Personality Disorders in DSM-5

Andrew E. Skodol

Department of Psychiatry, University of Arizona College of Medicine, Tucson, Arizona 85724, and the Sunbelt Collaborative, Tucson, Arizona 85718; email: askodol@gmail.com

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Abstract
A substantive revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM) last occurred in 1994; therefore, the mental health field should anticipate significant changes to the classification of mental disorders in the fifth edition. Since DSM-5 Work Groups have recently proposed revisions for the major diagnostic classes of mental disorders, an article on the current status of the personality disorders (PDs) is timely. This article reviews scientific principles that have influenced the development of proposed changes for the assessment and diagnosis of personality psychopathology in DSM-5, presents the proposed model as of the summer of 2011, summarizes rationales for the changes, and discusses critiques of the model. Scientific principles were articulated for DSM-5 more than a decade ago; their application to the process has not been straightforward, however. Work Group members have labored to improve the DSM-5 approach to personality and PDs to make the classification more valid and more clinically useful. The current model continues to be a work in progress.
INTRODUCTION

A revised classification of mental disorders is scheduled for publication in 2013 by the American Psychiatric Association (APA). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) will be the product of over 13 years of work on the part of many mental health professionals. A substantive revision of the DSM has not occurred since 1994; therefore, the mental health field should anticipate significant changes, which will impact patients, providers, families, and society at large and may influence future research agendas. Since DSM-5 Work Groups have recently proposed changes for each of the major diagnostic classes of mental disorders and have revised their proposals in anticipation of APA-sponsored and -conducted Field Trials now under way, an article on the current status of the personality disorders (PDs) in DSM-5 is timely. This article (a) reviews scientific principles that have influenced the development of proposed changes for the assessment and diagnosis of personality psychopathology for DSM-5, (b) presents the proposed model as of the summer of 2011, (c) summarizes the rationales for the proposed changes, and (d) discusses critiques of the model and their impact on its evolution. More complete summaries of the Personality and Personality Disorders Work Group’s progress and products to date can be found elsewhere (Bender et al. 2011; Krueger & Eaton 2010; Krueger et al. 2011a,b; Morey et al. 2011; Skodol 2011; Skodol & Bender 2009; Skodol et al. 2009, 2011a,b,c).

In September of 1999, an initial DSM-V Research Planning Conference sponsored by the APA and the National Institute of Mental Health was held to conceptualize the goals and methods needed to begin the DSM-V process. The switch from the Roman numeral V to the Arabic number 5 was deliberate, as is explained below. In this review, the acronym DSM-5 is used except when DSM-V appears in the name of a book, article, or conference.
Health (NIMH) was held to set research priorities for DSM-5. In the introduction to the published white papers from this conference in *A Research Agenda for DSM-V*, Kupfer and colleagues (2002) argued that the categorical approach to the diagnosis of mental disorders, including PDs, needed reexamination. Epidemiological and clinical studies showed high rates of within- and across-axis comorbidity and short-term diagnostic instability. No laboratory marker had been found to be specific for any DSM-defined syndrome. And a lack of treatment specificity for disorders was the rule rather than the exception.

Because the reliability of psychiatric diagnosis had improved over the previous 40 years with the innovations of explicit diagnostic criteria and of semistructured and fully structured diagnostic interviews, the authors believed that the classification in DSM-5 should emphasize or facilitate an understanding of the pathophysiology and etiology of mental disorders. Thus, the validity of diagnoses would be enhanced, and consequently, better preventative and treatment interventions based on them could be developed. Kupfer and colleagues also stated that a “slavish” adherence to DSM-defined syndromes might actually impede research and that a “paradigm shift” might be necessary to uncover the underlying etiologies of DSM-defined syndromes (Kupfer et al. 2002, p. xix). To encourage thinking that went beyond the DSM-IV framework, participants at the first series of planning meetings were primarily not involved in the development of DSM-IV and were encouraged to consider broad perspectives on diagnostic classification, including from the fields of neuroscience and genetics.

### Definition of Disorder

A personality disorder in DSM-IV is defined as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture and is manifested in cognition, affectivity, interpersonal functioning, and/or impulse control (two or more). The enduring pattern is inflexible and pervasive across a broad range of personal and social situations; leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning; is stable and of long duration, with an onset in adolescence or early adulthood; is not better accounted for as a manifestation or consequence of another mental disorder; and is not due to the effects of a substance or a general medical condition. Individuals who met the criteria for a PD in DSM-IV were assumed to meet the general definition, but were not explicitly required to do so.

