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Personality Disorders: Current Conceptualizations and Challenges

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Abstract

The personality disorders are said to be at the vanguard in the shift to a dimensional model of classification, as exemplified in the Alternative Model of Personality (AMPD) presented in Section III of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) for emerging models and in the 11th edition of the *International Classification of Diseases* (ICD-11). Considered herein are some limitations and challenges. For the DSM-5 AMPD trait model, these include problematic placements, inadequate coverage, perceived complexity, and lack of cutoff points. For the DSM-5 AMPD Level of Personality Functioning (LPF), they include the complexity, the questionable presumption that the LPF defines the core of personality disorder, the presumption that the LPF identifies what is unique to the personality disorders, and the premise that the LPF is distinct from the maladaptive traits. Limitations and challenges of the ICD-11 model are the absence of lower-order facet scales and the fact that only the level of severity is required. This review suggests that the trait of depressivity belongs with negative affectivity and suspicion belongs within antagonism, that maladaptive traits from all 10 poles of the five domains should be provided, and that cutoff points based on social-occupational impairment and/or distress should be provided. The review summarizes research that questions whether the LPF represents the core of personality disorder, identifies what is unique to the personality disorders, and is distinct from maladaptive traits. Finally, the review suggests that the ICD-11 should require the assessment of the traits and include facet scales.

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INTRODUCTION

The purpose of this article is to discuss the current conceptualizations and challenges facing the diagnosis of personality disorder. Personality disorders are said to be at the vanguard of the shift to a dimensional model of classification (Krueger 2013, Rounsaville et al. 2002). Considered herein are the Alternative Model of Personality Disorders (AMPD) included within Section III of the fifth edition of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA 2013) and the personality disorder section within the 11th edition of the World Health Organization's (WHO's) *International Classification of Diseases* (ICD-11; WHO 2023). The field is indeed shifting toward a dimensional rather than categorical model of personality disorder, although valid concerns remain concerning the proposed dimensional models.

DSM-5 ALTERNATIVE MODEL OF PERSONALITY DISORDERS

"The Personality and Personality Disorders Work Group (PPDWG) for DSM-5 was charged with developing a new approach to the personality disorder section that would begin to rectify" the many problems identified for the categorical personality disorder diagnoses (Skodol et al. 2013, p. 343). The DSM-5 AMPD has two components: (a) a Level of Personality Functioning (LPF) that determines whether a personality disorder is present and (b) a five-domain dimensional trait model. It is also important to note that the DSM-5 PPDWG proposed retaining 6 of the 10 DSM-IV personality disorders (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal), albeit with new criterion sets derived from the LPF and trait model. Each component will be discussed in turn, beginning with the dimensional trait model.

DSM-5 Dimensional Trait Model

The DSM-5 PPDWG initially proposed a six-domain model (with 37 underlying traits) including negative emotionality, introversion, antagonism, compulsivity, disinhibition, and schizotypy. Clark and Krueger asserted that this six-domain model did not align with any existing dimensional trait model, stating in particular that the domains of compulsivity and schizotypy were not present within the Five Factor Model (FFM) of general personality structure (L.A. Clark & R.F. Krueger, *Rationale for a Six-Domain Trait Dimensional Diagnostic System for Personality Disorder*, unpublished manuscript). This conclusion was disputed by Widiger (2011) and Miller & Lynam (2013) but was also embraced by persons who opposed a shift to a dimensional trait model. As stated by Shedler

et al. (2010, p. 1027), “the resulting model no longer rests on decades of research, which had been the chief rationale for including it.”

The DSM-5 proposal was subsequently revised to a five-domain trait model (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) that was aligned with the FFM. As affirmed by Krueger & Markon (2014, p. 480), “these domains can be understood as maladaptive extremes of the five-factor model (FFM) that has usefully framed extensive research in the field of personality and individual differences.” As stated in the DSM-5 itself, “these five broad domains are maladaptive variants of the five domains of the extensively validated and replicated personality model known as the ‘Big Five’ or Five Factor Model of personality” (APA 2013, p. 773).

DSM-5 dimensional trait model and the Five Factor Model. The predominant model of general personality structure is provided by the FFM (Caspi et al. 2005, John et al. 2008, Widiger 2017); it consists of the domains of neuroticism, introversion (versus extraversion), antagonism (versus agreeableness), conscientiousness, and openness. Its predominance is due in part to its comprehensive coverage and strictly empirical basis. The FFM traces its roots to the lexical paradigm (Goldberg 1993). The lexical approach rests on the compelling premise that what is of most importance, interest, or meaning to persons when describing themselves and others is naturally encoded within the language. The structure of personality is provided by the empirical relationship among the language’s trait terms (Goldberg 1993). The lexical research regarding the trait terms within the English language converged well onto the Big Five, as well as being replicated within the indigenous German, Czech, Dutch, Filipino, Hebrew, Hungarian, Italian, Korean, Polish, Russian, Spanish, and Turkish languages, although the replication of neuroticism and that of openness (or intellect) are less strong than for agreeableness, extraversion, and conscientiousness (de Raad & Mlačić 2017).

To the extent that the Big Five includes every maladaptive trait term, it naturally follows that the FFM, aligned with the Big Five, accounts for virtually every maladaptive personality trait. There is indeed a substantial body of research documenting that the FFM accounts for all of the DSM-IV personality disorders (Widiger et al. 2017). Saulsman & Page (2004, p. 1075) conducted a meta-analysis of 12 FFM personality disorder studies and reached the conclusion that “results of this meta-analysis are consistent with the view that personality disorders can be conceptualized using the five-factor model of normal personality.” Their meta-analysis was at the domain level. Samuel & Widiger (2008) conducted a meta-analysis at the lower-order facet level with 16 empirical studies that contained a total of 18 independent samples with a combined 3,207 participants (only one of the studies had been included in Saulsman and Page’s meta-analysis) and again reached the conclusion that the personality disorders are well-understood as maladaptive variants of the FFM. Multiple persons who have reviewed the FFM personality disorder research (e.g., Clark 2007, Livesley 2001, O’Connor 2005) and/or the FFM maladaptive trait research (e.g., García et al. 2024, Krueger & Markon 2014) have reached the same conclusion.

Existing measures of the FFM have even been used effectively to assess for some personality disorders (Miller 2012). For example, Trull et al. (2003) reported that the Revised NEO Personality Inventory (NEO PI-R; Costa & McCrae 1992) assessment of borderline personality disorder correlated as highly with traditional measures of borderline personality disorder as the latter did with each other. However, FFM measures will not always provide a valid personality disorder assessment. Measures of the FFM are confined largely to the normal range of personality functioning and can fail to include the maladaptive variants that are evident in personality disorders. This is particularly evident for personality disorders that concern maladaptive variants of conscientiousness (i.e., obsessive-compulsive), agreeableness (i.e., dependent), and/or extraversion (i.e., histrionic). Existing measures of the FFM will fail to include a sufficient number of items to assess

for the maladaptive variants of these FFM domains (e.g., the NEO PI-R does include a maladaptive conscientiousness item concerning workaholism, but only one such item). On the other hand, existing measures of the FFM will be quite effective in assessing personality disorders that concern high neuroticism (e.g., borderline), antagonism (antisocial and narcissistic), introversion (e.g., schizoid), and low conscientiousness (antisocial), as most of the items in these cases will concern maladaptive traits.

