounted for by the other (see Skodol, Bender, Morey et al., 2011). For example, Table 3.4 provides the proposed diagnostic criteria for borderline personality disorder. As currently proposed, the diagnosis of borderline personality disorder will include an assessment for impairments in self (e.g., excessive self-criticism, chronic feelings of emptiness, and/or dissociative states under stress) and impairments in interpersonal functioning (e.g., intense, unstable, and conflicted close relationships, marked by mistrust and neediness), along with the presence of the maladaptive traits of emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk taking, and hostility. The traits were selected on the basis of a careful mapping of *DSM-IV-TR* personality disorder criteria onto the trait definitions. Ratings on these traits were originally intended to be used to describe the particular trait profile of each patient who matched a type, and thus, to document potentially useful information about within type heterogeneity. However, it should also be noted that feedback from the Web site posting (see later) suggested that using the traits to further characterize the types was too complicated, redundant with the full clinicians' trait ratings, and unwieldy. Furthermore, the empirical basis for assigning trait facets to types was questioned. The relationships of the trait domains and facets to the types will be further evaluated empirically in field trials.

Personality Traits

The original proposal for *DSM-5* included six broad, higher order personality *trait domains*—negative emotionality, detachment (originally called introversion), antagonism, disinhibition, compulsivity, and schizotypy—each comprised of from four to ten (total = 37) lower order, more specific *trait facets*. This original proposal was recently simplified to five higher order domains (i.e., negative affectivity, detachment, antagonism, disinhibition, and psychoticism), each comprised of from three to seven (total = 25) lower order trait facets, based on a community survey (Krueger, Eaton, Derringer et al., 2011; see also Ro, Stringer, and Clark, Chapter 4). Table 3.5 provides a summary of this 25-trait model. This proposed trait model is in the process of further empirical validation and may change depending on the results, so it has been considered preliminary. The rationale for this pathological personality trait model is described in detail elsewhere (Krueger & Eaton, 2010; Krueger, Eaton, Clark et al., 2011, Skodol, Clark et al. 2011; see also Ro et al., Chapter 4, this volume).

A trait-based diagnostic system helps to resolve excessive comorbidity, which plagues all aspects of mental disorder classification, by acknowledging that individuals too easily meet criteria for multiple personality disorder diagnoses because the personality traits that comprise personality disorders overlap across diagnoses. The particular trait combinations that are set forth in the *DSM*, as a whole, do not represent "areas of density" in the multivariate trait space that has been identified empirically. In familiar words, the *DSM-IV-TR* personality disorder diagnoses fail to "carve nature at her joints." Traits can combine in virtually an infinite number of ways. A personality disorder diagnostic system that is

Table 3.4 Proposed Diagnostic Criteria for Borderline Personality Disorder (Second Revision)

- Significant impairment in Personality Functioning manifest by:
  - Impairments in self functioning:
    - Identity: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress
    - Self-direction: Instability in goals, aspirations, values, or career plans
  - Impairments in interpersonal functioning:
    - Empathy: Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes and vulnerabilities
    - Intimacy: Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes or idealization and devaluation and alternating between over involvement and withdrawal
- Elevated Personality Traits in the following domains:
  - Negative affectivity characterized by:
    - Emotional lability: Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances
    - Anxiousness: Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative events of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control
    - Separation insecurity: Fears of rejection by—and/or separation from—significant others, associated with fears of excessive dependency and complete loss of autonomy
    - Depressivity: Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; thoughts of suicide and suicidal behavior
  - Disinhibition, characterized by:
    - Impulsivity: Difficulty controlling behavior, including self-harm behavior, under emotional distress; acting with urgency or on the spur of the moment in response to immediate stimuli; acting on momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans
    - Risk taking: Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences
  - Antagonism, characterized by:
    - Hostility: Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults
- The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.
- The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or sociocultural environment.
- The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

trait-based—that is, using traits themselves as diagnostic criteria—provides a means to describe the personality (normal or abnormal) of every patient. This has the highly beneficial effect of addressing not only the comorbidity problem but also the high prevalence of PDNOS diagnoses. In a fully trait-based system, *all* patients have a specified personality profile, so it is impossible to have a profile that is "not otherwise specified."

Given the polythetic nature of current personality disorder (and many other *DSM-IV-TR*) diagnoses, individuals with markedly different overall trait profiles can meet criteria for the same diagnosis by sharing a small number of specific traits or behaviors, or even only one. A trait-based diagnostic system directly reflects the degree of similarity or difference between individuals. The general diagnostic category of personality disorder is designed to accommodate the naturally occurring heterogeneity of personality, but the heterogeneity of personality features within a personality disorder can be fully specified, rendering it understandable rather than obfuscating.

The discrepancy between personality disorders as "enduring patterns" and the empirical reality of short-term instability has been a puzzle (Grilo et al., 2004; Shea et al., 2002; Zimmerman, 1994),

Table 3.5 Personality Trait Domains and Facets Proposed for *DSM-5* (Second Revision)

Negative Affectivity: Emotional lability, anxiousness, separation insecurity, perseveration, submissiveness, hostility, depressivity, suspiciousness, and low restricted affectivity
Detachment: Restricted affectivity, depressivity, suspiciousness, withdrawal, anhedonia, and intimacy avoidance
Antagonism: Manipulativeness, deceitfulness, grandiosity, attention seeking, callousness, and hostility
Disinhibition: Irresponsibility, impulsivity, distractibility, risk taking, and low rigid perfectionism
Psychoticism: Unusual beliefs and experiences, eccentricity, and cognitive and perceptual dysregulation

Note: Traits of hostility, depressivity, suspiciousness, and restricted affectivity load on more than one domain.

until recent data suggesting that the *DSM-IV-TR* criteria were a mix of more stable trait-like criteria and less stable state-like criteria (McGlashan et al., 2005; Zanarini et al., 2005) rendering personality disorder diagnoses as a whole less stable than their trait components. Basing personality disorder diagnostic criteria on more stable traits, and considering the more state-like features that occur in individuals with personality disorder to be *associated symptoms* would eliminate the conceptual-empirical gap in personality disorder with regard to temporal stability.

The continuity between normality and pathology is not unique to personality. For example, subclinical anxiety and depression also have large literatures, and they have repeatedly been shown to be continuous with more severe manifestations of these disorders. In the case of personality, this is especially well documented; recent reviews and meta-analyses have documented clearly that an integrative structure can encompass the entire both normal range and abnormal personality (Markon, Krueger, & Watson, 2005; O'Connor, 2002, 2005; Saulsman & Page, 2004; Trull & Durrett, 2005). Implementing a trait-based system for personality disorder diagnosis, therefore, provides the beneficial option of assessing any patient's personality (i.e., not just those with personality disorder). Insofar as personality has been shown to be an important modifier of a wide range of clinical phenomena (Rapee, 2002), incorporating a dimensional trait model will strengthen not only personality disorder diagnosis but *DSM-5* as a whole.

Considerable evidence relates current *DSM* personality disorders to four broad, higher order trait domains of the FFM of personality: neuroticism, extraversion, agreeableness, and conscientiousness (O'Connor, 2005; Saulsman & Page, 2004). Widiger and Simonsen (2005c) reviewed the literature on personality pathology and found 18 extant models. They then demonstrated that these models could be subsumed by the same common four-factor model. These four factors are included in the proposed personality disorder trait model. Because the proposed model for *DSM-5* is a model of personality pathology, its focus is on the maladaptive end of each dimension, and thus it includes the four trait domains of negative affectivity, detachment, antagonism, and disinhibition. Negative affectivity corresponds to neuroticism and the latter three are the maladaptive ends of extraversion, agreeableness, and conscientiousness, respectively.

Meta-analyses indicate that FFM openness is not strongly related to personality disorder and that FFM traits tap only the social and interpersonal deficits of schizotypal personality disorder, and not the cognitive or perceptual distortions and eccentricities of behavior (O'Connor, 2005; Saulsman & Page, 2004). Several studies have been published demonstrating that the schizotypy domain forms an important additional factor in analyses of both normal and abnormal personality (Chmielewski & Watson, 2008; Tackett, Silberschmidt, Krueger, & Sponheim, 2008; Watson, Clark, & Chmielewski, 2008). Therefore, an alternative fifth factor, named schizotypy (recently changed to psychoticism), was added to the model. Meta-analyses further revealed that obsessive-compulsive personality disorder is not well covered by the FFM (Saulsman & Page, 2004), since compulsivity is more than extreme conscientiousness (Nestadt et al., 2008). Given the radically different nature of the proposed system compared to that in *DSM-IV-TR*, it is important to maintain continuity to the extent possible, and thus to provide coverage of all traits relevant to the *DSM-IV-TR* personality disorders. Therefore, a sixth domain of compulsivity was originally added to address this otherwise missing element (albeit subsequently represented as the opposite pole of the disinhibition domain, with the reduction of the original model from six to five broad domains; Krueger, Eaton, Derringer et al., 2011).

Finally, the proposed specific trait facets were selected provisionally as representative of the six domains (subsequently reduced to five), based on a comprehensive review of existing measures of normal and abnormal personality, as well as

recommendations by experts in personality assessment. In measurement-model development, it is recommended initially to be overinclusive rather than underinclusive, because it is easier to collapse dimensions and eliminate redundant or irrelevant traits at a later stage than it is to add missing elements (Clark & Watson, 1995). Thus, the original proposed trait-facet set was provisional and was anticipated to be overly comprehensive and overly complex. Accordingly, we expected that a number of the proposed facets may be highly correlated and would be combined into a smaller number of somewhat broader facets (e.g., the original proposal for 37 traits has already been reduced to 25, based on the community survey). It is also possible that some facets may be misplaced and will be moved to a different domain; others may still prove unreliable or structurally anomalous and be eliminated. In any case, the structural validity of the trait model is being tested and revised for introduction into the *DSM-5* in the future.