These general criteria for PD were introduced into DSM-IV without an empirical basis, and they have been considered too nonspecific. Incorporation of personality trait dimensions into DSM-5 (see below) necessitates the use of general criteria for PD that supplement those dimensions, because an extreme position on a trait dimension is a necessary but not sufficient condition to diagnose a PD (Wakefield 2008), and extreme traits may predispose to mental disorders other than PDs. Thus, the P&PD Work Group developed a new definition and set of general criteria for PD that would be more specific and empirical. In addition, consideration at the Task Force level of more clearly demarcating boundaries between the

### SCIENTIFIC ISSUES IN THE REVISION OF PERSONALITY DISORDERS FOR DSM-5

Seven basic nomenclature issues were identified for DSM-5: (a) the definition of mental disorders, (b) dimensional approaches to diagnosis versus categorical approaches, (c) rationales for changing existing categories or criteria, (d) the validation of diagnostic categories and criteria, (e) reducing the gaps between DSM-5 and ICD-11, (f) the applicability of criteria across cultures, and (g) facilitating psychiatric diagnosis in nonpsychiatric settings (Rounsaville et al. 2002). All of these issues have influenced the deliberations of the Personality and Personality Disorders (P&PD) Work Group in proposing revisions.
manifestations of psychopathology and its consequences (Narrow & Kuhl 2011) has led to discussion of discriminating “disability”—the impairments in functioning that are the consequences of disorders—from “dysfunction,” which describes core disturbances in capacities that underlie different forms of psychopathology, in keeping with Wakefield’s (1992) definition of mental disorder. The need for this discrimination is particularly apt for the PDs because impairment in “interpersonal functioning” is inherent to them.

The Work Group began with a “tripartite model of mental disorders” (Skodol et al. 2009) based on a model of patient assessment commonly used in clinical practice (Skodol & Bender 2008, Westen et al. 2006a). The tripartite model consists of three fundamental assessment domains: functioning, personality, and psychopathology. Within the functional domain, strengths and impairments are assessed in cognitive, self, emotional, behavioral, physical, interpersonal, occupational, and recreational (leisure) functioning. Functioning constructs span adaptive to maladaptive functioning, allowing integration of the assessment of dysfunctions with the assessment of functional strengths associated with mental health (Vaillant 2003) and the resilient personality (Skodol 2010).

Impairments in specific adaptive capacities in the functional domain map onto specific symptom disorders. For example, impairments in cognitive functioning suggest mental retardation, delirium, dementia, or psychotic disorders. Impairment in the function of emotional regulation suggests mood or anxiety disorders. Although most mental disorders have impairments in multiple domains, identification of the primary impairments can be helpful in the process of differential diagnosis and in guiding treatment. Impairments in the self and interpersonal domains are deemed by the Work Group to be most characteristic of PDs.

The originally proposed general criteria for PD, as posted on the DSM-5 Website in early 2010 (see table 4 in Skodol et al. 2011c) were based on Livesley’s (1998) theoretical model of adaptive failure, which included the failure to develop a coherent sense of self or identity and chronic interpersonal dysfunction. Evaluation of self pathology was based on 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 by indexing failure to develop the capacity for empathy, sustained intimacy and attachment (labeled intimacy in the proposal), prosocial and cooperative behavior (labeled cooperativeness), and complex and integrated representations of others.

Since its original posting, the general criteria for PD have been simplified, streamlined, and integrated with the Levels of Personality Functioning (see below). In its current iteration, two assessments combine to comprise the essential criteria for a PD: impairments in personality (self and interpersonal) functioning (criterion A) and the presence of pathological personality traits (criterion B). Criteria also require relative stability across time and consistency across situations and exclude developmentally or culturally normative personality features and those due to the direct physiological effects of a substance or a general medical condition. By integrating the Levels of Personality Functioning into criterion A of the revised general criteria, all PDs will meet the general criteria, the core component of impaired personality functioning has an empirical basis (see below), and core impairments can be represented in gradations of severity.

The focus on core impairments in personality functioning in the proposed new general criteria is expected to be more specific for personality psychopathology than the current DSM-IV general criteria for PD. These impairments will not be totally specific, however, just as psychosis is not totally specific for psychotic disorders, mood disturbance
for mood disorders, or anxiety for anxiety disorders. The assignment of disorder names and classes is a convention based on the most prominent aspects of psychopathology, with presumed treatment significance. Thus, the focus is on self and interpersonal dysfunction in the definition of PDs, for which various forms of psychotherapy dealing with issues of sense of self and interpersonal relations are regarded as the treatments of choice.

Consideration was given to changing the name of the class of PDs to a name that would be more meaningful and less pejorative. “Relational disorders” was considered because of the prominence of disturbances in interpersonal relations found in people with self-other issues. However, relational disorders have a very different meaning in the context of the DSM, since they have been proposed for the disturbed relationships between people, rather than the psychopathology of individuals (First et al. 2002). The name “adaptational disorders” (Svrakic et al. 2009) was also considered as a parallel to adjustment disorders. “Adaptational” moves away from the “adaptive failure” concept originally included in the revised definition of PD and is more consistent with the wealth of data from prospective longitudinal studies that indicates that PDs may improve with time (or treatment) (Skodol 2008) and with models of PDs as “maturational delays” (Cohen & Crawford 2009). At this time, however, the name “personality disorders” has been retained.