An FFM accounting for the personality disorders explains and resolves one of the major problems for the personality disorders, the excessive diagnostic co-occurrence. The co-occurrence among the personality disorders is due to the presence of overlapping FFM trait domains (Lynam & Widiger 2001). An additional concern for the personality disorders is a potential gender bias (e.g., whether there is a bias toward women in diagnosing borderline personality disorder and a bias against men when diagnosing antisocial personality disorder; Oltmanns & Powers 2012). The gender differences among the personality disorders are again explained by their FFM trait constellations (Lynam & Widiger 2007).

Empirical support for the FFM is substantial (Widiger 2017), including multivariate behavior genetics with respect to its structure (Jarnecke & South 2017), cognitive neuroscience coordination (DeYoung et al. 2010), childhood antecedents (Caspi et al. 2005), temporal stability across the lifespan (Roberts & DelVecchio 2000), and cross-cultural validity (Allik & Realo 2017). In contrast, “similar construct validity has been more elusive to attain with the current DSM-IV personality disorder categories” (Skodol et al. 2005, p. 1923). Given the close coordination of the DSM-5 trait model with the FFM, all that is known about the FFM can be applied to the DSM-5 trait model. For example, De Clercq et al. (2006) indicated how the childhood antecedents for the FFM can help to inform the childhood antecedents for personality disorders.

The FFM has also been shown across a vast empirical literature to be useful in predicting a substantial number of important life outcomes, both positive and negative (Widiger 2017). Meta-analytic reviews of this research have been provided by Ozer & Benet-Martinez (2006) and Roberts et al. (2007). One study worth noting in particular was conducted by Cuijpers et al. (2010). In a large representative sample ($N = 5,504$) of the Dutch general population, Cuijpers et al. compared the economic costs of FFM neuroticism (health service uptake in primary and secondary mental health care, out-of-pocket costs, and production losses) with the costs associated with common mental disorders (e.g., mood, anxiety, substance use, and somatic disorders). The total excess costs of neuroticism per one million inhabitants resulting from the 25% highest scorers (\$1,393 billion) were approximately 2.5 times higher than the excess costs of common mental disorders (\$585 million). Cuijpers et al. (2010, p. 1086) asserted that “the economic costs of neuroticism are enormous and exceed those of common mental disorders.”

In sum, the DSM-5 AMPD dimensional trait model provides a compelling alternative to the DSM-5 Section II categorical syndromes (García et al. 2024). The trait model has generated a considerable body of research (Zimmermann et al. 2019). However, this research has also identified important concerns regarding the trait model. Four are discussed in turn below: problematic placement of some traits, inadequate coverage, perceived complexity, and lack of compelling cutoff points.

Problematic placements. The DSM-5 dimensional trait model is an empirically derived model. As such, the placement of the 25 underlying traits within the five domains should have compelling empirical support. However, concerns have been raised regarding the placement of depressivity and interpersonal suspiciousness within detachment (Watson et al. 2013; Widiger 2011, 2013). Factor analytic research with other instruments has placed depressivity within negative affectivity (or neuroticism) and suspiciousness within antagonism (Widiger & Hines 2022). It would appear

self-evident that depressivity is a component of negative affectivity (along with anxiousness and vulnerability) and that suspiciousness is a component of antagonism. Indeed, depressivity is one of the facets of neuroticism and trust versus mistrust is one of the facets of agreeableness versus antagonism within the well-established NEO PI-R (Costa & McCrae 1992).

The predominant measure of the DSM-5 trait model is the Personality Inventory for DSM-5 (PID-5; Krueger et al. 2012). In defense of the DSM-5 placements, a meta-analysis of 14 PID-5 factor analytic studies (Watters & Bagby 2018) confirmed the primary placement of depressivity and suspiciousness within detachment (depressivity loaded 0.50 within detachment but cross-loaded 0.43 in negative affectivity). We suspect that the unusual trait placements reflect an idiosyncratic representation of one or more of the domains by the PID-5 relative to other commonly used measures of maladaptive trait models. A potential limitation of the DSM-5 trait model is that the structure is confined to the empirical results of one newly developed measure, the PID-5, rather than being informed by the vast body of existing maladaptive trait research.

Inadequate coverage. Coker et al. (2002) identified 803 maladaptive traits within the English language. Including all of the maladaptive trait terms within the DSM-5 trait model would be excessively redundant and inordinately complex. On the other hand, it is important for a DSM maladaptive trait model to cover at least all of the maladaptive traits necessary to account for the personality syndromes of particular interest to researchers and clinicians (Widiger & Hines 2022). The DSM-5 Section II syndromes lack validity as diagnostic categories, but they do identify maladaptive traits of primary interest.

There has been much research on the extent of coverage of the DSM-IV personality disorders by the DSM-5 trait model. Rojas & Widiger (2017) and Watters et al. (2019) provided meta-analytic summaries of this research. As expressed by Rojas & Widiger (2017, pp. 464–65), “the authors of the eight studies...concluded that the dimensional trait model demonstrated good to excellent coverage of the variance within each respective personality disorder” with the exception of obsessive–compulsive. Watters et al. (2019, p. 97) considered the results from 25 independent (published and unpublished) datasets: “The findings indicated general support for the traits proposed for each of the six personality disorders within the AMPD, with obsessive–compulsive personality disorder the notable exception.” The lack of adequate coverage of this personality disorder is likely due to the loss of the domain of compulsivity. The traits of perseveration and rigid perfectionism from this domain were retained, but only rigid perfectionism appears to be an indicator of the obsessive–compulsive personality disorder (Crego et al. 2015).

The inadequate coverage is due in part to the DSM-5 trait model not recognizing maladaptive variants at both poles of the FFM. The FFM has a bipolar structure with respect to maladaptivity (Widiger & Crego 2019), whereas the DSM-5 maladaptivity is unipolar: “There are healthy, adaptive, and resilient personality traits identified as the polar opposite of [the DSM-5] traits” (APA 2013, p. 773)—more specifically, “emotional stability, extraversion, lucidity, agreeableness, and conscientiousness” (APA 2013, p. 773). The DSM-5 does not recognize maladaptive low negative affectivity, maladaptive extraversion, maladaptive low openness, maladaptive agreeableness, or (with one exception) maladaptive conscientiousness. The one exception is the inclusion of rigid perfectionism, which is recognized as being opposite to disinhibition (Krueger et al. 2012).