General Criteria for Personality Disorder

The originally proposed general criteria for personality disorder as posted on the *DSM-5* Web site (see Skodol, Clark et al., 2011; Table 3.4) were based on the theoretical model of adaptive failure of Livesley (1998), which included the failure to develop coherent sense of self or identity and chronic interpersonal dysfunction. Evaluation of self pathology was based on criteria indexing three major developmental dimensions in the emergence of a sense of self: differentiation of self-understanding or self-knowledge (*integrity of self-concept*), integration of this information into a coherent identity (*identity integration*), and the ability to set and attain satisfying and rewarding personal goals that give direction, meaning, and purpose to life (*self-directedness*). Interpersonal pathology was evaluated using criteria indexing failure to develop the capacity for *empathy*, sustained intimacy and attachment (labeled *intimacy* in the proposal), prosocial and cooperative behavior (labeled *cooperativeness* in the proposal), and *complex and integrated representations of others*.

The proposal to change the general criteria for personality disorder was based on the observation that the *DSM-IV-TR* criteria are poorly defined, not specific to personality disorder, and were introduced in *DSM-IV* without theoretical or empirical justification. Incorporation of dimensional classification into *DSM-5* necessitates the use of criteria for general personality disorder that are distinct from trait dimensions, because an extreme position on a trait dimension is a necessary but not sufficient condition to diagnose personality disorder (Wakefield, 2008).

Feedback received on the Web site posting (see later) indicated that these criteria were too complicated, without a sufficiently empirical basis, set at too severe a level of dysfunction, inconsistent with more recent views of personality pathology as developmental "delays" as opposed to "failures," and not integrated with the other parts of the proposed model. Therefore, these general criteria were simplified, and empirically based assessments of the level of impairment in personality functioning were integrated with the type and trait assessments (see Table 3.1). The comments in published critiques were based on the originally proposed general criteria, but some also apply to the revised criteria.

Clinical Application

The new assessment model is designed to be flexible and to "telescope" clinical attention onto personality pathology by degrees (Skodol, Bender, Oldham et al., 2011). Even a busy clinician with limited time or expertise in the assessment of personality or personality disorders should be able to decide whether a personality-related problem exists and how severe it is. A further step in the assessment of personality problems would be to characterize their type according to the proposed criteria. The patient can also be evaluated for the remainder of the traits, a sort of trait-based "review of systems," in order to identify other important personality characteristics. The levels of functioning and trait profile steps are informative regardless of whether a patient is believed to have a personality disorder. A trait assessment is also needed to describe the particular, individual trait profile of patients who have sufficient personality psychopathology to receive a personality disorder diagnosis but do not match one of the six *DSM-5* types. These patients, formerly diagnosed with personality disorder not otherwise specified (PDNOS) in *DSM-IV-TR*, would receive a diagnosis of *personality disorder trait specified* (PDTS) in *DSM-5*.

Assessment of Levels of Personality Functioning

Consideration of the core capacities of personality related to self and interpersonal functioning and determining the severity of any impairment in these areas is accomplished by using the Levels of Personality Functioning Scale (see Table 3.2). Any rating above "zero" (i.e., at least a mild level of impairment) is significant and consistent with a

personality disorder. If not evident from the chief complaint or the history of the presenting problems, a few basic questions about how patients feel about themselves and about the nature of their relationships with others should enable clinicians to say with some confidence whether a personality problem exists. For example, research has shown that a question such as "Do you ever get the feeling that you don't know who you really are or what you want out of your life?" has high sensitivity for the kinds of problems with identity and self-concept typically associated with personality disorders. Similarly, a question such as "Do you feel close to other people and enjoy your relationships with them?" (answered negatively) has high sensitivity for problems with intimacy. Problems with identity and self-concept and with intimacy and interpersonal reciprocity may be the result of another type of mental disorder (i.e., a mood or anxiety disorder), but they are especially characteristic of personality psychopathology.

A full assessment of impairment in personality functioning, however, is considerably more nuanced. Thus, a 5-point rating scale of functional impairment in the self and interpersonal domains is being proposed for *DSM-5*. The scale ranges from 0 = no impairment to 4 = extreme impairment (see Skodol, Bender, Oldham et al., 2011), with detailed descriptions of the types of dysfunctions defining each level. Based on a review of existing measures (Bender, Morey, & Skodol, 2011), the assessment of personality functioning is expected to have clinical utility. For example, the more severe the level of impairment, the more likely the person is to have a personality disorder, to have a severe personality disorder, and to receive multiple (more than one) personality disorder diagnoses according to *DSM-IV* (Bouchard et al., 2008; Loffler-Stastka, Ponocny-Seliger, Fischer-Kern, & Leithner, 2005; Verheul et al., 2008). The severity of impairment in personality functioning has also been shown to be an important predictor of concurrent and prospective general impairment in psychosocial functioning (e.g., Hopwood et al., 2011) and to be important in planning treatment and predicting its outcome (e.g., Diamond, Kaslow, Coonerty, & Blatt, 1990; Piper et al., 1991).

Assessment of Personality Trait Domains and Facets

Trait ratings are of two kinds: domain ratings and facet ratings (see Skodol, Bender, Oldham et al., 2011). Trait domains and facets are rated on a 4-point scale: 0 = very little or not at all descriptive, 1 = mildly descriptive, 2 = moderately descriptive, 3 = extremely descriptive. The six broad trait domains proposed for *DSM-5*—negative affectivity, detachment, antagonism, disinhibition, compulsivity, and psychoticism—are rated to give a "broad brush" depiction of a patient's primary trait structure. Some of these domains are close counterparts to *DSM-IV-TR* personality disorders. For example, the domain of detachment (DT) (and its facet traits) is virtually synonymous with *DSM-IV-TR* schizoid personality disorder and many of the traits of the domain of negative affectivity (NA) suggest (*DSM-IV-TR* Appendix) depressive personality disorder. The domains figure prominently in the personality disorder types proposed for *DSM-5*, as well—for example, a combination of traits from the antagonism and the disinhibition (DS) domains make up criterion B of the antisocial type. Traits from the domains of negative affectivity and of detachment make up the trait criterion of the avoidant type. A rating of 2 or greater on one or more of the personality trait domains in the presence of impairment in personality functioning also qualifies for a personality disorder diagnosis, providing that the exclusion criteria for the general criteria for personality disorder are met (see below). The most detailed trait profile is obviously derived from the rating of the 25 trait facets. These may be found in myriad combinations and provide the most specific picture of a patient from the personality trait point of view, regardless of whether the person has a personality disorder. In addition, the trait domains and facets have the salutary effect of converting a nonspecific PDNOS diagnosis into a specific personality disorder trait specified diagnosis.

Assessment of the Criteria for Personality Disorder

The third part of the evaluation is the application of the criteria for personality disorder. The criteria are considered last for three reasons: (1) even if a patient does not have a personality disorder, the descriptive information from the other parts of the assessment can be clinically useful; (2) the assessment of levels of personality functioning and personality traits are needed to rate the criteria and, so, logically must precede them; and (3) the various exclusion criteria may well prove to be the most time-consuming and labor intensive parts of the assessment and require the most knowledge about patients and their clinical histories, and thus they should not interfere with an assessment of personality functioning and traits, which have clinical utility in their own right.

Critiques of Proposed Model

Critiques of the model over the course of its development have been received from participants in three developmental workshops, comments posted on the APA's *DSM-5* Web site (and/or submitted directly to the Work Group following the posting), and in published articles, including special issues of several personality disorder journals.

Workshop Experience

During the development of the initial proposed model for *DSM-5*, three workshops were conducted between April and September of 2009 by the author and Donna S. Bender, Ph.D., a Work Group member. The workshops were held at the invitation of the Southern Arizona Psychological Association (SAPA), the International Society for the Study of Personality Disorders (ISSPD), and the Oregon Psychiatric Association (OPA). The participants in these three workshops were primarily clinical psychologists (SAPA), psychiatrists and psychologists with particular interest or expertise in personality disorders (ISSPD), and clinical psychiatrists (OPA), respectively. At the ISSPD workshop, international participants outnumbered participants from the United States by 61% to 39%. Different versions of the proposed model that were under discussion by the Work Group were presented to the audiences and applied to brief written clinical case histories. Detailed information was sought from the participants on their perceptions of the clinical utility of the versions of the model and the various parts (i.e., the levels of personality functioning, types, traits, and general criteria) of each. Participants were also asked whether the new approaches were improvements over the *DSM-IV-TR* approach.

In essence, the two main variations of the model were (1) the use of broad versus narrow narrative prototypes, and (2) a trait assessment "embedded" with a type rating versus completely independent ratings of both types and traits. The broad narrative prototypes recognized that some traditional personality disorder types, such as narcissistic and antisocial or histrionic and borderline, appear to vary on a continuum of severity, rather than have clear demarcations between them. The narrow types were more faithful to personality disorder constructs as embodied in *DSM-IV-TR* (though in narrative form). The embedded traits were an attempt to provide a "type" context for rating traits, since it has been shown that rating traits outside of a type context could be difficult and lead to diagnostic errors (Rottman et al., 2009).

Overall, preferences for broad vs. narrow personality disorder prototypes and embedded trait ratings vs. independent ratings were about equal, although those with more clinical experience preferred the broad types with embedded traits, while those with less experience liked the narrow types and independently rated traits. Of the components of the model, the levels were rated the most clinically useful and the general criteria the least useful, with the types and the traits in between. The majority of the participants rated the model in either version better or much better than *DSM-IV-TR*.

Following discussions of the workshop experiences, the Work Group decided to propose a model with narrow prototype descriptions, but each with a set of carefully selected, relevant traits listed with the type narratives, as well as in a free-standing personality trait rating form.

DSM-5 Web Site Comments

In February 2010, a draft of the originally proposed changes to the assessment and diagnosis of personality disorders (and other disorders) for *DSM-5* was posted on the American Psychiatric Association's *DSM-5* Web site (http://www.dsm5.org). The proposed changes and their rationales are summarized in Skodol, Clark et al. (2011). Public comments were invited for the next 6 weeks. The personality and personality disorders section of the Web site received 408 comments, and 85 relevant general comments were submitted. The following sections summarize the major themes of the comments and how the Work Group responded to them.