**Dimensional Versus Categorical Approaches**

A debate about the relative merits of categorical and dimensional approaches to the PDs arose almost immediately after the publication of DSM-III in 1980 (Frances 1980, 1982). Since then, considerable research has shown excessive co-occurrence among PDs diagnosed using the categorical system of the DSM (Oldham et al. 1992, Zimmerman et al. 2005): Most patients diagnosed with a PD 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) is 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 (BPD) in DSM-IV-TR (Johansen et al. 2004). Furthermore, all of the PD categories have arbitrary diagnostic thresholds, i.e., the number of criteria necessary for a diagnosis. Finally, despite having criteria for 10 different PD types, the DSM system may still not cover the domain of personality psychopathology adequately. In fact, the most frequently used PD diagnosis is personality disorder not otherwise specified (PDNOS) (Verheul et al. 2007), a residual category indicating that a patient is considered to have a PD but does not meet full criteria for any one of the DSM-IV-TR types, or is judged to have a PD not included in the official classification (e.g., depressive, passive-aggressive, or self-defeating PDs).

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

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: Even the recently revised and pared-down DSM-5 personality trait assessment (see below) still

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Heterogeneity among patients with the same disorder is not limited to PDs but would be found for any disorder defined by a polythetic criteria set. In fact, the revised criteria for substance use disorder proposed for DSM-5 (any two or more of 11 criteria) result in over 2,000 possibilities!
requires 25 trait facet dimensions 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. Proponents of dimensional models point out how extremes of some continuous clinical phenomena in medicine, 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.

Widiger & Simonsen (2005) reviewed 18 alternative proposals for dimensional models of PDs. The proposals included (a) dimensional representations of existing PD constructs, (b) dimensional reorganizations of diagnostic criteria, (c) integration of Axes II and I via common psychopathological spectra, and (d) integration of Axis II with dimensional models of general personality structure.

A proposal by Oldham & Skodol (2000) converted each DSM-IV PD into a six-point scale ranging from absent traits to prototypic disorder. Significant personality traits and subthreshold disorders could be noted in addition to full diagnoses. Another person-centered dimensional system is the prototype matching approach described by Shedler & Westen (2004, Westen et al. 2006b), by which a patient is compared to a description of a prototypic patient with each disorder, and the degree of match is rated on a five-point scale.

A dimensional system in which criteria for PDs are arranged by trait dimensions instead of by categories is the model of the Schedule for Nonadaptive and Adaptive Personality (SNAP) (Clark 1993), with three higher-order factors (negative temperament, positive temperament, and disinhibition), in addition to 12 lower-order trait scales measuring traits such as dependency, aggression, and impulsivity. Livesley’s (Livesley & Jackson 2000) Dimensional Assessment of Personality Pathology has broad domains of emotional dysregulation, dissocial behavior, inhibition, and compulsivity, plus 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 & Davis’s (1991) model, for example, which hypothesizes fundamental dimensions of cognitive/perceptual disturbance, affective instability, impulsivity, and anxiety that link related disorders across the DSM axes. Thus, schizophrenia and schizotypal personality disorder (STPD) are on a spectrum of cognitive/perceptual disturbance, sharing some fundamental genetic and neurobiological processes (Siever & Davis 2004). Another integrative model hypothesizes only two fundamental dimensions: internalization and externalization (Krueger 2005, Krueger et al. 2001). Internalizing disorders include mood and anxiety disorders from Axis I and avoidant and dependent personality disorders from Axis II. Externalizing disorders include substance use disorders, for example, from Axis I and antisocial personality disorder from Axis II.

Finally, the fourth group of alternatives hypothesizes that PDs are on a continuum of general personality functioning, i.e., are extremes of normal personality traits. Three-Factor Models (Eysenck 1987, Tellegen & Waller 1994) include neuroticism, extraversion, and psychoticism (or disinhibition versus constraint) as higher-order factors, and the Five-Factor Model (FFM) includes neuroticism, extraversion, agreeableness, openness, and conscientiousness (Costa & McCrae 1992), with each of the FFM factors composed of six trait facets. The Temperament and Character Model (Cloninger 2000) consists of four dimensions of temperament (novelty seeking, harm avoidance, reward dependence, and persistence) and three dimensions of character (self-directedness, cooperation, and self-transcendence).

Trull (2005) has summarized descriptions of PDs in terms of dimensional models. According to the Five-Factor Model, PDs in general would be characterized by high neuroticism. A specific PD, such as BPD, would also be characterized by low agreeableness and low cooperativeness. According to the Temperament...
Character Model, PDs would be characterized by low self-directedness and low cooperativeness. PDs in Cluster B would also show high novelty seeking; those in Cluster C, high harm avoidance; and those in Cluster A, low reward dependence.

The various models have also been synthesized into an overarching dimensional model. Widiger & Simonsen (2005) proposed an integration over four levels of specificity. First, personality psychopathology was divided at the highest level by the dimensions of internalization and externalization. Below these were broad domains of personality: extroversion versus introversion, antagonism versus compliance, impulsivity versus constraint, emotional dysregulation versus emotional stability, and unconventionality versus closed to experience. Below these were a number (25–30) of lower-order traits, each with behaviorally specific diagnostic criteria. Despite this integration, questions remain about which approach—categorical or dimensional—has more validity and clinical utility and which would be more accepted by clinicians.