Antisocial personality disorder appears to be well-covered by the trait model (Rojas & Widiger 2017, Watters et al. 2019), but the alternative conceptualization of psychopathy does not (Lynam & Vachon 2012). In particular, missing from the trait model are the traits of fearlessness, invulnerability, boldness, and glib charm, which are strongly evident within recent models of psychopathy (e.g., Lilienfeld & Widows 2005, Lynam et al. 2011, Patrick et al. 2009). Boldness, fearlessness, invulnerability, and glib charm are traits of low neuroticism and high extraversion (Crego & Widiger 2014,

Strickland et al. 2013). The authors of the DSM-5 trait model attempted to address this concern by suggesting that the DSM-5 traits of attention-seeking, anxiousness (reverse coded), and social withdrawal (reverse coded) could serve as proxy measures of glib charm, boldness, and fearlessness: “High attention-seeking and low withdrawal capture the social potency (assertive/dominant) component of psychopathy, whereas low anxiousness captures the stress immunity (emotional stability/resilience) component” (APA 2013, p. 765). However, high attention-seeking and low social withdrawal have been shown to provide weak proxy measures for boldness (Crego & Widiger 2014). Maladaptive anxiousness does correlate negatively with fearlessness (Strickland et al. 2013), but the absence of maladaptive anxiousness does not indicate the presence of the opposite trait of fearlessness (Crego & Widiger 2014). Persons who lack maladaptive anxiousness may simply be generally calm or relaxed and not necessarily boldly fearless.

Perceived complexity. Andrew Skodol, who served as Chair of the DSM-5 PPDWG, considered clinical utility (or more specifically, ease of use and professional communication) to be a major problem for the dimensional trait model (A. Skodol, *Rationale for Proposing Five Specific Personality Types*, unpublished manuscript), citing the clinical utility studies of Rottman et al. (2009) and Spitzer et al. (2008), which reported weak and problematic results for the FFM trait model. Shedler et al. (2010, p. 1027), in an editorial published in the *American Journal of Psychiatry*, likewise asserted that “clinicians find dimensional approaches significantly less relevant and useful, and consider them worse than the current DSM-IV system,” citing again the two studies by Rottman et al. (2009) and Spitzer et al. (2008). However, neither Skodol nor Shedler et al. provided a comprehensive summary of the clinical utility research, and they neglected to acknowledge the subsequent refutations of the Rottman et al. and Spitzer et al. studies that identified and addressed those studies’ fundamental methodological flaws.

Spitzer et al. (2008) did report better results for a DSM prototype matching relative to the FFM. However, the clinicians had to complete a six-page rating form when providing the FFM assessments, whereas the prototype matching required very little effort. Lowe & Widiger (2009) modified Spitzer and colleagues’ approach by using a rating form for each model that was comparable in length and effort. The clinicians then favored the FFM over the DSM (including with respect to professional communication).

Rottman et al. (2009) had clinicians attempt to reproduce DSM categories on the basis of FFM profiles in comparison to the DSM criterion sets. The clinicians favored the DSM for this task. However, if a trait model was to replace the categories, the task of the clinician would not be to return to the DSM syndromes. In addition, the trait model provided to the clinicians would not be simply the normal traits of the FFM but would instead be the maladaptive trait variants (e.g., as in the eventual DSM-5 Section III trait model). Glover et al. (2012a) modified Rottman and colleagues’ approach by providing to the clinicians the maladaptive variants of each FFM facet that would be considered specific to each respective DSM syndrome. The FFM and the DSM criterion sets were then provided with equal clinical utility ratings (the FFM was favored with respect to communicating with patients).

Reviewers who have actually covered all of the clinical utility studies have reached the conclusion that dimensional trait models are superior to the DSM-IV categorical syndromes (Bornstein & Natoli 2019, Mullins-Sweatt & Lengel 2012, Widiger 2019). Bornstein & Natoli (2019), for example, provided a meta-analytic review, integrating data from 11 studies (103 total effect sizes; 2,033 raters). They concluded that the “dimensional models in general, and the five-factor model in particular, received more positive clinical utility ratings than categorical personality disorder models in the majority of clinical utility domains (Bornstein & Natoli 2019, p. 479). As one example, Morey et al. (2014) had clinicians describe one of their clients with respect to the DSM-IV-TR

personality disorder syndromes and also with respect to initial versions of the various components of the DSM-5 proposal, including the trait model. With respect to communication with patients, treatment formulation, comprehensiveness, and global descriptive utility, the trait model received higher ratings than the DSM-IV-TR syndromes: “Perhaps the most striking finding was with respect to the pathological trait rating component of the DSM-5 model, which clinicians rated as superior in utility to DSM-IV-TR in every respect [including ease of use]” (Morey et al. 2014, p. 403). Morey et al. also noted that the results favored the trait model even when the analyses were confined to just psychiatrists (i.e., excluding the results for the psychologists and social workers).

In sum, clinicians typically prefer the FFM and the dimensional trait model over the categorical syndromes. The FFM and the DSM-5 trait models might appear at first to be complex, perhaps because they are largely unfamiliar to the clinicians. However, the trait model structure is consistent with how these traits are organized within the natural language. They involve traits that are readily understood and structured in a manner in which the language itself organizes them (Goldberg 1993).

Lack of cutoff points. One of the common criticisms of the DSM-IV categories is a lack of a clear or compelling demarcation between the presence and the absence of a respective personality disorder (Clark 2007, Widiger & Trull 2007). The diagnostic thresholds are arbitrary. They are not carving nature at a discrete joint.

This problem is perhaps even worse for the dimensional trait model, which currently has no official cutoff points. There is no basis for determining if a person has a clinically significant level of antagonism or a clinically significant level on any one of its facets, such as lack of empathy. It is unclear how clinicians can describe their patients in terms of the dimensional trait model in the absence of any cutoff points. Cutoff points are being developed for when clinicians apply the trait model to their patients, but no official cutoff points have yet been developed for the PID-5 self-report inventory.

Morey & Skodol (2013) proposed cutoff points for the hybrid criterion sets that would maximize agreement with DSM-IV prevalence rates. However, a significant limitation of this approach is the presumption that the prior cutoff points were optimal for each personality disorder, when clearly they were not (Clark 2007, Widiger & Trull 2007).

One of the more common and simplest methods for establishing cutoff points is a specified deviation from the mean within a representative sample from a population. Miller et al. (2022) took this approach for the PID-5 assessment of the DSM-5 trait model, comparing prevalence rates with cutoff scores based on 1.0, 1.5, and 2.0 deviations from the mean. Samuel et al. (2013) also considered this approach, among other methods.

A difficulty with this approach is the cost of obtaining a large and truly representative sample. However, a more fundamental flaw is the problematic assumption that diagnostic decisions should be governed primarily by statistical deviance (Widiger & Sankis 2000). Even more problematic is the false assumption that all of the maladaptive traits and maladaptive trait domains have the same prevalence rates within the population (e.g., presence determined by the same deviation from the mean for each trait and trait domain). It would appear evident, for example, that there is likely to be considerably more negative affectivity than antagonism within a clinical population, but the same prevalence rate would be obtained through the use of the same deviation from the mean.

Cutoff scores that are coordinated with the actual base rate of a disorder will provide more accurate diagnoses (Meehl & Rosen 1955). Millon et al. (1997) agreed with Meehl & Rosen (1955) when establishing cutoff points for the personality disorder scales of the Millon Clinical Multiaxial Inventory (MCMI). They identified cutoff points based on what would be optimal for identifying the known (or at least identified) cases of each personality disorder within what they described

as a large normative clinical sample. However, these cutoff points would only work well within a clinical setting that matched the prevalence rates within the derivation sample. That would rarely occur. Millon et al. (1997, p. 5) recognized this problem: “Local base rates and cutting lines must still be developed for special settings.” However, this effort was confined to just one adjustment: lowering the cutoff point for the antisocial scale when used within a prison setting. Clinicians working within settings in which substantial symptomatology is not commonplace (e.g., college counseling, divorce mediation, child custody evaluations) have found that the MCMI cutoff points overestimate substantially the extent and breadth of personality disorder (e.g., Lampel 1999).