NAME CHANGES

A substantial number of comments requested revised terminology for key concepts or disorders. The most common request was to change the name of the trait domain "introversion," which was viewed by those who commented as a normal personality variant, not pathology. The Work Group decided to change the domain name to "detachment," a term that has been used to describe traits of social and emotional withdrawal or inhibition in other trait models. Another common request was to change the name of borderline personality disorder, because it did not, in the opinion of some writers, reflect the nature of the disorder and it was stigmatizing. The most commonly suggested alternative was "emotional dysregulation disorder." The Work Group decided not to change the name for several reasons. The proposed name changes do not reflect a consensus on the core pathology of borderline personality

disorder. The problem of stigma does not emanate from the name. Disorders such as schizophrenia and anorexia nervosa also have names that no longer represent the nature of the disorders but are maintained to preserve important historical continuities for research and treatment.

PERSONALITY DISORDER TYPES AND TRAITS

A second group of comments were directed at the Personality Disorder Type model. The most common request was to increase the number of types beyond the five originally proposed, because clinicians found others to be useful in describing their patients. The most commonly requested type was narcissistic personality disorder, but all *DSM-IV-TR* personality disorders were mentioned by at least several people. The Work Group is sensitive to the needs of clinicians but believes on the basis of literature reviews that very little empirical support exists for certain personality disorders. Narcissistic personality disorder was recently added as a specific type, however. Other comments questioned the rationale and support for the traits that were listed in the original proposal as associated traits for the types. Finally, comments inquired about how the diagnosis by types (or traits) would be made and the reliability of these diagnoses. A careful, phrase-by-phrase analysis of the originally proposed narrative types indicated a degree of matching between the proposed types and proposed component traits. Thus, that their relationships were questioned did not necessarily indicate a fundamental problem with the proposal, but that the trait-type linkage needed to be empirically specified. The Work Group suggested separate ratings of the types on the type matching scale and of all of the traits on the trait rating scales, when the narrative types were being tested in the field trials, in order to assess the reliability of both kinds of ratings, to establish the relationship of the traits to the types, and to develop empirical, trait-based diagnostic algorithms for the types. In fact, the recommendation currently is to have clinicians rate all aspects of the model—levels of personality functioning, traits, and the criteria for personality disorders in the field trials to determine reliability, to document interrelationships, and to reduce redundancy.

IMPLEMENTATION

A third group of comments involved confusion about how the model would actually work in practice and whether it was too unwieldy for everyday clinical use. The Work Group has described the model components and their rationales, including their clinical utility, and illustrated the application of the original model to the assessment and diagnosis of patients with varying degrees and kinds of personality psychopathology in recent papers (Krueger & Eaton, 2010; Krueger, Eaton, Clark et al., 2011; Skodol, Bender, Morey et al., 2011; Skodol, Bender, Oldham et al., 2011; Skodol, Clark et al., 2011). This clinical application emphasizes the flexible, "telescoping" nature of the assessment, whereby clinicians can describe a patient's personality problems with increasing degrees of specificity, depending on the need to do so, as well as on available time and information, and on expertise.

LANGUAGE

Finally, there were many comments that raised questions about complex language and concepts throughout the proposed new model. All parts of the model, including the Levels of Personality Functioning and the General Criteria for Personality Disorder, were reviewed with an eye toward simplification and clarification of language to make them more accessible to clinicians of all levels of training and experience. Principles for differentiating traits from related symptom disorders (e.g., traits of disinhibition vs. symptoms of attention-deficit hyperactivity disorder) will be developed for the final *DSM-5* text.

Published Critiques

Published critiques of the model as it was represented on the APA's *DSM-5* Web site appear in three special issues of personality disorder journals: two in *Personality Disorders: Theory, Research and Practice*, and one in the *Journal of Personality Disorders*. These critiques have generally praised the levels of personality functioning, argued against the deletion of *DSM-IV-TR* personality disorder types, been mixed on the shift from diagnosis by criteria to diagnosis by prototype matching, and expressed both criticism of the 6-domain/37-trait system originally proposed and skepticism toward its clinical utility.

LEVELS OF PERSONALITY FUNCTIONING

Impairment in self and interpersonal functioning has been recognized by reviewers of the proposed *DSM-5* model to be consistent with multiple theories of personality disorder and their research bases, including cognitive/behavioral, interpersonal, psychodynamic, attachment, developmental, social/cognitive, and evolutionary theories, and to be key aspects of personality pathology in need of clinical attention (Clarkin & Huprich, 2011; 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 measured (Ro & Clark, 2009). The Levels of Personality Functioning constructs align well with the National Institute of Mental Health Research Domain Criterion (RDoC) of "social processes" (Sanislow et al., 2010). The interpersonal dimension of personality pathology has been related to attachment and affiliative systems regulated by neuropeptides (Stanley & Siever, 2010), and neural instantiations of the "self" have been linked to the medial prefrontal cortex (MPFC) and the brain's so-called default network (Fair et al., 2008).

Critiques of the *DSM-5* proposal generally have praised the Levels of Personality Functioning as an advance over *DSM-IV-TR* (e.g., Ronningstam, 2011; Shedler et al., 2010) and have suggested that the presence of personality disorder and its severity are the primary distinctions of importance for clinicians (Pilkonis, Hallquist, Morse, & Stepp, 2011). Some have suggested even broader and more complex constructs for the levels (Clarkin & Huprich, 2011; Pilkonis et al., 2011) and separate ratings of all components (Pilkonis et al., 2011), and they have also pointed out the need for further reliability testing (Pincus, 2011).

PERSONALITY DISORDER TYPES

Critiques of the *DSM-5* proposal have almost universally been against the deletion of *any* of the *DSM-IV* personality disorder types, arguing that existing types have clinical utility and treatment relevance (Gunderson, 2010; Shedler et al., 2010) or have "heuristic value" (Costa & McCrae, 2010; Pilkonis et al., 2011). The empirical basis for retaining versus deleting types has been questioned (Bornstein, 2011; Clarkin & Huprich, 2011; Pincus, 2011; Widiger, 2011a), and it has been suggested that a limited research base does not mean a lack of utility (Gunderson, 2010) and should not be a criterion for deletion (Shedler et al., 2010). Deletion of types is anticipated to result in loss of coverage of personality pathology (Widiger, 2011a), make comparisons of specific types and trait-specified disorders difficult (Clarkin & Huprich, 2011), and may lead to coding problems (First, 2010; Widiger, 2011a). By far the most support for a personality disorder to be reintroduced into the system (reminiscent of the comments posted on the Web site) has been for narcissistic personality disorder (e.g., Pincus, 2011; Ronningstam, 2011), but dependent personality disorder has also had advocates (Bornstein, 2011), even though the evidence presented for the validity of both of these disorders has often been dimensional in nature. Proponents for narcissistic personality disorder agree, however, that its current representation in *DSM-IV-TR* is inadequate, because the *DSM-IV-TR* definition captures only grandiose narcissism, and not the vulnerable aspects or the "covert" type. Pilkonis et al. (2011) argued for the inclusion in *DSM-5* of *all* personality disorder types that have appeared in any *DSM* since *DSM-III*.

Reaction to the proposed shift from criterion-based to a prototype-based diagnosis was more mixed. A number of reviewers have supported the prototype approach because it is simple and more familiar (types than traits) (First, 2010), conforms to "what clinicians do" (Clarkin & Huprich, 2011), and is judged to be more clinically useful than criterion-based or trait-based diagnosis (Gunderson, 2010; First, 2010; Shedler et al., 2010) and have suggested that prototypes replace categories in *DSM-5*. Questions were also raised about the reliability of prototype ratings, however, and further testing of their reliability and validity in field trials was recommended (Pilkonis et al., 2011; Widiger, 2011a; Zimmerman, 2011). In a related vein, since there were no "criteria" per se for the narrative personality disorder types, their utility for research was also been questioned (Widiger, 2011a; Zimmerman, 2011). The derivation of the type descriptions and their relationships to *DSM-IV-TR* personality disorder criteria sets have been questioned (Pilkonis et al., 2011), as has the impact of a shift to prototypes on prevalence and comorbidity of personality disorders (Zimmerman, 2011).

Most critics believe that the originally proposed linking of traits to types was ambiguous and without an empirical basis and that traits should be rated separately from the types (Costa & McCrae, 2010; Pilkonis et al., 2011; Pincus, 2011). Widely divergent opinions were expressed about the role of traits in the proposed new diagnostic system, however. Some believe that trait ratings should be the basis for rating the types (Costa & McCrae, 2010). Some believe that the traits needed better "rule-based" methods for translating traits to types and that both types and traits should be "optional," finer grained distinctions (after personality disorder presence and severity) (Pilkonis et al., 2011). Some suggest they be an optional rating on a separate axis (Axis II) (First, 2010; Widiger, 2011 a). And, finally, some thought that they were not needed at all (First, 2010; Gunderson, 2010; Shedler et al., 2010).

Pilkonis et al. (2011) questioned whether the hybrid model (types and traits) was of limited value or, in fact, had the best potential for

representing personality pathology (see also Hallquist & Pilkonis, 2010).

PERSONALITY TRAITS

Published critiques of the originally proposed trait system have been predominantly negative. The proposed trait system has been criticized as unfamiliar to clinicians and unlikely to be used because the traits lack an experiential or empirical basis for clinical salience. Although the proposed trait system may represent a factor structure that is scientific, there is an insufficient research base regarding cut points for diagnosis, the relationship of the model to other trait models, the delineation of the facet-level traits, the mapping of the traits onto personality disorders, a consensus on the optimal number of traits and their definitions, and their use for making clinical inferences (Gunderson, 2010). The traits have also been criticized for being nonspecific in that the same trait may apply to many types (First, 2010; Paris, 2011); be inherently ambiguous, static (as opposed to dynamic) representations of personality; be difficult to incorporate into coding systems; and be of uncertain clinical utility (First, 2010). Limited clinical utility was also raised as a problem by Shedler et al. (2010), who noted that clinicians judged dimensional trait systems as less useful than *DSM-IV-TR*, and by Clarkin and Huprich (2011), who believed that clinicians do not assess traits and that traits would impede communication. Bornstein (2011) also bemoaned the loss of useful shorthand diagnostic labels.