Thus, a new hybrid dimensional-categorical model for personality and PD assessment and diagnosis has been proposed for DSM-5 field testing. Hybrid models combining elements of categories and dimensions have been suggested by personality disorder experts since before the publication of DSM-IV (Benjamin 1993, Blashfield 1993). In a recent survey of personality disorder experts (Bernstein et al. 2007), Bernstein and colleagues found that a (unspecified) mixed system of categories and dimensions was the most frequently endorsed alternative system for PDs.

Six specific PD types are being recommended for retention in DSM-5: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal. The DSM-IV-TR PDs not represented by a specific type will be diagnosed as PD trait specified (PDTs) and will be represented by significant impairment in personality functioning combined with descriptions of patients’ unique personality trait profiles. Criteria sets for each specific PD require the presence of typical impairments in personality functioning and particular pathological personality traits, but these can each vary in degree. The rationale for the types is described below and elsewhere (Skodol et al. 2011a).

For the assessment of pathological personality traits, the Work Group now proposes five broad, higher-order personality trait domains—negative affectivity, detachment, antagonism, disinhibition versus compulsivity, and psychoticism—each composed of several lower-order, more specific trait facets. The proposed trait model originally consisted of six domains and 37 trait facets but was revised on the basis of a three-wave community survey (Krueger et al. 2011b; RF Krueger, J Derringer, KE Markon, D Watson, & AE Skodol, unpublished data). The model continues to be under development and may change further based on future data, so it should be considered preliminary. The rationale for this specific pathological personality trait model is summarized briefly below and has been described in detail elsewhere (Krueger & Eaton 2010; Krueger et al. 2011a,b). Individual traits were tailored and assigned to PD criteria sets (the B criteria) based on empirical data and the Work Group’s assessment of their ability to represent characteristics of current disorder constructs.

Ideally, despite their being based on prior models and research, the alternative model components would all be tested to determine whether they are, in fact, improvements to the DSM-IV categorical system. Specifically, in their chapter in A Research Agenda for DSM-V, First and colleagues (2002) suggested that the dimensional alternatives should (a) better account for existing behavioral, neurobiological, genetic, and epidemiological data and adequately represent all clinically important aspects of a PD; (b) be more reliable, specific, and clinically informative; (c) more effectively guide treatment decisions; (d) have adequate levels of temporal stability in clinical settings; (e) relate to motivational and cognitive systems of the brain; (f) provide a better understanding
of the interaction between temperaments and environment that result in PD; and (g) explicate the mechanisms by which maladaptive and adaptive personality traits impact physical disease and health. Although the results of prior research on which the proposed revisions are based suggest affirmative answers to many of these questions, only extensive future research will answer them with certainty.

Criteria for Change

The beginning deliberations of the DSM-5 Task Force revolved around a paradigm-shift that was needed to characterize DSM-5 because of the shortcomings of the neo-Kraepelinian model. For the first year or so, everything was on the table, and Work Groups were encouraged to think outside the box. Tinkering with the diagnostic criteria for disorders was referred to as “vandalism” because even small changes in criteria could result in large changes in prevalence rates and in difficulties in learning the revised criteria, applying current treatments, or translating existing research findings (First 2005).

Eventually, various Work Groups became anxious about the scope and nature of a paradigm-shift and wondered whether one was justified. Thus, many Work Groups assumed a traditional tinkering approach to revising their criteria sets. The P&P&PD Work Group persisted in the pursuit of a dimensional model for PDs, for which the PD field had long waited (e.g., Frances 1993) and was apparently eager (Bernstein et al. 2007, Clark 2007, Trull & Widiger 2008), and which the DSM-5 research agenda had embraced. Eventually, the Work Group’s dimensional model became an outlier with respect to the other Work Groups’ criteria-based, categorical approaches, and the revised hybrid model for PDs surfaced.

For the first year or so of Work Group meetings, there were no guidelines for change for DSM-5. The P&P&PD Work Group developed our own set of priorities for change—including such goals as increased specificity for treatment selection, prediction of treatment response/outcome, reliability, internal consistency, and acceptance/adherence by clinicians. Finally, criteria for change were proposed by the Task Force to be applied across all categories, which focus mostly on traditional measures of validity (antecedent, concurrent, and predictive) for making changes. The motivation for DSM-5 was the lack of validity of existing categories of mental disorders according to traditional (e.g., Robins & Guze 1970) criteria, yet new options for these disorders are intended to somehow meet these standards.

Furthermore, different validators (e.g., family history versus consistent longitudinal course) are known to support different definitions of disorder, and which is prioritized depends on the specific purpose of the diagnosis (e.g., to study heritability versus to predict prognosis). This exact issue has been playing out over the placement of STPD in the DSM-5 metastructure. Genetic and some neurobiological findings in STPD would suggest placement with the schizophrenic disorders in DSM-5 (as it is in ICD-10) rather than with the other PDs. Other neurobiological findings that protect against the development of frank psychosis, the absence of a deteriorating clinical course in STPD, and considerations of differential diagnosis (i.e., STPD is not characterized by psychotic symptoms) would suggest the opposite placement.