Perhaps the optimal approach would be to identify the cutoff point that would indicate the presence of clinically significant social and/or occupational impairment or personal distress, consistent with the definition of a personality disorder within the DSM-IV and DSM-5 Section II. The cutoff point based on personal distress would likely be rather low for negative affectivity and its underlying traits. There may also be more social impairment for antagonism and detachment and more occupational impairment for disinhibition or low conscientiousness (Mullins-Sweatt & Widiger 2010). However, this approach to setting cutoff points has not yet been implemented, in part because of the cost and effort to obtain well-validated measures of social and occupational impairment and sufficient clinical samples within which each these impairments can be readily assessed. A further difficulty is obtaining consensus as to what is a clinically meaningful level of impairment. A clinically significant level of impairment would be the degree of impairment that would warrant clinical intervention, but it is likely that reasonable persons would disagree over when clinical intervention is needed or would be useful.

Level of Personality Functioning

The LPF involves an assessment of level of impairments with respect to identity, empathy, self-directedness, and intimacy. The LPF was derived from the psychodynamic theory that central to the presence of a personality disorder are impairments (or distortions) in the sense of self and interpersonal relatedness (Bender et al. 2011, Kernberg 2012, Sharp & Wall 2021, Zimmermann et al. 2023). As Zimmermann et al. (2023, p. 582) wrote, “It is one of the central assumptions of many psychodynamic models that maladaptive mental representations of self and others form the core of personality pathology.” The “deficits in self and interpersonal functioning [are said to] constitute the core of personality psychopathology” (APA 2013, p. 762).

Hopwood (2018) suggested that clinicians focus primarily on the treatment of the LPF, relegating the maladaptive personality trait model to an ancillary option. His proposal is consistent with the view that the LPF defines what is the core or is common to all personality disorders, whereas the trait model simply describes the style of personality functioning. Once a person is below the threshold for the presence of a personality disorder, based on the LPF, there is perhaps no real need for further treatment. Nevertheless, several concerns have been raised with respect to the LPF (García et al. 2024). One is its complexity, another concern is whether it does actually involve the core of personality disorder, a third concern is whether its attributes are in fact unique to the personality disorders, and the fourth concern is whether it even identifies aspects of personality disorder that are not already within the dimensional trait model. Each of these concerns is discussed in turn below.

Complexity. One of the concerns raised regarding the DSM-5 LPF is again complexity (Skodol 2012). The LPF involves an assessment of level of identity, empathy, self-directedness, and intimacy, with each having three different facets and five levels of severity, for a total of 60 different components. Many of the components involve psychodynamic constructs that can be difficult to infer. The DSM-IV diagnostic criterion sets are said to be complex and lengthy, yet each requires

only about half a page within the diagnostic manual to be described. The LPF requires four full pages of text for its description.

Core of personality disorder? The “deficits in self and interpersonal functioning” are said to “constitute the core of personality psychopathology” (APA 2013, p. 762). If that is indeed the case, there should then be strong positive correlations of the LPF with each of the DSM-5 Section II personality disorders. Some studies have reported strong relationships with all of the personality disorders (e.g., Hopwood et al. 2018a,b; Stone & Segal 2021). However, many studies suggest that the LPF relates strongly to only a few of the personality disorders (especially borderline) and weakly with others (García et al. 2024).

In one early study, Few et al. (2013) reported a consistently strong relationship of all four components of the LPF with borderline personality disorder, and similar results for schizotypal and antisocial personality disorders. However, no significant relationship was obtained with any one of the four identity, empathy, self-directedness, or intimacy components with obsessive–compulsive personality disorder (and only one weak relationship of empathy with histrionic personality disorder). Hemmati et al. (2020) similarly reported a strong relationship with borderline, as well as antisocial, paranoid, schizoid, avoidant, dependent, and narcissistic, but only a weak relationship with obsessive–compulsive. Hutsebaut et al. (2016), Hutsebaut et al. (2017), and Weekers et al. (2021) reported a significant relationship with borderline personality disorder but no substantial relationship with other personality disorders.

In sum, for the most part the LPF does not seem to relate in a comparable manner to all of the personality disorders. There is indeed a consistently strong relationship of the LPF with borderline personality disorder. This is consistent with the perspective that borderline personality disorder captures global personality pathology to a greater extent than the other personality disorders (Morey 2019, Wright et al. 2016), a hypothesis to be discussed further below. An alternative understanding is that borderline is the one personality disorder that explicitly includes aspects of the LPF within its criterion set: more specifically, identity disturbance and unstable-intense relationships.

The relationship with other personality disorders is less consistent and, in the case of obsessive–compulsive, consistently weak. This finding is consistent with research relating the LPF self-interpersonal impairments with the maladaptive traits of compulsivity (Bastiaansen et al. 2013; Berghuis et al. 2013, 2014; Hentschel & Pukrop 2014). Berghuis et al. (2014) and Hentschel & Pukrop (2014) suggested that the absence of a meaningful relationship with compulsivity may suggest that obsessive–compulsive personality disorder does not belong within the personality disorder nomenclature. An alternative hypothesis is simply that the LPF does not in fact define what is the core or what is common to the personality disorders.

Support for the belief that the LPF defines the core of personality disorder has also been attributed to a finding that the LPF may largely define the general factor of personality disorder (g-PD). The first to provide this suggestion were Sharp et al. (2015). They considered the covariation among the diagnostic criteria for the six personality disorders retained within DSM-5 Section III. An exploratory bifactor analysis yielded a general personality disorder factor. They noted that all of the borderline personality disorder criteria loaded solely and highly on the g-PD: “Although we do not yet know the exact nature of the general factor, to stimulate further research, we speculate on some intriguing interpretative possibilities. One answer may lie in Criterion A of the new DSM-5-III General Criteria of Personality Disorder” (Sharp et al. 2015, p. 394).

Wright et al. (2016) also submitted the covariation among the personality disorder criteria (this time the diagnostic criteria for all the personality disorders) to a bifactor analysis, yielding a g-PD along with five more specific factors. They again found that the borderline criteria loaded uniquely

on the g-PD and not on any of the specific factors. With respect to the substantive interpretation of g-PD, they acknowledged that “the core makeup of the general factor remains. . .ambiguous” (Wright et al. 2016, p. 1129), but, consistent with Sharp et al. (2015), they suggested that “one possible interpretation is that it reflects borderline personality organization (Kernberg 1984), with core impairments involving maladaptive self and other representations and identity formation” (Wright et al. 2016, p. 1129).