Ronningstam (2011) found the trait representation of narcissistic personality disorder to be scattered (across domains) in a way that interfered with the perception of an integrated, clinically meaningful concept, to be missing important traits, and to include facet traits with definitions that were neither clinically meaningful nor empirically representative. Pincus (2011) echoed that the traits provided for narcissistic personality disorder were too narrow, that some trait definitions were confounded with interpersonal elements, and that there was no empirical basis for reconstructing deleted types from traits. Shedler et al. (2010) also believed combinations of traits would not easily yield omitted personality disorder types. The recommendation from First (2010) was that a variable-centered trait approach should not replace categories in *DSM-5*, but it could be on a separate axis (Axis II). Costa and McCrae (2010) argued that the notion of personality dimensions as adjuncts to personality disorder types is supported and that traits should be assessed in all patients, not just those with personality disorders.

Pilkonis et al. (2011) said that, although the emphasis on personality traits as a basis for diagnosis was well founded, traits (and types) were "finer" distinctions that should be secondary (domain level first, followed by relevant trait facets) to establishing the presence of a personality disorder and its severity. They also found the new trait system and the diagnosis of personality disorder trait-specified to be "jarring." They found the trait definitions complex and inferential and believe that an assessment tool would be needed. They argued for a detailed translation of traits to types and that personality disorders were not merely extreme traits.

Widiger (2011a) found that the trait definitions were cumbersome and suspected that they would not have official coding. He also argued that there is much redundancy in some of the proposed trait facets, while other key traits were missing, and that the definitions of the traits were very inconsistent, with some defined broadly and others narrowly (Widiger, 2011b). Both Widiger (2011b) and Shedler et al. (2010) found the trait system too complex. Paris (2011) wrote that the traits did not map onto biological systems and ignored the emergent properties of cognitive, affective, and behavioral systems in personality disorders.

The basic structure of the proposed trait system was questioned by several authors. A number of commentators suggested that traits should be bipolar, not unipolar, because pathological personality characteristics exist at both ends of the domain spectra (Costa & McCrae, 2010; Pilkonis et al., 2011; Widiger, 2011a, 2011b). The lack of bipolarity to the traits leads to the omission of clinically relevant traits and misplaced traits (within domains) (Pilkonis et al., 2011; Widiger, 2011a, 2011b). Several authors argued that the proposed trait structure did not correspond to the consensus "Big 4" and that the domains of compulsivity and schizotypy were not needed (Pincus, 2011; Widiger, 2011a, 2011b). Several authors also argued for the importance of including both normal and abnormal traits in *DSM-5* and believed that the FFM does a better job at representing important personality variation than the proposed new model (Costa & McCrae, 2010; Widiger, 2011a, 2011b). Finally, limitations and ambiguities in factor analytic methods to derive trait structures were mentioned by several authors (Clarkin & Huprich, 2011; Hallquist & Pilkonis, 2010).

GENERAL CRITERIA FOR PERSONALITY DISORDER

Integration of the general criteria for personality disorder into the diagnostic process has been viewed as an advance, by distinguishing normality and

abnormality separately from describing individual differences (Pincus, 2011). The general criteria for personality disorder in *DSM-IV-TR* were not supported by research. The constructs embedded in the proposed general criteria for *DSM-5* are consistent with research and many theories of personality disorder, including the interpersonal, but will require training to be rated reliably (Pincus, 2011). Costa and McCrae (2010) believed that the originally proposed definitions of impairment in self-identity contradicted data on the internal consistency and stability of self-reported personality traits.

Personality disorders should be defined by impairments in functioning and adaptation (not by extreme traits), but the originally proposed general criteria were viewed as too esoteric, inferential, and narrow (Pilkonis et al., 2011). Pilkonis et al. (2011) advocated for including constructs of agency, community, autonomy, achievement, self-definition (identity vs. confusion), capacity for attachment (intimacy vs. isolation), generativity, and prosocial engagement. Their proposal for general criteria would reflect (1) failure to achieve autonomy and self-direction (with objective markers) and inability to develop consistent and realistic representation of self, (2) failures in interpersonal relatedness manifest by inability to develop and maintain close relationships and general social integration; (3) failures in generativity manifest by inability to engage with purpose beyond self-interest and imposition of distress on others. All of the above would be rated separately and the clinician should be able to stop an assessment after establishing presence and severity of personality disorder. Clarkin and Huprich (2011) viewed the originally proposed general criteria as too onerous and lacking a coherent theme, but they believed that a more elaborated rating of severity of impairment in functioning combined with prototypes should be the core of clinical assessment.

Personality Disorders and *DSM-5* Metastructure

The *DSM-5* Task Force received conflicting proposals regarding the placement of personality disorders in a proposed revised metastructure of mental disorders intended to reflect recent research on spectrum relationships between disorders. The Task Force consequently charged an ad hoc Study Group with developing and analyzing all possible options.

The *DSM-5* Personality and Personality Disorder Work Group and the *ICD-11* group both have recommended retention of a reduced number of personality disorder types from those included in *DSM-IV-TR*. The Study Group discussed only the five specific types of personality disorder originally proposed for *DSM-5*: (1) antisocial/psychopathic (ASPD), (2) avoidant (AVPD), (3) borderline (BPD), (4) obsessive-compulsive (OCPD), and (5) schizotypal (STPD), plus the sixth residual personality disorder type, personality disorder trait specified (PDTS), which would replace PDNOS.

Three fundamental options were reviewed and analyzed by the Study Group; the analysis of these options led also to hybrid proposals.

(1) Distribute some or most personality disorder types, as they are currently proposed by the Work Group to other chapters of the classification,[3] thereby dissolving the class of personality disorders in *DSM-5*.

(2) Embed a trait metastructure throughout all the chapters, perhaps with similarity to personality disorder types mentioned in some chapters in the text, but with personality disorders residing entirely in their own chapter. This option included either the representation of currently proposed personality disorders as specified types or as combinations of pathological traits without type specification.

(3) Retain personality disorders in their own chapter as proposed by the Work Group but cross-reference or cross-list specific personality disorder types to other related disorder chapters.

A tension exists as to what is more important in grouping disorders in the metastructure: similarities of varying kinds and degrees between specific personality disorder types and disorders in other chapters (e.g., STPD and schizophrenia, ASPD and conduct disorder), or similarities between personality disorders themselves (e.g., self and interpersonal relatedness problems). Thus, any distribution plan that fully placed personality disorder types in other disorder spectra would violate the conceptual formulation of personality disorder as a coherent clinical entity. On the other hand, retaining a personality disorder chapter without any connection to other chapters weakens the *DSM-5* metastructure goal of linking disorders in spectra using a trait-based or dimensional structure. To the degree the metastructure tends toward one or the other end of these tensions, concomitant advantages and disadvantages are encountered. Likewise, dispositional trait dimensions are related both conceptually and empirically to much of psychopathology, not just to personality disorder. Yet personality disorder is unique in that personality characteristics are integral

to its definition. Thus, the strength of the linkage of traits to personality disorders inevitably may be different than for other classes of psychopathology.

The following tentative recommendations were made, built on these fundamental tensions: (1) The *DSM-5* should include an introductory section (not a disorder coding chapter) on traits and spectra describing the metastructure of disorders and personality traits, including explanation of how disorders of personality may relate to disorders of affect, cognition, and behavior (i.e., other clinical disorders). A multidimensional trait space exists for organizing mental disorders. *DSM-5* should describe this conceptualization succinctly and in a manner that has direct clinical applicability. This section would set the stage for further development of trait-dimensional structure in subsequent iterations of *DSM*. (2) To the extent that a spectrum approach is implemented (i.e., by distributing or cross-listing of personality disorder types), potential unintended implications for treatment must be communicated carefully. Thus, it would be important to make clear that a spectrum approach does not necessarily mean that everyone in the spectrum should get the same treatment. The purpose of a spectrum would be to highlight related but distinguishable disorders. (3) Option 1 (removing some personality disorder codes from a personality disorder chapter for distribution to other chapters, and possibly eliminating the personality disorder chapter) was not recommended; instead, it was recommended that a coding chapter on personality disorder be retained. Without it, the conceptual and empirical work unique to personality disorder, uniting the various types in relation to dysfunction of self and interpersonal relations would be lost. (4) Each chapter in the *DSM-5* should have explicit trait associations embedded into it as proposed in Option 2, so that each chapter contains a multiple trait accounting of its included disorders. This idea has very little "downside" other than potential controversy over particular trait associations. However, these would be directly amenable to ongoing empirical correction as the literature develops and continually improves. The personality disorder chapter also should list the traits related to each personality disorder type in a fashion that allows recognition of the parallelism between (a) the relations of traits to other disorders and (b) the relation of traits to personality disorder types. (5) Although the Study Group did not have resources to discuss it in depth, serious consideration should be given to adding IQ to the dimensional structure of individual differences in *DSM-5* and in the introductory chapter(s). This individual differences dimension has been in the *DSM* and is relevant to both developmental disorders and cognitive degenerative disorders, aiding in creating a comprehensive "trait" metastructure. (6) If personality disorder types are retained and not reduced to trait-based diagnosis, it is recommended that they be cross-listed or cross-indexed in the other chapters, to the extent possible, and that this be displayed in the metastructure. At minimum, these interrelationships would be described in the text, but a more formal cross-listing also should be considered. Controversy over placements may ensue, but the spectra relationships would be highlighted, while simultaneously retaining personality disorders in an integral placement in their own chapter.

Subsequent to this Study Group's deliberations, representatives from the Personality and Personality Disorders Work Group and the Schizophrenia and Other Psychotic Disorders Work Group discussed the placement of schizotypal personality disorder in the metastructure. It was tentatively agreed that STPD would be listed (and coded) with the schizophrenia disorders (as it is in *ICD-10*), despite its not being characterized by psychosis or a deteriorating course. Evidence of the neurobiological and genetic similarities between STPD and schizophrenia took precedence over the dissimilarities and the differences in differential diagnostic, treatment, and prognostic implications of STPD. This preference appears to contradict the goal of increasing the clinical utility of the *DSM* (Regier, Narrow, Kuhl, & Kupfer, 2009), in favor of its scientific agenda. In addition, with little or no discussion of the scientific or clinical pros and cons, antisocial personality disorder has been listed with the antisocial and disruptive behaviors in the current draft of the revised metastructure, leading to questions about the evidence base and decision-making process for *DSM-5*. The three other originally recommended personality disorders are currently in a separate personality disorder class, along with narcissistic personality disorder, but other *DSM-IV-TR* personality disorder types might be added during or after Phase I (see later) of the field trials. Metastructural issues and preliminary decisions are still under discussion and will need to be approved by the Task Force and by APA governance. The recommendation to cross-list or cross-index specific personality disorder types to more than one diagnostic class has not been acted on, as yet.