The guidelines for change in DSM-5 state that the magnitude of a suggested change should be supported by a proportional amount and quality of evidence in support of the change. In the PD field, literature reviews support the validity of some PDs much better than others, but the general problems with the existing 10-category system for diagnosing PDs appear so severe that a reduced threshold for change seems warranted. Whether this assumption will pass the scrutiny of the Scientific Review Committee appointed to review all recommended changes for DSM-5 remains to be seen.

Furthermore, the relationship of empirical findings and clinical utility is not entirely clear. Should recommended changes in the classification reflect and promote progress on
understanding pathophysiology and etiology or should they assist clinicians in doing their essential tasks? When these goals are in conflict, on what basis, by what process, and by whom—Work Group members with expertise in their particular field, general Task Force members, the Scientific Review Committee, or boards of governance of the APA—will decisions be made?

DSM-5, as a whole, is intended to be a “living document,” with the potential for partial revision in an ongoing process, as research advances warrant (Regier et al. 2009). Thus, the edition scheduled for publication in 2013 technically should be called DSM-5.0, with future revisions called 5.1, 5.2, etc. Whether a continuing process of revision will be acceptable and can be implemented by the APA, or will be too disruptive to practice and research, is a matter for the future.

Validity Versus Clinical Utility

The question of the validity of a diagnostic system versus its clinical utility has loomed large in DSM-5 deliberations. Related, the constructs of validity and of clinical utility have been debated. Within the PD area, some Work Group members believe that research on personality pathology approached from the factor analytical perspective fails to validate any current PD category, whereas clinicians on the Work Group see evidence of the health impact, treatment and prognostic significance, neurobiology, and genetics of certain PD categories or their components as compelling evidence of their validity.

The DSM-5 Work Groups were charged with developing a more clinically useful system. However, discussions of clinical utility are often limited to the user friendliness, feasibility, and clinician acceptability of proposals rather than their usefulness in communication between clinicians or between clinicians and patients or their ability to guide treatment decisions or estimate prognosis (First et al. 2004). According to strict definitions of validity (e.g., Kendell & Jablensky 2003), few psychiatric diagnoses are valid, because few “zones of rarity” (p. 4) in the manifestations of disorders have been found, and few disorders have been identified to have specific mechanisms of pathophysiology or etiology. According to Kendell & Jablensky (2003), however, a diagnosis possesses utility “if it provides nontrivial information about prognosis and likely treatment outcomes…. Diagnostic categories provide invaluable information about the likelihood of future recovery, relapse, deterioration, and social handicap; they guide decisions about treatment…. “ (p. 9). Therefore, in addition to the structural validity of personality pathology, it is the belief of many of the clinician/researchers on the Work Group that attention should be paid to the clinical utilities for which diagnoses are used.

Cultural Applicability

A DSM-5 Study Group has been reviewing issues involving age, gender, and culture (Regier et al. 2009). Sensitivity to cultural differences in what constitutes personality pathology and how it is manifested is important. For example, the proposed Levels of Personality Functioning continuum (see below) specifies impairment in self and interpersonal functioning—identity and self-direction and empathy and intimacy, respectively—as the core disturbances in PDs and incorporates these into criterion A of the revised general and specific criteria for the PDs. These concepts, especially those focused on individualism and self-reliance, may be most relevant in Western cultures and societies, where they are highly valued. In other cultures, in which relationships to the family, the community, or the social group, and religion and spirituality are highly valued, the balance between individual and collective resources and deficits may shift significantly in determining personality psychopathology. Similar considerations apply to the pathological significance of the B criteria personality traits. The revised criteria for PDs now proposed for DSM-5 require that the impairments (and traits) are “not better understood as normative within the individual’s… socio-cultural environment.”
DSM-5 and ICD-11

Attention is being paid to the harmonization of DSM-5 and ICD-11. The scheduled publication of DSM-5 is likely to precede the publication of ICD-11 by several years, based on current timelines. Compatibility between the American and international classifications has always been a goal of DSM revisions, but this time the DSM-5 leadership has been more responsive to proposals made by members of the ICD committees than before, in some cases favoring international proposals over ones made by the DSM-5 Work Groups, despite considerable advantages in the amount of time and resources being devoted to the DSM-5 efforts in comparison to those of the ICD-11.

Diagnosis in Specialty Versus Primary Care Settings

Enhancing the use of DSM-5 in primary care settings has received considerable attention in the DSM-5 development process. The so-called Level 1/Level 2 crosscutting measures have been motivated by this objective. These measures are meant to function as self-report screening scales (Level 1) and diagnostic checklists (Level 2) to ensure that clinicians do not miss important psychopathology in basic assessments. Crosscutting dimensions of psychopathology are also meant to reduce artificial comorbidity of diagnoses in complex cases with mixed features and to describe heterogeneity within disorder categories (Regier et al. 2009).

Two Level 1 screening inquiries were recommended to the Task Force to screen for core self and interpersonal personality psychopathology with high sensitivity based on secondary data analysis: “Not knowing who you really are or what you want out of life” and “Not feeling close to other people or enjoying your relationships with them.”