It is perhaps noteworthy, though, that neither Sharp et al. (2015) nor Wright et al. (2016) actually included a measure of the LPF in their studies. They inferred that the g-PD was defined largely by the LPF on the presumption that the borderline criterion set is largely synchronous with the LPF. However, this presumption may not in fact be valid. The borderline personality disorder diagnostic criteria include nine items. Only two of them align explicitly with the LPF impairments. Borderline identity disturbance clearly aligns with LPF identity impairment, which includes a “markedly impoverished, poorly developed, or unstable self-image” (APA 2013, p. 766). The borderline criterion of “unstable and intense interpersonal relationships” (APA 2013, p. 663) likewise aligns well with LPF intimacy impairment, which involves “intense, unstable, and conflicted close relationships” (APA 2013, p. 766). However, the remaining seven borderline criteria are frantic efforts to avoid abandonment; impulsivity that is self-damaging (e.g., reckless spending, sex, and/or driving); recurrent suicidal behavior; affective instability; chronic feelings of emptiness; intense anger; and/or transient, stress-related paranoid ideation or dissociative symptoms. None of these has a clear counterpart to the two remaining LPF impairments: impaired self-direction [“instability in goals, aspirations, values or career plans” (APA 2013, p. 766)] and impaired empathy [“compromised ability to recognize the feelings and needs of others” (APA 2013, p. 766)].

Subsequent studies concerning the g-PD have included LPF measures. Bliton et al. (2021) investigated the underlying factor structure of the LPF. Within each of three alternative measures of the LPF they reported a single underlying factor, and across the three measures Bliton et al. (2021, p. 175) reported that a “robust general factor was identified accounting for the majority of the variance.” It is, however, noteworthy that the g-PD did not include a loading from any personality disorder. Bliton et al. just obtained a general factor for the LPF measures.

Morey (2017, p. 1306) similarly found evidence for a single unifying factor across the four LPF subscales and concluded that this finding, when combined with the robust associations of the LPF with measures of maladaptive personality pathology, provided evidence to support the idea that “these measures are all tapping a global dimension of personality pathology.” But, once again, no personality disorders were actually included in this study.

Zimmermann et al. (2020), using bifactor rotation, analyzed 163 items from six measures assessing for impairment in personality functioning and found that LPF items all loaded positively onto a single, relatively strong general factor. The factor loadings associated with this factor were almost perfectly correlated (0.99) with a unidimensional item response theory model; this result may indicate that the content of this general factor remains consistent across different models even if the number of factors varies across these different models. They noted that in addition to this general factor, there were at least two specific factors at play. In line with the AMPD conceptualization, Zimmermann and colleagues (2020, p. 174) concluded that each of the instruments used to assess for severity of personality dysfunction tapped a common unidimensional general factor “broadly defined by impairments in self- and interpersonal functioning, with a slight preponderance of internalizing personality pathology,” but they noted that a different methodological approach (i.e., using an oblique rotation) would likely be better suited to evaluating the relationship between this general factor, the LPF, and maladaptive traits.

Oltmanns et al. (2018) offered an alternative interpretation of the g-PD, considering the g-PD in comparison to the general factor of psychopathology (p factor) and the general factor

of personality (GFP). They extracted a g-PD, a p factor, and a GFP within the same dataset and indicated substantial correlations among these three general factors (ranging from 0.70 to 0.92). They considered the potential implications of this considerable convergence. It might appear compelling to suggest that the g-PD is largely equivalent to the self-interpersonal impairments of the LPF (Sharp et al. 2015, Wright et al. 2016), but it would be difficult to suggest that the LPF self-interpersonal impairments also largely define the general factors of psychopathology and normal personality (Smith et al. 2020). It would appear inconsistent to suggest that the LPF identifies what is unique to the personality disorders (Morey 2017, 2019; Pincus et al. 2020; Skodol 2012) yet also contributes heavily to the p factor.

The strong correlations of the g-PD with the GFP and the p factor were subsequently replicated by Littlefield et al. (2021). They further extracted a single general factor across the three domains of personality, personality disorder, and psychopathology, reporting strong loadings for the personality disorders, personality, and psychopathology on this general factor, inconsistent with the LPF defining what is unique to the personality disorders.

McCabe et al. (2022) conducted a g-PD study that included indicators of the p factor and the GFP as well as a measure of the LPF. They found that “the g-PD was indeed defined in large part” (p. 152) by LPF impairments in personality functioning, with a similar loading also found for the PID-5 Perceptual Dysregulation scale. Additionally, there was evidence of considerable convergence of the g-PD with both the p factor (0.94) and the GFP (0.78). There was also a robust association of the p factor and the GFP (0.74). They suggested that these results point to the probability that the general factors of personality disorder, psychopathology, and personality are not capturing unique, discrete information but are likely to be capturing the same underlying secondary social-occupational impairments and personal distress. McCabe and colleagues (2022, p. 153) concluded that “the general factors all reflect the impairments that are secondary to the respective personality disorders, personality traits, mood disorders, and substance use disorders.” The g-PD may not actually be defined by the LPF but instead be defined by social-occupational impairments and personal distress that are also evident in mood, anxiety, and substance use disorders and other forms of psychopathology (Smith et al. 2020).

Unique to the personality disorders? The LPF is also said to identify what is unique to the personality disorders (Morey 2017, Skodol 2012): “Criterion A [or the LPF] is meant to play an important role in distinguishing what is personality disorder from what is not” (Morey 2019, p. 1195). As Pincus et al. (2020, p. 134) wrote, “Self and interpersonal functioning deficits are the core feature of personality pathology, and it is the centrality of these impairments in self and other functioning that distinguishes personality pathology from other classes of psychopathology (e.g., eating, mood, anxiety, psychotic, substance use disorders, etc.).”

Multiple studies have indicated that the LPF impairments are higher within personality disordered samples and can distinguish between the presence and the absence of a personality disorder (e.g., Buer Christensen et al. 2020; Doubková et al. 2022; Hemmati et al. 2020; Hutsebaut et al. 2016, 2017; Nazari et al. 2021; Ohse et al. 2023). However, comparable results would be obtained with any other measure of personality disorder impairment. Sleep et al. (2019a,b) suggested that demonstrating that the LPF can distinguish between the presence and the absence of a personality disorder, even within a clinical population, is not really addressing the question of whether the LPF is not meaningfully evident within other mental disorders in the absence of a personality disorder. Sleep et al. (2019a) reported that the LPF impairments were as highly correlated with mood, anxiety, and other Axis I disorders as they were with personality disorders, inconsistent with being unique to the personality disorders—a finding replicated by Sleep et al. (2020). Sleep and colleagues (2019a, p. 1189) concluded that “personality dysfunction measured in Criterion

A [LPF] is not unique to personality disorders and is unable to distinguish between personality and nonpersonality based forms of psychopathology.” Note also the previously reported finding that the g-PD is heavily correlated with the general factors of psychopathology and personality (i.e., Littlefield et al. 2021, McCabe et al. 2022, Oltmanns et al. 2018), inconsistent with the LPF identifying impairments unique to the personality disorders.

Distinct from personality traits? The AMPD hybrid criterion sets for the six personality disorders carried over from the DSM-IV include self-interpersonal deficits from the LPF and maladaptive traits from the dimensional trait model. Their joint occurrence presumes that the two components offer different information. More specifically, the LPF is said to represent an “intrapsychic system” distinct from traits or behaviors (Sharp & Wall 2021, p. 313). However, the LPF may not in fact be distinct from personality traits.