Conclusions

A new hybrid dimensional-categorical model for personality and personality disorder assessment

and diagnosis has been developed for *DSM-5* field testing. Criteria based on dimensional ratings of impairments in personality functioning and of pathological personality traits have been proposed for six specific personality disorders and for a residual category of personality disorder trait specified. The justifications for the proposed modifications in approach to diagnosing personality disorders include lack of specificity in the *DSM-IV-TR* definition of personality disorder, inadequate representation of personality disorder severity and arbitrary thresholds for diagnosis, excessive comorbidity among personality disorders, limited validity for some existing types, heterogeneity within types, and instability of current personality disorder criteria sets. The revision process has proceeded in a systematic and deliberate manner, based on literature support, data analyses, and practical experience using the model.

The levels of personality functioning are based on the severity of disturbances in self and interpersonal functioning. Disturbances in thinking about the self are reflected in dimensions of *identity* and *self-directedness*. Interpersonal disturbances consist of impairments in the capacities for *empathy* and for *intimacy*. Five broad personality trait domains (e.g., disinhibition and antagonism) are defined, as well as component trait facets (e.g., impulsivity and callousness). The personality domain in *DSM-5* is intended to describe the personality characteristics of all patients, regardless of whether they have a personality disorder. The assessment "telescopes" the clinician's attention from a global rating of the overall severity of impairment in personality functioning through increasing degrees of detail and specificity in describing personality psychopathology that can be pursued depending on constraints of time and information and on expertise.

Parts of proposal have generated considerable support from the personality disorder field (e.g., the personality disorder specific severity measure), while other parts (e.g., the reduced number of types, the trait domains and facets) have met with more criticism. The Personality and Personality Disorders Work Group has revised and simplified the proposal based on feedback received, but it has been waiting now for a number of months to begin to receive data from field trials before making the next set of revisions. Because data on reliability on all component parts of the model and some on feasibility and clinical utility are absent, all potential improvements are speculative. The Work Group fully expects at least one (or more) major reiteration of its revised model prior to final publication.

Future Directions

The next major step in the development of the *DSM-5* personality assessment and diagnosis model will be the *DSM-5* field trials, scheduled to begin in January 2011. The first stage of the field trials will be short-term and longer term test-test reliability studies of a large number of disorders, including personality disorders in approximately 3,000 patients recruited at large academic medical centers in the United States and Canada (Kraemer et al., 2010). Sites scheduled to evaluate the personality disorder model include the Menninger Clinic/Houston VAH, the Dallas VAH, the University of Pennsylvania, and the Center for Addiction and Mental Health in Toronto. In addition to the large academic medical centers, individual clinicians are being recruited to test the new proposals in the context of their individual practice setting. The academic center and physician practice network field trials ("Phase I") were expected to be finished by the end of April 2011, but the academic center field trials now have been extended until the end of September 2011, and the individual clinician field trials are just starting. After these data are analyzed, the Work Group plans to revise its proposal, post the revisions on the *DSM-5* Web site for comments, and prepare a version for a Phase II field trial expected to be conducted in early 2012. Based on this trial, final revisions will be made for recommendation to and approval of the APA Assembly and Board of Trustees in the fall of 2012. The final *DSM-5* manuscript is scheduled to be submitted for publication in December 2012 and available in print by May 2013.

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Notes

1. The switch from the Roman numeral V to the Arabic number 5 was deliberate. In this paper, the acronym *DSM-5* will be used except when *DSM-V* appears in the name of a book, article, or conference.

2. Heterogeneity among patients with the same disorder is not limited to personality disorders, but it applies to any disorder defined by a polythetic criteria set. In fact, the revised criteria for substance use disorder proposed for *DSM-5* (any 2 or more of 11 criteria) results in over 2,000 possibilities.

3. Schizotypal personality disorder was proposed to be distributed to the schizophrenic disorders, antisocial/psychopathic

to antisocial and disruptive behavior disorders, borderline to mood disorders, avoidant to anxiety disorders, and obsessive compulsive to obsessive compulsive spectrum disorders.

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CHAPTER 4

The Schedule for Nonadaptive and Adaptive Personality: A Useful Tool for Diagnosis and Classification of Personality Disorder

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Abstract

This chapter discusses new theoretical and research developments related to the Schedule for Adaptive and Nonadaptive Personality-2 (SNAP-2; Clark, Simms, Wu, & Casillas, in press) in the context of the forthcoming *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), particularly regarding personality disorder (PD). The theoretical underpinnings of dimensional taxonomies of personality traits and PD, and between personality and psychosocial functioning, are considered first. Next, recent SNAP-2 research is reviewed, most notably in the areas of dependency, impulsivity, and schizotypy. In aggregate, the findings suggest that existing SNAP-2 scales cover significant variance in these content domains, but that a SNAP-3 would benefit by increased coverage of each, specifically active/emotional dependency, carefree/-less behavior, and schizotypal disorganization. Information about additional SNAP versions for informant ratings and adolescent personality/PD, respectively, is provided. Finally, the utility of a program of research elucidating relations between personality and functioning is presented.

Key Words: SNAP, SNAP-2, *DSM-5*, personality traits, personality disorder, psychosocial functioning, dependency, impulsivity, schizotypy, informant ratings, adolescent personality

As is well known, a pivotal event in the history of the diagnosis of personality disorder (PD) was the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (*DSM-III*; American Psychiatric Association, 1980), which adopted a multiaxial classification system that placed PD on a separate "Axis II," distinct from "Axis I" clinical syndromes (e.g., schizophrenia, depression and anxiety disorders, and substance abuse). PD was conceptualized as a finite set of distinct categorical entities (although the inclusion of a PD–Not Otherwise Specified diagnosis actually allowed for infinite variation), which carried the implication that the diagnoses were internally homogenous natural categories, and that meaningful cross-category distinctions could be made. To their credit, the framers of the *DSM-III* PD diagnoses acknowledged that this was not entirely true, noting that, frequently, finding "a single, specific Personality Disorder that adequately describes the individual's disturbed personality functioning . . . can be done only with difficulty, since many individuals exhibit features that are not limited to a single Personality Disorder" (APA, 1980, p. 306); accordingly, multiple PD diagnoses were to be made if the diagnostic criteria were met for each.

The placement of PD on a separate axis in *DSM-III* clearly had some important positive effects. In particular, more clinicians and researchers in both psychology and psychiatry became interested in personality pathology in its own right, and knowledge about PD increased dramatically over the

next 30 years. Professional and lay societies devoted to the advancement of knowledge about PD and its treatment sprung up and thrived and, for example, a conference in Berlin focused on borderline PD drew over a 1,000 attendees from around the world in 2010.

However, as a result of this explosion of knowledge, considerable evidence now challenges several key tenets of the *DSM* system: (1) That comorbidity of PD within its own Axis and with Axis I pathology are roughly equal (Clark, 2005b) challenges the notion that PD is qualitatively distinct from Axis I clinical syndromes. (2) The high degree of change found in *DSM* PD diagnoses over 2- and 4-year periods (Grilo et al., 2004; Shea et al., 2002) challenges the simple view of PD as highly stable. Perhaps most important, (3) the validity of the *DSM* PD categorical diagnoses is challenged by several robust findings: (a) There is considerable heterogeneity among individuals in each PD category and (b) within-PD comorbidity is rampant (e.g., Clark, 2007; Dolan, Evans, & Norton, 1995; Fossati et al., 2000; Widiger & Trull, 2007). (c) With the possible exception of schizotypal PD, taxometric research has found the *DSM* PDs to be dimensional rather than taxonic (Haslam, in press), and (d) sophisticated latent class analyses on a large and diverse dataset did not reveal robust PD entities (Eaton, Krueger, South, Simms, & Clark, 2011) either within or outside the *DSM* system.

Fortunately, the expansion of PD research over the past three decades also has provided information useful in developing an empirically based trait-dimensional PD diagnostic system. For example, we now know that PD can be well modeled by the same set of traits and trait structure that comprise normal range personality (see Samuel & Widiger, 2008, for a metaanalytic review), that personality and psychopathology are inherently interrelated (see Krueger & Tackett, 2006, for a review), and that both can be fit into a single integrated structure (although, admittedly, many details of the latter are yet unknown; Clark, 2005b). However, it also became clear that there were important conceptual and empirical issues that needed to be addressed in the process of implementing a fully dimensional trait-based model. We discuss each of these briefly, and then devote the rest of the chapter to describing the Schedule for Nonadaptive and Adaptive Personality (SNAP; Clark, 1993) and its second edition, SNAP-2 (Clark, Simms, Wu, & Casillas, in press), a dimensional measure of personality traits relevant to PD.[1]

Issues That Need to Be Addressed by Any Personality Disorder Model

A number of issues need to be addressed by any model for assessing PD. Whereas all of these issues encompass both conceptual and empirical aspects, we divide them for the purposes of our discussion, based on the degree of conceptual clarity and the status of measurement in the field. When the conceptual aspects of an issue remain relatively unclear and the measurement issues relatively undeveloped, we consider them conceptual challenges, whereas when the primary challenges are measurement based, we discuss them as empirical challenges.

Conceptual Challenges

PERSONALITY FUNCTIONING AND CORE PERSONALITY DISORDER PATHOLOGY

Allport (1937) theorized that "personality 'is' something and personality 'does' something" (p. 48). In the 75 years since then, work in what personality "is" (e.g., trait structural models) has dominated the field. Recently, however, interest has emerged in understanding in what personality "does," that is, the *function* of personality and *how* personality serves to adapt individuals' behaviors to their situations (Parker et al., 2002; Ro & Clark, 2009). The "does" aspect of personality is particularly important as there now is widespread agreement that the existence of maladaptive traits alone is insufficient for conceptualizing personality pathology (see Clark, 2007). At least three measures of personality functioning have been developed (Livesley, 2010; Parker et al., 2004; Verheul et al., 2008), but research in this area is still in its infancy, including how personality functioning relates to other kinds of psychosocial functioning and to personality traits (Ro & Clark, 2009).