In addition, a 25-item self-report Scale of Personality has been developed from a community survey to tap into the five-domain personality trait model now proposed by the Work Group. This scale is meant to serve as a self-report “review of systems” for major pathological trait domains and is being tested in the DSM-5 Field Trials. Patients who score above average (based on a community population of persons who reported ever having sought help for an emotional problem) will be flagged for more detailed personality assessment by Field Trials clinicians. The inventory can also provide a snapshot of the personality traits of all patients, whether they have a PD or not.

Other questions have been asked about the proposed model, such as whether nonpsychiatric medical practitioners will be able to understand the meaning of certain key terms, such as “identity” and “empathy,” despite the fact that these terms have appeared in the DSM for the past 30 years, are represented in most theories of personality, and can be readily found in newspaper articles and in television scripts. Also, whether PDs can be diagnosed in 15 minutes has been asked. It is interesting that similar questions are not asked about the meaning of less obvious diagnostic terms in other areas of psychopathology (e.g., avolition or prosody in schizophrenia), nor whether schizophrenia, attention-deficit disorder, posttraumatic stress disorder, or other complex mental disorders can (or should be) diagnosed in 15 minutes.

The PD proposal is responsive to limitations on clinicians. The model has been designed to be flexible and to telescope a clinician’s attention onto personality psychopathology with increasing specificity, depending on limitations on time, information, and expertise. The model is intended to facilitate identification of personality-related problems and their severity (i.e., the Levels of Personality Functioning, see below) and then to characterize these problems according to clinically salient types and ultimately by patient-specific personality trait profiles. The assessments of personality problems and of pathological personality traits are relevant whether a patient has a PD or not. Nonetheless, many would argue that DSM-5 should be for specialists in psychiatry and that a primary care version should be developed for primary care, rather than gearing the manual toward the nonspecialist.
PROPOSED DSM-5 PERSONALITY DISORDER MODEL

The currently proposed DSM-5 model consists of three interrelated parts: the Levels of Personality Functioning scale, diagnostic criteria for six specific PDs and for PDTS, and a five-domain/25-facet pathological personality trait assessment.

Levels of Personality Functioning

Personality psychopathology emanates from disturbances in thinking about self and others. Because there are degrees of disturbance in the self and interpersonal domains, a continuum composed of levels of self and interpersonal functioning was developed for assessing individual patients. A review of the empirical literature on dimensional models pertinent to individuals’ mental representations of self and others (Bender et al. 2011) and subsequent empirical analyses (Morey et al. 2011) identified the components most central to a personality functioning continuum: identity and self-direction (self); empathy and intimacy (interpersonal). The Levels of Personality Functioning scale uses each of the components to differentiate five levels of impairment in self-interpersonal functioning, ranging from no impairment, i.e., healthy functioning (level = 0), to extreme impairment (level = 4). (See http://www.dsm5.org for the complete scale.)

Pathological Personality Traits

The Work Group has proposed five broad, higher-order personality trait domains—negative affectivity, detachment, antagonism, disinhibition versus compulsivity, and psychoticism—each composed of from three to nine lower-order, more specific trait facets. Trait domains and facets are rated on a four-point dimensional scale of descriptiveness. (See http://www.dsm5.org for the definitions of all DSM-5 trait domains and trait facets.)

General Criteria for Personality Disorder

The revised general criteria for PD are described on the DSM-5 Web site (http://www.dsm5.org). All PDs described by criteria sets and PDTS will meet the general criteria.

RATIONALES FOR PROPOSED CHANGES

Revised Levels of Personality Functioning

Recent research suggests that generalized severity may be the most important single predictor of concurrent and prospective dysfunction in assessing personality psychopathology and that PDs are optimally characterized by a generalized personality severity continuum with additional stylistic elements, derived from PD symptom
constellations and personality traits (Hopwood et al. 2011). A number of experts (e.g., Parker et al. 2002, Tyrer 2005) concur that severity assessment is essential to any dimensional system for personality psychopathology. Neither the DSM-IV-TR general severity specifiers nor its Axis V GAF Scale have sufficient specificity for personality psychopathology to be useful in measuring its severity.

Literature reviewed by Bender et al. (2011) demonstrated that PDs 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 to assess personality functioning and psychopathology demonstrate that a self-other dimensional perspective has an empirical basis and significant clinical utility. 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 these measures 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. Because many of the constructs measured by these instruments have significant validity and utility for characterizing levels of personality psychopathology, they serve as the foundation for creating a new measure.

To this end, the various concepts across self-other models were synthesized to form a foundation for rating personality functioning on a continuum. A preliminary structure with three broad dimensions in each of the self and interpersonal domains was proposed: Self (identity integration, integrity of self-concept, self-directness) and Interpersonal (empathy, intimacy, complexity and integration of representations of others) (Skodol et al. 2011b,c). This was posted in February 2010 on the APA’s DSM-5 Website.