There are some studies in which the authors suggested they found support for a distinction between the LPF and maladaptive personality traits (e.g., Meisner et al. 2022, Sexton et al. 2019, Weekers et al. 2021). In contrast, much research has suggested substantial overlap and little distinction. Stone & Segal (2021) found large effect size relationships between the LPF and each of the five PID-5 domains, ranging from 0.79 (detachment) to 0.87 (psychoticism, disinhibition) with a mean of 0.84. Sleep et al. (2019a,b) found moderate to strong correlations of all PID-5 domains with LPF total and subscale scores (mean correlation of 0.62), and regression analyses indicated that the maladaptive personality trait domains accounted for 51–70% of the variance in the LPF. The authors concluded that the high convergence was problematic for the AMPD model, indicating that “a comprehensive assessment of personality disorder traits can obviate the need for the assessment of personality dysfunction” (Sleep et al. 2019a, p. 1189). In a subsequent study, Sleep and colleagues (2020) again found a robust relationship between LPF (total and subscale scores) and each of the PID-5 domains. Comparable results were also reported by Somma et al. (2020) and Zimmermann et al. (2020).

There is even a substantial convergence of the LPF with normal personality traits. Sleep et al. (2020) reported significant relationships between LPF domains and FFM traits. FFM domains accounted for 28–48% of the variance in LPF domains while FFM facets accounted for 34–56% of the variance.

McCabe et al. (2021) reported substantial convergence for four LPF measures with FFM neuroticism, agreeableness, and conscientiousness. There was no significant relationship between LPF and FFM openness and extraversion. Interestingly, this study found a robust relationship between LPF identity and FFM neuroticism across all four LPF measures and concluded that the “Criterion A self-identity scale can be understood as a maladaptive variant of FFM neuroticism” (McCabe et al. 2021, p. 826).

Hopwood et al. (2018a) found robust correlations of LPF scales with 88% of PID-5 facets. In relation to FFM traits, Hopwood et al. (2018a) found a strong positive correlation between FFM neuroticism and overall LPF, and strong negative correlations with FFM agreeableness and conscientiousness. Hopwood et al. (2018a, p. 657) concluded that the AMPD model would be improved by efforts “to create some separation between personality pathology severity and PD style.” Stone et al. (2021) similarly reported a large effect size relationship of LPF total and domain scores with FFM neuroticism as well as with extraversion, agreeableness, and conscientiousness. Stone et al. (2021, p. 531) concluded that “the high correlation. . . indicates that the two scales are not as distinct as the AMPD suggests they should be.”

Some studies have even shown no meaningful incremental validity of the LPF over the maladaptive traits in accounting for personality disorder variance (e.g., Few et al. 2013), whereas the maladaptive traits routinely obtain considerable incremental validity (Zimmermann et al. 2019).

Some studies have reported incremental validity of an LPF measure over a maladaptive personality trait (e.g., Berghuis et al. 2014). However, in these studies the common variance is typically far larger than the unique variance (e.g., Sleep et al. 2020).

In addition, incremental validity may not optimally address the question of distinctness (Widiger & McCabe 2020). Incremental validity indicates that some of the variance within a criterion measure is uniquely accounted for by one of two competing measures. Maladaptive personality traits have also been shown to obtain incremental validity over normal FFM traits in accounting for personality disorder variance, yet these traits are still readily understood as falling within the FFM personality structure (Clark 2007, Krueger & Markon 2014). Even measures of precisely the same constructs will often obtain incremental validity over one another in accounting for variance within an external validator (Widiger & McCabe 2020).

More informative are studies that address whether the deficits and traits can or cannot be understood as falling within a common latent structure. For example, Berghuis et al. (2012) submitted to a factor analysis the correlations among the scales of a measure of the FFM along with scales assessing the LPF self and interpersonal deficits. They reported that the two interpersonal deficit scales loaded within FFM antagonism and introversion factors, and self-directedness scales loaded with a low conscientiousness factor. Nevertheless, Berghuis et al. (2012, p. 704) concluded that their results indicated that the LPF deficits and the FFM involve “clearly distinct components of personality” consistent with the DSM-5 AMPD. This conclusion was based on the finding that one of the four components of the LPF, identity disturbance, did separate to form its own factor.

Oltmanns & Widiger (2016) subsequently indicated that the identity disturbance results of Berghuis et al. (2012) illustrated the phenomenon of a bloated specific factor. Berghuis et al. had included a large number of scales (i.e., 19) to assess alternative forms of self-pathology. Even if these scales assessed a component of neuroticism, they would correlate much more highly with one another than with the other facets of neuroticism, such as angry hostility, vulnerability, and depressiveness. If one facet of neuroticism is much more heavily represented by multiple scales relative to the others, the respective scales of that facet will bind together to yield a factor independent of the other facets. Oltmanns & Widiger (2016) demonstrated that the self-pathology scales separated from neuroticism when an excessive number was included, but loaded within neuroticism when the self-pathology facet was not represented disproportionately. This finding was subsequently replicated with four alternative measures of the LPF by McCabe et al. (2021).

In sum, the research suggests strong overlap and little distinction between the LPF and maladaptive personality traits. Even among LPF proponents there is an acknowledgment that the value of the LPF as it is currently conceptualized within the AMPD warrants some reconsideration (e.g., Huprich et al. 2018, Morey 2019). To the extent that an impaired sense of self reflects a characteristic or consistent expression of the self, it would be considered a personality trait. Indeed, some of the DSM-5 impairments and traits are virtually identical (Widiger & Hines 2022). For example, there is no meaningful distinction between a “lack of concern for feelings, needs, or suffering of others; lack of remorse after hurting or mistreating another” (APA 2013, p. 764) and a “lack of concern for feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one’s actions on others” (APA 2013, p. 764). The former is an LPF self-impairment and the latter is from the trait model.

ICD-11 PERSONALITY DISORDERS

Work on the DSM-5 AMPD was well underway when work began on the ICD-11 personality disorders classification (Tyrer et al. 2019). The ICD-11 did not initially receive much opposition despite the fact that the proposal for the personality disorders provided a much more radical

shift than the DSM-5 AMPD (Widiger et al. 2024). The ICD-11 personality disorders classification includes three components: a level of personality disorder severity, a dimensional trait model [negative affectivity, detachment, dissociality, disinhibition, and anankastia (compulsivity)], and a borderline pattern specifier (diagnosed with the DSM-IV criterion set).

Empirically, the DSM-5 LPF and the ICD-11 level of severity are highly convergent (McCabe & Widiger 2020, Oltmanns & Widiger 2019). Historically, however, there were fundamental differences. The ICD-11 level of severity was not considered to be identifying the core of personality disorder, nor was it considered to be distinct from the traits. On the contrary, the original version of the ICD-11 level of severity was defined explicitly by maladaptive traits (e.g., avoiding other persons, not trusting others, having no friends) along with impairments that are secondary to these traits, such as dysfunction within relationships and risk of harm to self or others (Tyrer et al. 2015). As stated by Tyrer et al. (2015, p. 723), “the ICD-11 classification contains no assessment of self-pathology.” However, in the final year of its consideration the ICD-11 proposal received substantial external opposition (i.e., Herpertz et al. 2017). In an effort to address the opposition, the level of severity was revised to emphasize LPF self-interpersonal impairments comparable to those provided in the DSM-5 AMPD while still retaining some aspects from the original level of severity (Bach et al. 2021, Reed 2018).