The question of what constitutes personality dysfunction arises naturally upon considering the function of personality, and current conceptualizations and operationalizations of PD, including the *DSM-IV*, are inadequate with regard to the core dysfunction of PD (Livesley, Schroeder, Jackson, & Jang, 1994; Livesley, 1998). A consistent theme in the literature is that personality pathology reflects dysfunction in both the self-system and in relationships with other individuals and society in general (e.g., APA, 1994; Bender, Morey, & Skodol, 2011; Parker et al., 2002, 2004; Verheul et al., 2008), but relatively little empirical work has been done on the issue of core PD dysfunction. Moreover, although the issues of core PD dysfunction and personality traits are clearly intertwined, to date the former has been considered primarily conceptually and

the latter by empirical researchers who have largely ignored core PD dysfunction except as it is inherent in extreme traits. As a result, we lack a full understanding of—including how to assess—the fundamental, common elements that characterize malfunctioning personality in general, distinct from maladaptive-range traits, about which we know a great deal from abundant research into their empirical assessment.

Taking an evolutionary perspective, Livesley and Jang (2000) theorized that severe personality pathology reflects a tripartite failure of three adaptive systems: a "self-system" (i.e., development of a stable concept of self and, correspondingly, of others), and two "other-systems"—the capacity for close personal relations and intimacy, and the ability to function effectively at a societal level—which together lead to inability to handle major life tasks. Milder forms of personality pathology may represent either lesser degrees of dysfunction in these systems and/or dysfunction in only one or two systems rather than all three. This formulation provides a theoretical basis for linking the *functional* aspect of personality (what personality *does*) with the descriptive aspect of personality (what personality *is*, i.e., personality traits). Specifically, we can postulate that the self- and other-systems describe the functional aspect of personality, and that adaptive-range personality traits evolved evolutionarily to fulfill the functions of modulating healthy self-systems and interpersonal/social systems to develop a sense of personal cohesion and goal-oriented behavior, to form meaningful relationships, and to function at a societal level—in effect, Freud's "lieben und arbeiten," to love and to work.

Maladaptive-range traits interfere with successful development and thus may signal dysfunction in self and interpersonal systems. However, under certain environmental conditions, a person may develop functional self and interpersonal systems despite having maladaptive-range traits. Thus, although extreme traits are always abnormal in a statistical sense, they do not per se constitute PD, so a determination of PD requires a two-pronged assessment of personality pathology, including both maladaptive-range personality traits and impaired personality functioning (see also Livesley, 1998; Livesley et al., 1994). Given our current relatively low-level state of both conceptualization and measurement of personality (dys)function per se, attempts to work within this framework necessarily will be crude. Nonetheless, the *DSM-5* Personality and PD Work Group has incorporated this theoretical framework into their proposed reformulation of PD diagnosis by requiring both adaptive failure in self and interpersonal domains and maladaptive traits for a PD diagnosis.

Note that this conceptualization is consistent with Wakefield's concept of *harmful dysfunction* (Wakefield, 1992), which also takes an evolutionary perspective. In addition to such dysfunction (i.e., personality pathology characterized by maladaptive traits and personality dysfunction), Wakefield's definition of a disorder posits that a dysfunction must also be *harmful,* meaning that it must "impinge harmfully on the person's well-being as defined by social values and meanings" (Wakefield, 1992, p. 373). How to assess the degree of *harmfulness* is a daunting question, but one possibility is how the dysfunction is reflected in the level of individuals' *disability*. This conceptualization aligns with another "paradigm shift" that is occurring in relation to *DSM-5*: separating assessment of psychopathology per se (i.e., dysfunction within the individual reflected in symptoms—in the case of PD, in dysfunctional self and interpersonal systems) from that of its consequences, assessed as disability.

Although information about both disability as well as symptoms may be needed for clinical decision making, confounding these two domains of individual difficulties, as they have been in *DSM-III* through *DSM-IV*, has impeded progress in understanding the underlying processes and mechanisms through which psychopathology develops and is maintained. Thus, separating their assessment is an important development in *DSM-5.* Whether both should be required for a diagnosis of disorder, as postulated by Wakefield and as is the case currently in the *DSM*, or whether disorder should be diagnosed only on the basis of dysfunction with information about harmfulness/disability used to determine the level and type of care remains an open question.

STABILITY AND INSTABILITY

Emerging empirical evidence suggests that PD may encompass not only more stable traits but also more changeable, that is, "state" elements, and both may need to be accounted for to characterize PD completely (e.g., Clark, 2007, 2009; McGlashan et al., 2005; Verheul et al., 2008; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005). However, we still lack both theoretical and measurement models for these unstable elements that may be an aspect of PD. That is, we do not yet have either a coherent conceptualization of PD that accounts for the observed instability or instruments

designed to measure these more transient elements, other than those developed to measure "Axis I" symptomatology. It may be that the instability observed in individuals with PD is epiphenomenal, for example, reflecting comorbid symptoms that are not inherent to PD, or it may be simply the result of unreliable measurement instruments. The latter possibility is suggested by the fact that, although individuals' PD diagnoses have been shown to be unstable (McGlashan et al., 2005; Shea et al., 2002; Zanarini et al., 2005), their psychosocial functioning is highly stable (Skodol, Pagano et al., 2005; see also Clark, 2009).

PERSONALITY IN RELATION TO OTHER TYPES OF PSYCHOPATHOLOGY

As mentioned earlier, it is now well established that personality can be conceptualized as foundational for a great deal of psychopathology (e.g., Clark, 2005b; Krueger & Tackett, 2006). Trait neuroticism is an extremely important personality trait, in that it is nearly a universal dimension underlying mental disorders (Lahey, 2009). Thus, it is likely that at some future point, we will develop a "grand unified theory," to borrow a term from the physicists, encompassing these interrelated domains. This future is contemplated in considerations of the "metastructure" of *DSM-5* (see Andrews et al., 2009), and it is mentioned here only to note that developing a trait-dimensional model for PD may be only the beginning of a much broader paradigm shift, so it will serve the field well to be mindful of this fact as we move forward in developing a new model for diagnosing PD.

One possibility that is suggested by juxtaposing the issue of PD stability/instability and a larger personality-psychopathology integration is that a key difference between PD and other types of psychopathology may be more quantitative than qualitative, specifically, the *relative* importance of stable personality dimensions and more transient symptoms, respectively.

MISALIGNMENT OF *DSM'S* PERSONALITY DISORDER DEFINITION VIA TRAITS AND DIAGNOSIS VIA CRITERIA

Many researchers have advocated replacing the current PD diagnostic system with a dimensional, trait-based system, which has been equated to a seismic shift (Widiger & Trull, 2007). However, it is interesting and important to note that, beginning with *DSM-III*, PD actually *has* been defined via personality traits—"enduring patterns of perceiving, relating to, and thinking about the environment and oneself [that] are exhibited in a wide range of important social and personal contexts" (APA, 1980, p. 305)—a definition that would not be out of place in a personality psychology textbook. Specifically, a PD was to be diagnosed when the individual's traits "are inflexible and maladaptive . . . cause either significant impairment in social or occupational functioning or subjective distress . . . are typical of the individual's long-term functioning, and are not limited to discrete episodes of illness" (APA, 1980, p. 305).

Thus, the magnitude of a shift to a trait-based dimensional system logically would appear to lie not with the trait-based aspect per se, but with either the *particular* trait-based system to be used and/or *how* traits were used to diagnose PD. Importantly, the way in which PD has been diagnosed since *DSM-III* is not well aligned with its trait-based definition: Although recent *DSM*s defined PD via traits, they operationalized PD diagnosis using the same *criterion*-based system that is used for "Axis I" clinical syndromes. However, criterion-based measures are better suited to categorical than dimensional measurement models and, importantly, are inconsistent with typical trait dimensional measurement models, which rely on sampling reliably from the universe of potential exemplars of the target trait. Moreover, the mapping between the traits that conceptually defined varieties of PD and the diagnostic criteria that operationalized them was quite inconsistent, both within a given *DSM* version and over time across versions.

Specifically, in *DSM-III*, the traits that comprised each of what were considered individual disorders were provided only for some PDs (e.g., Paranoid), whereas for others (e.g., Dependent), they had to be inferred from the criteria. Beginning in *DSM-III-R*, the traits characteristic of each specific PD were listed before each criterion set and, further, *DSM-IV* made greater use of terminology consistent with personality-trait research. For example, *DSM-III-R* and *DSM-IV*, respectively, characterized Paranoid PD as a "tendency . . . to interpret the actions of people as deliberately demeaning and threatening" (APA, 1987, p. 339), and as "distrust and suspiciousness of others such that their motives are interpreted as malevolent" (APA, 2000, retrieved from online version), the latter thus using well-researched trait language that could facilitate linkage between PD and personality research. Although each new version clearly took a positive step in the direction of aligning the definition and operationalization of PD, the

alignment remains incomplete, which we consider here as a conceptual challenge. However, this issue has empirical aspects as well, to which we now turn.

Empirical Challenges

CRITERION-BASED MEASUREMENT

Since *DSM-III-R*, all PDs have been diagnosed polythetically, meaning that only a subset of the criteria (e.g., five of nine) are required for diagnosis. However, there are three empirical difficulties with this system. First, if the pattern comprising a PD contains only one element, as in Paranoid PD, then the criterion set functions like a trait scale, such that making a diagnosis of Paranoid PD is equivalent to saying that individuals endorsing four to seven (out of seven) items on the listed personality-trait scale have Paranoid PD. Typically in personality assessment, an individual's scale score must be 1.5 to 2 standard deviations above the population mean to be considered a high score, but seven-to-nine-item scales are of insufficient length to establish such cut points with adequate precision (i.e., confidence intervals) for effective clinical decision making. Moreover, the *DSM* PD cut points have been set without any reference to population norms.

Second, the characteristic pattern of most *DSM*-defined PD types encompasses multiple elements, yet individuals may be diagnosed with those PDs without exhibiting all their elements. For example, schizotypal PD includes "social and interpersonal deficits," "cognitive or perceptual distortions," and "eccentricities of behavior," yet a person can be diagnosed with this PD type through meeting criteria that characterize only the latter two traits, that is, without meeting any of the criteria that reflect social and interpersonal deficits. This is one aspect of the *DSM* system that allows the well-documented heterogeneity within a given PD diagnosis. Furthermore, the problem of measurement imprecision discussed earlier is exacerbated if the pattern comprising a particular PD type has several traits, resulting in "scales" of only two to three items per trait. Even if an individual meets the *DSM* criteria for all relevant traits, the diagnosis is based on a highly unreliable and imprecise measure.