To both validate the dimensional approach of the proposed Levels of Personality Functioning and to make the continuum more readily accessible and usable by clinicians of various disciplines, four subsequent steps were taken: (a) a secondary data analysis, (b) a focus on only the most reliable constructs from the various measures surveyed for the Levels development, (c) a synthesis of 1 and 2 into a revised Levels of Personality Functioning, and (d) a further simplification and reorganization of the Levels into a tabular format, with a five-point numerical scale.

To determine the validity of the core dimension of personality pathology based on deficits in representations of self and others, Morey et al. (2011) used data from two samples: 424 patient participants from the Psychotherapeutic Center De Viersprong and 2,730 participants from various treatment centers and the general population in the Netherlands (Verheul et al. 2008). The instruments measuring personality functioning were the Severity Indices of Personality Problems (Verheul et al. 2008) and the General Assessment of Personality Disorder (WJ Livesley, unpublished manuscript). The instruments measuring DSM-IV PD diagnoses were the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First et al. 1997) and the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl et al. 1997).

First, specific items in the Severity Indices of Personality Problems and the General Assessment of Personality Disorder were identified as reliable and discriminating markers of the dimensions identified above in the preliminary Levels of Personality Functioning. Then, IRT analyses were conducted to identify items characterizing the types of problems associated with different levels of severity. In addition, discrimination parameters indicated the ability of a particular item to distinguish patients at a particular level from those at lower levels. The results of these analyses demonstrated and delineated a coherent global dimension of severity of impairment in personality functioning that was clearly related to the likelihood of receiving
Impairment in self and interpersonal functioning is consistent with multiple theories of PD and their research bases, including cognitive/behavioral, interpersonal, psychodynamic, attachment, developmental, social cognitive, and evolutionary theories, and is a key aspect of personality pathology in need of clinical attention (Clarkin & Huprich 2011, Luyten & Blatt 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). Furthermore, the Levels of Personality Functioning constructs align well with the NIMH Research Domain Criterion 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 variation in the encoding of receptors for these neuropeptides may contribute to variation in complex human social behavior and social cognition, such as trust, altruism, social bonding, and the ability to infer the emotional state of others (Donaldson & Young 2008). Neural instantiations of the self and of empathy for others have also been linked to the medial prefrontal cortex and other cortical midline structures—the sites of brain’s so-called default network (Fair et al. 2008, Northoff et al. 2006, Preston et al. 2007).

Revised Personality Disorder Types

The original proposal for the specified PD types in DSM-5 had three main features: (a) a reduction in the number of specified types from ten to five, (b) description of the types in a narrative format that combined typical deficits in self and interpersonal functioning and particular configurations of traits and behaviors, and (c) a dimensional rating of the degree to which a patient matched each type. Five specific PDs were recommended for retention: antisocial/psychopathic, borderline, schizotypal, avoidant, and obsessive-compulsive.
Each DSM-IV-TR PD was the subject of a literature review performed by Work Group members and advisors. Antisocial, borderline, and schizotypal PDs 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 PDs.

There are no clinical or empirical justifications for the number of criteria needed to make a PD diagnosis according to DSM-IV-TR. 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. Of the number of ways to dimensionalize PD diagnoses, a person-centered dimensional approach was originally adopted by the Work Group to represent specific PD types. Using this system, a clinician compares a patient to paragraph-length narrative descriptions of the prototypic patient with each disorder, and the match is rated on a 5-point scale, with 5 being a very good match to 1 representing little or no match. Prototype matching ratings have been shown to have good interrater reliability (Westen et al. 2010), to reduce comorbidity, to predict external validators as well as DSM-IV PD diagnoses (Westen et al. 2006b), 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 PDs when given ratings of patients on a list of traits of normal-range personality than when given prototype PD descriptions (Rottman et al. 2009). These findings were replicated in comparisons of DSM-IV to the FFM with raters who were experts in PD and familiar with the FFM (Rottman et al. 2011).

In the original DSM-5 Website posting, selected personality trait facets from relevant trait domains (see table 2 in Skodol et al. 2011c) were grouped with each of the five types to provide context for the trait ratings. The traits were selected on the basis of a careful mapping of the language of the types onto the trait definitions. Ratings on these traits were 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. Feedback from the Website posting suggested that this system was too complicated, redundant with the full clinicians’ trait ratings, and unwieldy. Furthermore, the empirical basis for assigning trait facets to types was questioned. Therefore, the trait ratings were completely separated from the type ratings in the first revised assessment model developed for field testing, with the goal of establishing relationships empirically. Now, however, traits have been reintroduced as the B criteria for the six new PD criteria sets.