A further compromise was the addition of a borderline personality disorder diagnosis. The inclusion of the borderline syndrome is understandable. The syndrome of borderline personality disorder is of substantial clinical interest (Gunderson & Zanarini 2011). Borderline personality disorder also has a considerable body of research and clinical literature concerning its etiology, pathology, course, and treatment (Blashfield & Intoccia 2000). Borderline is the only personality disorder category for which the APA (2001) has recognized the presence of empirically validated treatment protocols. The many clinicians and researchers who specialize in the treatment and study of borderline personality disorder were understandably concerned that the lack of an explicit reference to this syndrome within the ICD-11 would be problematic to its continued research and clinical funding. Its inclusion would appear to be a reasonable compromise (Gabel 2017, Tyrer et al. 2019).

It is worth noting that Peter Tyrer, Chair of the ICD-11 Working Group for the Personality Disorders, declined to participate in the discussions with those opposing the ICD-11 proposal (Tyrer et al. 2019). Tyrer (2009) had previously argued for the deletion of one personality disorder from the ICD: borderline. Tyrer argued that persons currently diagnosed with borderline personality are better understood as having a mood or some other form of Axis I disorder. It would have been quite ironic, and clearly difficult, for him to engage in a discussion for the retention of the one personality disorder he most wanted to delete (and he likely would have opposed shifting the level of severity to be closer to a psychodynamic model).

The ICD-11 dimensional trait model does not include a psychoticism domain because the ICD has never included a schizotypal personality disorder diagnosis. The WHO (1992) has considered schizotypal to be a form of schizophrenia rather than a personality disorder. The DSM-5 trait model does not include an anankastia domain, but a closely corresponding compulsivity domain was included within the initial proposal (L.A. Clark & R.F. Krueger, *Rationale for a Six-Domain Trait Dimensional Diagnostic System for Personality Disorder*, unpublished manuscript). It was deleted through an effort to shorten and/or simplify the trait model (Krueger et al. 2011, 2012). The ICD-11 trait model is again aligned with the FFM. As stated by the authors of the ICD-11 trait model, “Negative Affective [aligns] with neuroticism, Detachment with low extraversion, Dissocial with low agreeableness, Disinhibited with low conscientiousness and Anankastic with high conscientiousness” (Mulder et al. 2016, p. 85). ICD-11 negative affectivity, detachment, dissociality, and disinhibition, of course, align closely with DSM-5 AMPD negative

affectivity, detachment, antagonism, and disinhibition, respectively (McCabe & Widiger 2020), but they are not defined in precisely the same manner. Bach et al. (2017) developed ICD-11 personality trait scales from the PID-5, and it is noteworthy that they did not include all of the PID-5 scales given the differences in how the trait domains are defined.

The DSM-5 AMPD has been said to provide a paradigm shift in the classification of personality disorder (Skodol 2012, Skodol et al. 2013). However, this status is more appropriately awarded to the ICD-11 (Krueger 2016, Tyrer 2014). The DSM-5 AMPD proposal retained six of the DSM-IV personality disorder types (Skodol 2012). If the DSM-5 AMPD had been adopted, it is quite possible that there would have been little change in clinical practice as clinicians would still be focused on the six diagnostic categories rather than the level of personality functioning or the dimensional trait model. The ICD-11 retains only one of the prior diagnostic categories (borderline). There are, however, some limitations and problems with the ICD-11 personality disorders (note that the discussion of lack of cutoff points for the PID-5 also applies to the ICD-11 self-report measures). Each identified issue is discussed in turn below.

Only Level of Severity Is Required

A concern with the DSM-5 AMPD has been its perceived complexity (Clarkin & Huprich 2011, Pilkonis et al. 2011, Shedler et al. 2010). One way in which this concern is addressed in the ICD-11 is to only require a rating for level of severity. Clinicians are not required to code or assess the patient with respect to the dimensional trait model or the borderline pattern specifier. This does indeed simplify the assessment a great deal.

However, it is difficult to imagine that clinicians will be satisfied with just determining if a personality disorder is present and, if so, how severe it is. It is difficult to imagine clinicians being disinterested (for instance) in whether the maladaptive traits concern dissociality, disinhibition, and/or negative affectivity. This is analogous to a clinician being uninterested in whether the patient has psychopathic, borderline, or narcissistic personality traits. How can a clinician treat a patient without actually knowing the nature of the maladaptive personality traits that are present?

The most common personality disorder in clinical practice is borderline, and it is then possible that clinicians would limit their assessment simply to the level of severity, presuming that if a personality disorder is present then it is likely to be defined largely by borderline personality traits. Nevertheless, why not at least confirm this presumption through an application of the borderline pattern specifier? Of course, if the clinician was using the DSM-5 LPF then this presumption would quite likely be correct given the close alignment of the LPF with borderline personality disorder (Sharp et al. 2015, Wright et al. 2016); yet, even in this case, as noted above, most of the borderline diagnostic criteria are not actually included within the LPF.

Hansen et al. (2019) had clinicians apply the ICD-10 syndromes and the ICD-11 trait model to their own clients. The ICD-11 trait model consistently obtained higher clinical utility ratings, particularly for treatment planning. It would have been useful to compare the ICD-11 level of severity, considered by itself, with the ICD-10 syndromes, and to compare as well the perceived clinical utility of the level of severity, considered by itself, with the ICD-11 dimensional trait model. We would hypothesize that clinicians would provide higher clinical utility ratings for the trait model, and they might even prefer the ICD-10 syndromes over the level of severity, when considered alone.

No Facet Traits Within the Domains

An additional problem for the ICD-11 personality disorders classification is that only broad domains are provided. No underlying facets are provided (e.g., callousness, deceitfulness, and

manipulativeness within antagonism are not provided). This was considered by the ICD-11 working group to add unnecessary complexity to the model (Mulder et al. 2011, Tyrer et al. 2011). Reference to potential facets is included within the descriptions of the domains, but there is no coding for specific facets (WHO 2023). Domain description will provide a substantial amount of useful information and considerably more information than simply the level of severity. But a lot more information is lost by not being able to assess for the underlying traits. The advantage of trait profile description is the ability to provide a nuanced or precise description of the individual patient (Clark 2007, Widiger & Trull 2007). Confining the description to just domains is not much better than the diagnostic categories. The DSM-IV categories can at least indicate whether the patient is closer to an antisocial or a narcissistic personality disorder. It is unclear whether a domain-level description can make this distinction.

Ideally, the AMPD and ICD-11 should indicate how the DSM-IV syndromes can be recovered from the trait profile. This should not be done in the manner of the DSM-5 AMPD, wherein clinicians code for the presence of one or more of six DSM-IV categories. Instead, the coding should be with respect to the domains and facets of the trait model. The text discussion can then provide the trait profiles for each of the DSM-IV categories so that the clinician can still recover the syndromes in which they are most interested. It is not at all clear how one can recover many of the ICD-10 syndromes from the ICD-11 trait domains.