Third, not all PD criteria are clear manifestations of the defining pattern. For example, paranoid PD's criterion 5—"bears grudges, i.e., is unforgiving of insults, injuries, or slights"—is not clearly and directly related to distrust and suspiciousness. Similarly, it is not clear how both "displays rapidly shifting and shallow expression of emotions" and "shows . . . exaggerated expression of emotion" can be manifestations of "excessive emotionality." Typically, personality scale development involves several rounds of (1) trait conceptualization, (2) operationalization, and (3) data collection, analysis, and revision to create homogeneous measures of the target trait (Clark & Watson, 1995). The heterogeneity of many of the *DSM-IV* PD criterion sets suggests that the requisite research was not conducted, again contributing to the oft-observed heterogeneity within PD diagnoses. Thus, even if the *DSM-IV* diagnoses were continued in *DSM-5* with their current defining patterns and still used a criterion-based system for PD diagnosis, considerable work is needed (a) to align the criteria with the traits they are supposed to assess, (b) to ensure that an individual diagnosed with a given PD manifests *all* its component traits, and (c) to ensure reliable and valid measurement of all traits via the criteria.

INADEQUATE RANGE AND CONTENT

Owing to dissatisfaction with the inadequacies of *DSM-III* through *DSM-IV*, researchers who advocated development of a dimensional trait-based PD diagnostic system using well-established trait measurement models started exploring alternatives, including both consideration of existing dimensional approaches as well as developing potentially viable alternatives. The most widely studied and advocated existing personality trait model is the "Big Five" or Five-Factor Model (FFM), which is operationalized in two research streams: the seminal "lexical tradition," championed by John and Goldberg, and the work of Costa and McCrae (see McCrae & John, 1992, for overviews and history of both).

However, it has become clear that these models, developed to assess normal-range personality, do not—in their current forms—reflect the full range of PD-relevant personality traits in terms of either severity or content (e.g., Krueger, Eaton, Clark et al., 2011; Watson, Clark, & Chmielewski, 2008). Given the dominance of the FFM and current instruments used to assess it, one reason for the apparent reluctance of some clinicians to embrace trait-dimensional models of PD may be concern that certain clinically relevant traits (e.g., dependency) are not well represented in normal-range personality trait models. Thus, adopting such a model without modification could reduce the clinical utility of the domain.

However, it has been argued cogently that trait models that were developed originally to assess the normal range of personality could be extended in

both range and content (e.g., Widiger & Mullins-Sweatt, 2009). Indeed, the latest *DSM-5* proposal—discussed further subsequently—which was developed explicitly to focus on the maladaptive range of personality traits, arguably can be characterized as an exemplar of the FFM (Krueger, Eaton, Derringer et al., 2011). Moreover, other researchers have developed alternative instruments specifically to assess traits in the maladaptive range and, although these other measures were not developed within the FFM tradition, they have been shown to be compatible with the FFM (e.g., Clark & Livesley, 2002; Clark, Livesley, Schroeder, & Irish, 1996; Samuel, Simms, Clark, Livesley, & Widiger, 2010; Widiger, Livesley, & Clark, 2009). These include the SNAP, the measure that is the focus of this chapter and discussed subsequently in more detail. Widiger and Simonsen (2005) provide an excellent overview of all of the field's existing models and measures.

NATURE OF THE DIMENSIONALITY OF TRAITS

Another empirical measurement issue that has confronted PD assessment researchers is the nature of the dimensionality of traits comprising the model, of which there are at least five possibilities conceptually, although we are unaware of any examples of the final two (see also Krueger, Eaton, Clark et al., 2011). (1) Traits may be bipolar with regard to maladaptivity, ranging from one type of maladaptivity at one extreme through normality to another type of maladaptivity at the other extreme (e.g., a dimension ranging from extreme impulsivity through normality to extreme inhibition). (2) Traits may be bipolar in nature but unipolar with regard to maladaptivity, ranging from maladaptivity at one extreme through normality to highly adaptive (i.e., "supernormal") at the other extreme (e.g., ranging from extreme rigidity through normality to highly adaptive to changing circumstances at the other extreme). (3) Traits may be essentially unipolar in nature, ranging only from extreme maladaptivity to normality (e.g., ranging from extreme suicidality to the normal lack of suicidal ideation or impulses). We are unaware of empirical exemplars of the remaining two possibilities, so we offer them only for the sake of completeness and do not discuss them further. (4) Traits may be bipolar in nature, ranging from highly adaptive at one extreme through normality to a different kind of high adaptivity at the other extreme. (5) Traits may unipolar in nature, ranging only from extreme high adaptivity to normality.

Conscientiousness (C) is an example of when the empirical dimensionality of a trait is consequential. If conscientiousness fit the first model, then it would range from extreme, maladaptive "overconscientiousness"—for example, rigid perfectionism or compulsivity—through the normal range of high to low conscientiousness, and on to extreme, maladaptive "underconscientiousness," that is, irresponsible, rash behavior. In contrast, if conscientiousness fit the second model, then it would range from extreme and highly *adaptive* conscientiousness to extreme and highly *maladaptive* lack of conscientiousness (again, irresponsibility), and perfectionism/compulsivity then would represent a *different* dimension that was not simply the opposite of irresponsibility and that would have to be measured separately.

Conscientiousness might also fit the third model, ranging from extreme lack of conscientiousness (irresponsibility) up to the "normal range" of high conscientiousness, meaning that it is impossible to find indicators of very high conscientiousness (i.e., beyond 2 SDs above the population mean) *that lie on the same dimension* as extremely low and normal-range conscientiousness. In such a case, compulsivity again would have to be measured as a separate dimension.[2] Similar possibilities exist for the FFM domains of neuroticism, extraversion, and agreeableness, whereas evidence suggests that Openness fits the third model. Specifically, the postulation that extreme Openness is part of schizotypy has not been supported empirically. Rather, schizotypy is a sixth dimension that must be added to the FFM for comprehensive assessment of normal- and maladaptive-range personality (Watson et al., 2008).

Research into the nature of personality trait dimensionality requires using item response theory (IRT)-based approaches and is in its relative infancy. The first study of this type that we are aware of (Simms & Clark, 2005) was published only a few years ago. Simms now has a large National Institute of Mental Health–funded research grant to apply an IRT-based approach on a major scale to the full range of normal to maladaptive traits, and reports finding, to date, that most traits are *not* fully bipolar, that is, ranging from either one maladaptive pole to another, or from one type of super-normality to another. Rather, it seems that most traits have only one clearly maladaptive end, with the opposite end reaching only to low (or high—depending on the trait's valence) normalcy. Importantly, research into traits in the highly adaptive and maladaptive ranges, respectively, has been conducted largely independently, although each has been studied in relation to the normal range, so the question of whether all of the dimensional possibilities discussed earlier

exist—and which type of dimensionality characterizes which traits—remains to be explicated fully.

The SNAP

The SNAP/SNAP-2 (Clark, 1993; Clark et al., in press) is a self-report measure assessing personality traits across the adaptive-to-maladaptive range to capture personality pathology in a dimensional manner. The instrument consists of 390 items with 7 validity indices to identify response biases and other types of invalid responding, 15 trait dimensional scales that form a three-factor higher order structure of Negative Emotionality (NE; aka neuroticism)—negative temperament, mistrust, manipulativeness, aggression, self-harm, eccentric perceptions, and dependency; Positive Emotionality (PE; aka extraversion)—positive temperament, exhibitionism, and entitlement versus detachment; and Disinhibition versus Constraint (DvC)—dishinibition and impulsivity versus propriety and workaholism—as well as 10 scales to assess the *DSM-IV* PD diagnoses, scored three ways: dimensionally, by number of criteria, and dichotomously. Table 4.1 provides a brief description of each validity and trait scale. We focus only on the trait scales in this chapter.

The SNAP was developed using a "bottom-up" approach, that is, without a priori determination of the instrument's lower or higher order dimensions, guided instead by reiterated rounds of item-pool development and empirical testing that led to item-pool revision, and so on. The original basis for scale development was trait descriptors derived from *DSM-III* and *DSM-III-R*, as well as from the clinical literature on personality pathology (see Clark, 1990), which led ultimately to 15 lower order scales. When these had been finalized, factor analyses revealed the three higher order factors named earlier. These factors have replicated clearly in college-student, community, military, and patient samples (total $N = 8{,}690$; Eaton et al., 2011). Thus, the SNAP corresponds well to the "Big Three" model of Eysenck (1990) and Tellegen (1985), while clarifying component lower order dimensions of these three broad higher order traits.

Simms and Clark (2006) provided a detailed introduction of the SNAP-2 (Clark et al., in press), so rather than reiterating this material, we provide this summary introduction, followed by a discussion of the SNAP in the context of the proposed *DSM-5* PD diagnostic system, and then focus on developments since the previous chapter. Specifically, we discuss recent research in our lab that was conducted for the purpose of clarifying and furthering our understanding of the lower order facets of trait dependency (Morgan & Clark, 2010), impulsivity (Sharma, Morgan, Kohl, & Clark, unpublished data), and oddity/schizotypy/psychoticism (Stringer, Kotov, Robels, Schmidt, Watson, & Clark, unpublished data). Also, because understanding personality pathology in both developmental and interpersonal contexts is critical, we discuss two versions of the SNAP-2: The Youth version (SNAP-Y; Linde, 2001) and the Other Description Rating Form (SNAP-ORF; Harlan & Clark, 1999; Ready & Clark, 2002; Ready, Watson, & Clark, 2002) for use by informants (e.g., a spouse or friend).

Psychometric Properties

The SNAP trait scales' internal consistency coefficients show them to be quite reliable in college, community, and patient samples, averaging .80 to .84, with ranges from .76 (manipulativeness) to .92 (negative temperament). Further, retest correlations show them to be appropriately stable: In college samples with 1–2 month retest intervals, reliability averaged .80; in community adults with retest intervals from 7 days to 4.5 months, the average was .87; short-term retest in patients was .81, whereas pre-post treatment retest correlations, averaging .70, indicated moderate change.

Gender differences that are robust across various patient and nonpatient samples have been found on negative temperament (women higher), plus disinhibition and manipulativeness (men higher). In addition, community and patient women score higher on dependency and propriety, whereas community and college men score higher on impulsivity. Effect sizes are small, however, except for a medium effect size on disinhibition. Other gender differences have not replicated across sample type, but four small effects replicated in two college samples: men score higher on aggression, low self-esteem, and detachment, and lower on positive temperament.

SNAP and Dimensional Assessment of Personality Pathology in Relation to the DSM-5

The current *DSM-5* proposal is for five trait domains (i.e., Negative Affectivity, Detachment, Antagonism, Disinhibition vs. Compulsivity, and Psychoticism) represented by 25 trait facets (e.g., emotional lability, restricted affectivity, callousness, impulsivity, and eccentricity, respectively) as part of a more generally dimensional approach to PD diagnosis (see Skodol, Chapter 3, this volume).

Table 4.1 The SNAP-2 Trait and Validity Scale Names, Abbreviations, and Descriptions

Negative Temperament (NT)	Tendency to experience a wide range of negative emotions and to overreact to the minor stresses of daily life
Mistrust (MST)	Pervasive suspicious and cynical attitude toward other people
Manipulativeness (MAN)	Egocentric willingness to use people and to manipulate systems for personal gain without regard for others' rights or feelings
Aggression (AGG)	Frequency and intensity of anger and its behavioral expression in aggression
Self-Harm (SFH)	Two strongly related subscales: low self-esteem and suicide proneness
Eccentric Perceptions (EP)	Unusual cognitions, somatosenory perceptions, and beliefs
Dependency (DEP)	Lack of self-reliance, low self-confidence in decision-making, and preference for external locus of control
Positive Temperament (PT)	Tendency to experience a wide variety of positive emotions and to be pleasurably, actively, and effectively involved in one's life
Exhibitionism (EXH)	Overt attention seeking versus withdrawal from others' attention
Entitlement (ENT)	Unrealistically positive self-regard; the belief that one is—and should be treated as—a special person
Detachment (DET)	Emotional and interpersonal distance
Disinhibition (DvC)	Tendency to behave in an under- vs. overcontrolled manner
Impulsivity (IMP)	The specific tendency to act on a momentary basis without an overall plan
Propriety (PRO)	Preference for traditional, conservative morality vs. rejection of social rules and convention
Workaholism (WRK)	Preference for work over leisure time; perfectionism; self-imposed demands for excellence
Validity Indices	
Variable Response Inconsistency (VRIN)	Inconsistency related to random responding, carelessness, poor reading ability, etc.
True Response Inconsistency (TRIN)	Acquiescence vs. denial; tendency to respond "True" vs. "False," regardless of the content
Desirable Response Inconsistency (DRIN)	Tendency to respond to items on the basis of their social desirability features rather than their content
Rare Virtues (RV)	Self-presentation in a unrealistically favorable manner
Deviance (DEV)	Self-presentation as broadly deviant
Invalidity Index (II)	Overall index of profile invalidity based on five scale scores above
Back Deviance (BDEV; SNAP-2 only)	Careless, inconsistent, or deviant responding on the test's second half

Although the *DSM-5* trait set has not been finalized, its broad outlines have emerged, and, as shown in Table 4.2, the SNAP maps well onto the current proposal. Specifically, close matches exist for 21 of the 25 proposed facets, and existing SNAP scales have similar content—and are likely, therefore, to correlate moderately with—three others. Thus, the SNAP lacks only one proposed facet, Separation Insecurity, and, interestingly, this lacuna also was revealed in our own research, discussed later (Morgan & Clark, 2010).

In this context, the SNAP is one of the most comprehensive existing measures of maladaptive-range personality traits. It has strong, theory-based relations with other dimensional measures such as the Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley & Jackson, 2010), the MMPI-2, and different measures of the FFM (see Clark et al., in press). For example, factor analytic studies have shown that both the SNAP and DAPP-BQ correspond well to four domains (i.e., Neuroticism, Extraversion, Agreeableness, & Conscientiousness) of the FFM (Clark et al., in press; Schroeder, Wormworth, & Livesley, 1992) and that the SNAP and DAPP-BQ also overlap significantly in these four domains (Clark & Livesley, 2002; Clark, Livesley, Schroeder, & Irish, 1996; Markon, Krueger, & Watson, 2005).

In one of the most extensive PD research projects ever—the Collaborative Longitudinal Personality Study (CLPS; Gunderson et al., 2000)—the SNAP's stability and ability to predict functional outcomes was compared to that of *DSM-IV* categorical diagnoses, *DSM-IV* dimensional assessment via criteria counts, and the domains and facets of the Revised NEO Personality Inventory (NEO PI-R; Costa & McCrae, 1992). The CLPS followed patients with at least one of four major *DSM-IV* PD diagnoses (i.e., Borderline, Avoidant, Schizotypal, and Obsessive Compulsive), as well as patients diagnosed with major depressive disorder but no PD, for 10 years, repeatedly assessing personality traits (both adaptive and maladaptive-range traits), psychosocial functioning outcomes (the Global Assessment of Functioning [GAF; APA, 2000], Longitudinal Interval Follow-up Evaluation's psychosocial functioning domain, LIFE-RIFT; Keller et al., 1987), and other meaningful outcomes (e.g., depressive symptoms).

Results strongly support the SNAP's utility in this context. First, concurrently, the SNAP dimensions explained unique aspects of specific PDs (e.g., self-harm, negative temperament, and impulsivity related to Borderline PD; mistrust and eccentric perceptions to Schizotypal PD; Morey et al., 2003). Second, the SNAP scales showed strong 10-year stability correlations, corrected for short-term dependability, ranging from .57 (Dependency) to .97 (Disinhibition) with a mean stability coefficient of .73, exactly the same as that of the NEO PI-R (Costa & McCrae, 1992). Regarding predictive validity, at 4 years post baseline, the SNAP predicted functional outcomes (the average of the GAF, LIFE-RIFT, and other indices) as well or better than either the categorical or dimensional *DSM* assessment methods or the FFM model (both domain and facet levels), and significantly incremented the explanatory power of the FFM (Morey et al., 2007). Finally, at 6, 8, and 10 years post baseline, the SNAP predicted functional outcomes as well as the *DSM* and FFM models *combined* (hybrid model; Morey et al., 2011).

Thus, the SNAP is one of the strongest available measures of maladaptive-range personality traits that could be used to assess the trait domains and facet dimensions proposed by the *DSM-5.* Nonetheless, it is not without limitations. For example, its facet-level coverage is comprehensive, but not complete. Moreover, it assesses only maladaptive range traits, not personality functioning per se, nor disability. In the remainder of this chapter, we describe recent research findings that help clarify what is needed at the facet level, introduce alternative versions of the SNAP, and discuss what more is needed to advance PD assessment using the SNAP.

Recent Research Findings on the SNAP

The higher order (domain) structure of personality is well understood and highly robust (e.g., Markon et al., 2005; Widiger & Simonsen, 2005), but far less is known about the lower order (facet) level, yet trait facets differentiate among various PD presentations better than do trait domains (e.g., Reynolds & Clark, 2001; Morey et al., 2002) and, accordingly, facet-level information has been shown to have greater clinical utility than the *DSM-IV* categories or domain-level traits (Samuel & Widiger, 2006; Sprock, 2002). Thus, to advance the use of traits within a PD diagnostic system, understanding and developing a comprehensive set of trait facets is a pressing need (Clark, 2007). Later we describe several studies that were conducted in this regard to clarify the SNAP's facet-level structure in trait dependency, impulsivity, and oddity.

Dependency

Dependency is a common concept among both lay people (e.g., I am dependent on her; he needs

Table 4.2 Mapping of SNAP Scales With Proposed *DSM-5* Trait Scales (as of May 2012; *DSM-5* Model Subject to Change)

SNAP Scale	*DSM-5* Domains/ Facets (*r*)	Brief Facet Definitions
Negative Affectivity		
NT	Emotional Lability (.74)	Gets very emotional easily; mood changes often without good reason
NT	Anxiousness (.79)	Worries about everything; often on edge, fears that bad things will happen
NT/ DEP	Separation Insecurity (.54/ .42)	Cannot stand being alone; fears being alone more than anything
—[a]	Perseveration	Has difficulty changing approach to tasks, even when it is not working
DEP	Submissiveness (.52)	Does whatever others say they should do
AGG	Hostility[b] (.80)	Has a very short temper, easily becomes enraged
Detachment		
DET	Restricted Affectivity[c] (.48)	Does not get emotional; any emotional reactions are brief
Self-harm	Depressivity (.77)	Feels worthless/useless, hopeless; feels life is pointless
MIS	Suspiciousness[c] (.80)	Feels like always getting a raw deal, feels betrayed, even by friends
DET	Withdrawal (.82)	Dislikes being around or spending time with others
PT	Anhedonia (-.64)	Does not enjoy life; finds nothing interesting
(DET)	Intimacy Avoidance (.42)	Is not interested in and avoids intimate, romantic relationships
Antagonism		
MAN	Manipulativeness (.63)	Sees self as good at conning others or otherwise making them do what they want
MAN/DvC	Deceitfulness (.70/ .66)	Willing to lie or cheat to get ahead or what they want
ENT	Grandiosity (.54)	Feels superior to and more important than others
EXH	Attention Seeking (.71)	Likes to draw attention, be noticed, stand out in a crowd
AGG/ DvC/ MAN	Callousness (.57/ .57/ .55)	Does not care if hurts others or their feelings
Disinhibition		
IMP/ DvC	Irresponsibility (.59/ .58)	Careless with own and others' property, does not follow through on obligations
IMP	Impulsivity (.72)	Acts on impulse without considering the consequences
WRK	*Rigid Perfectionism (.53)*	*Insists on absolute perfection in everything, extreme orderliness*
—[a]	Distractibility	Has trouble focusing on tasks; cannot concentrate
DvC/IMP	Risk Taking (.59, .55)	Likes taking risks; does dangerous things without concern

(*continued*)