One would not really want to lose the DSM-IV or ICD-10 syndromes. They are quite interesting and intriguing constellations of traits. The DSM-IV syndromes do not exist in nature. They do not have specific etiologies or pathologies. They are social constructions, but they were constructed because they represent constellations of traits that are of substantial social and/or clinical interest. The borderline trait profile describes someone who is intensely emotional, labile, vulnerable, rageful, suicidal, and dramatic, along with having some traits of antagonism (manipulative) and disinhibition (rash), presenting one of the most difficult patients to treat, yet one for whom treatment is intensely desired (Mullins-Sweatt et al. 2012).

Consider, as well, psychopathy. As Crego & Widiger (2022, p. 674) wrote, “The psychopathic syndrome is probably the most dangerous and virulent constellation of personality traits that one can imagine—hence, the long-standing interest in identifying its presence.” At the core of psychopathy are the traits of antagonism, including (for instance) callousness, deceitfulness, manipulativeness, aggressiveness, ruthlessness, and exploitative behavior (Miller & Lynam 2015). Someone with just these traits would be seriously threatening, harmful, and dangerous. One then adds to these traits of antagonism traits of extraversion, such as assertiveness, boldness, and gregariousness (Lilienfeld & Widows 2005, Lynam et al. 2011, Patrick et al. 2009). It is considerably less dangerous for an exploitative, aggressive person to be introverted than to be extraverted. A truly introverted person would largely keep to oneself and perhaps then would not be as harmful to others. An exploitative, aggressive person who is also bold and assertive would be especially dangerous. One then adds to the traits of antagonism and extraversion some traits of high neuroticism (i.e., angry hostility and impulsive urgency) and, even more importantly, traits of low neuroticism, such as fearlessness, glib charm, invulnerability, low anxiousness, and unconcern (Lilienfeld & Widows 2005, Lynam et al. 2011, Patrick et al. 2009). The thought of committing acts of violence, aggression, and brutal exploitation is likely to make most persons anxious, nervous, and fearful, but not prototypic psychopaths. They have the glib charm to seduce and con others, the fearlessness to attempt the most heinous acts of exploitation and brutality, and the lack of anxiousness to allow them to remain calm and collected during their horrific criminal exploits. These are the frightening psychopaths portrayed in popular media (Lilienfeld & Arkowitz 2007). Finally, one adds to this lethal constellation traits of low constraint, such as recklessness, immorality, irresponsibility, and rashness. The exploitative, aggressive, and deceitful persons are then also reckless, unpredictable,

and impulsive in their expression of their aggression. In sum, it is not at all surprising that the constellation of traits of psychopathy was constructed (Crego & Widiger 2018).

Mullins-Sweatt et al. (2010) suggested that an even more dangerous profile would be the presence of the psychopathic traits of antagonism, extraversion, and high and low neuroticism coupled with traits of high rather than low conscientiousness, which they identified as the profile for the “successful psychopath.” These would be psychopathic persons who would be able to avoid being arrested for their crimes for a significant period of time. Two potential examples are Ted Bundy and Bernie Madoff (Crego & Widiger 2022), who had very similar FFM trait profiles consistent with that of the successful psychopath, likely contributing to their ability to get away with their crimes for many years.

Most importantly, the ability to characterize alternative variants of a syndrome is one of the strengths of a dimensional trait model (Widiger & Trull 2007). One can distinguish between the grandiose narcissist and the vulnerable narcissist (Glover et al. 2012b). Both have the trait of arrogance (from antagonism), but the vulnerable narcissist has additional traits from neuroticism (reactive anger, shame, and need for admiration). The ICD-11 trait model, confined to just the trait domains, would not even be able to effectively identify the narcissistic person because of an inability to code for the cardinal trait of arrogance.

Clinical utility studies indicate that clinicians prefer the trait model over the syndromes (Bornstein & Natoli 2019, Mullins-Sweatt & Lengel 2012, Widiger 2019), but no study has yet compared a domain-level with a trait profile description. This ICD-11 simplification may severely handicap the utility of the trait model and may even turn clinicians away from the trait model, finding that it provides too broad or blunt a personality description.

CURRENT STATUS OF REVISION EFFORTS

In the future, neither the DSM nor the ICD is likely to undergo major revisions at one particular time. The WHO is more interested in helping member countries around the world implement effective medical services than in spending a considerable amount of money, time, and effort revising diagnostic nomenclatures. A singular overhaul of the entire diagnostic manual also encourages substantial and unnecessary revisions (i.e., work group members are not going to spend 5–6 years on a committee that implements no change at all; Frances & Widiger 2012). The APA as well is shifting away from conducting massive, singular overhauls of the DSM in favor of simply having a standing committee, the DSM-5 Revision Steering Committee (initially chaired by Paul Appelbaum), to which persons can submit proposals at any time they believe a revision or addition has become suitable.

Indeed, this APA committee has been considering a proposal, coauthored by Carla Sharp, Lee Anna Clark, Tom Widiger, Robert Krueger, Stephanie Stepp, and Mark Zimmerman, to revise the DSM-5 personality disorders section. This proposal is generated by the need to have the DSM nomenclature be consistent with that of the ICD-11. It is unclear if it will be approved.

CONCLUSIONS

The personality disorder field is shifting toward a dimensional rather than categorical model of classification, although valid concerns remain concerning the DSM-5 AMPD and ICD-11. More specifically, this review suggests that the AMPD trait of depressivity belongs within negative affectivity and suspicion belongs within antagonism, that maladaptive traits from all 10 poles of the five domains of the AMPD should be provided, and that cutoff points based on social-occupational impairment and/or distress should be provided. The review summarizes research that questions whether the LPF represents the core of personality disorder, identifies what is

unique to the personality disorders, and is distinct from the maladaptive traits. Finally, the review suggests that the ICD-11 should require the assessment of the traits and include facet scales.

SUMMARY POINTS

1. The classification of personality disorders is shifting to a dimensional model.
2. Both Section III of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and the 11th edition of the *International Classification of Diseases* (ICD-11) include a level of personality functioning scale and a dimensional trait model.
3. Both DSM-5 Section III and the ICD-11 retained the borderline personality disorder syndrome, and the DSM-5 also retained the antisocial, avoidant, schizotypal, narcissistic, and obsessive-compulsive syndromes.
4. It is unclear if the DSM-5 Level of Personality Functioning scale, defined by deficits in sense of self and other, identifies the core of personality disorder, is unique to the personality disorders, or is even distinct from the maladaptive personality traits.
5. Concerns for the DSM-5 dimensional trait model include questionable placements, inadequate coverage, perceived complexity, and lack of meaningful cutoff points.
6. Problematic for the ICD-11 classification are the facts that only the level of severity is required and that no facet scales for the trait model are provided.

FUTURE ISSUES

1. Future research needs to determine if the level of personality functioning scales identifies the core of personality disorder, is unique to the personality disorders, or is even distinct from the maladaptive personality traits.
2. Future research on the dimensional trait model should address whether it provides adequate coverage and has meaningful cutoff points for interpretation.
3. Research is also needed on the treatment of all of the domains of the dimensional trait model.
4. Facet scales for the ICD-11 dimensional trait model should be developed.

DISCLOSURE STATEMENT

The authors are not aware of any affiliations, memberships, funding, or financial holdings that might be perceived as affecting the objectivity of this review.

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