The rationales for retaining six of the 10 DSM-IV PDs are reviewed in detail elsewhere (Skodol et al. 2011a). Briefly, the rationales were based on their prevalence (and the consistency of prevalence estimates) in community and clinical populations, psychosocial impairment associated with individual PDs, and other evidence of the validity and clinical utility of the disorders. The evidence does not align completely, but on the whole, there are stronger arguments for retaining certain PDs than for others. For example, two PDs recommended for retention, avoidant personality disorder and obsessive-compulsive personality disorder (OCPD), are consistently among the most common in both epidemiological (Torgersen 2009) and clinical (Stuart et al. 1998, Zimmerman et al. 2005) samples. Avoidant personality disorder (perhaps surprisingly) is also one of the most impairing of the PDs, according to empirical studies. Although OCPD has less broadly associated impairment, it nonetheless predicts poor outcomes, including suicide (Diaconu & Turecki 2009), and has high levels of associated health and productivity loss costs (Soeteman et al. 2008). STPD has relatively low prevalence in both populations, is highly impairing, and has considerable research to support it. BPD has an average prevalence in community studies but is one of the most common in the clinic, is associated with high levels of impairment and poor
outcomes, and has a wealth of data to support its validity and utility. Antisocial personality disorder is less common, and of average impairment, but has also been extensively studied and has considerable relevance in forensic settings. Narcissistic personality disorder was originally slated for deletion as a disorder, with dimensional representation in DSM-5 by typical personality functioning impairment levels and traits. It is among the less common PDs, is moderately impairing, and has an average research base. Following the original Website posting, however, many comments were received bemoaning its deletion as a specific PD. It has been reintroduced in the criteria sets for DSM-5 with significant conceptual revisions to capture both the overt, grandiose presentation and the covert, deflated one.

In contrast, schizoid PD (recommended for deletion as a type and representation by PDTS) is consistently among the least common, especially in clinical samples, although it has been found to be impairing. Two other PDs to be recommended for deletion as types, histrionic and dependent, have lower prevalence in the community, widely variable (by factors of 10 to 20 times) prevalence estimates in clinical populations, relatively low levels of impairment, and little empirical study as distinct PDs. Paranoid PD has been found to be common and impairing, but little research has been done to support it as a disorder separate from others.

New Criteria for Six Specific Personality Disorders and Personality Disorder Trait Specified

In response to feedback from the DSM-5 Task Force, new diagnostic criteria sets have been developed for the six specific PDs as well as the category of PD Trait Specified, which is intended to replace PD Not Otherwise Specified (PDNOS) in DSM-5. Descriptions of typical levels of impairment in self (identity or self-direction) and in interpersonal (empathy or intimacy) are included in the A criteria of the newly proposed diagnostic criteria for the specific PDs. The diagnosis of a trait-specified personality disorder requires a rating of significant impairment in personality functioning combined with the presence of pathological trait domains or facets and is intended to provide a diagnosis to replace PDNOS. That is, when the presentation does not neatly resemble a specific PD type, the clinician has the option of diagnosing PDTS and tailoring the description of the PD to fit the specific patient, using the specific features encoded by pathological traits.

A number of recent studies support a hybrid model of personality psychopathology consisting of ratings of both disorder and trait constructs. Morey & Zanarini (2000) found that FFM domains captured substantial variance in the borderline diagnosis with respect to its differentiation from nonborderline PDs but that residual variance not explained by the FFM was significantly related to important clinical correlates of BPD, such as childhood abuse history, family history of mood and substance use disorders, concurrent (especially impulsive) symptoms, and two- and four-year outcomes. In the Collaborative Longitudinal Personality Disorders Study, dimensionalized DSM-IV-TR PD diagnoses predicted concurrent functional impairment, but this diminished over time (Morey et al. 2007). In contrast, the FFM provided less information about current behavior and functioning but was more stable over time and more predictive in the future. The 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 & Zanarini (2010) found that FFM extraversion and agreeableness were incrementally predictive (over a BPD diagnosis) of psychosocial functioning over a 10-year period and that borderline cognitive and impulse action features incremented FFM traits.
They concluded that both BPD symptoms and personality traits are important long-term indicators of clinical functioning and supported the integration of traits and disorder in DSM-5.

**Revised Pathological 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 composed of from four to 10 (total = 37) lower-order, more specific trait facets (see Appendix B, DSM-5 Clinicians’ Trait Rating Form, in Skodol et al. 2011b). The rationale for this pathological personality trait model is described in detail elsewhere (Krueger & Eaton 2010; Krueger et al. 2011a,b; Skodol et al. 2011c).

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 PD diagnoses because the personality traits that comprise PDs 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 PD diagnoses fail to “carve nature at her joints.” Traits can combine in virtually an infinite number of ways. A PD diagnostic system that is 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 PD (and many other DSM-IV) 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 PD is designed to accommodate the naturally occurring heterogeneity of personality, but the heterogeneity of personality features within a PD 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 (Grilo et al. 2004, Shea et al. 2002) had been a puzzle until recent data suggested that the DSM 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 PD diagnoses as a whole less stable than their trait components. Basing PD diagnostic criteria on more stable traits and considering the more state-like features that occur in individuals with PD to be associated symptoms would eliminate the conceptual-empirical gap in PD 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 repeatedly have been shown to be continuous with more severe manifestations of these disorders. In the case of personality, this is especially well documented, and recent reviews and meta-analyses have documented clearly that an integrative structure can encompass both normal-range and abnormal personality (Markon et al. 2005; O’Connor 2002, 2005; Saulsman & Page 2004; Trull & Durett 2005). Implementing a trait-based system for PD diagnosis, therefore, provides the beneficial option of assessing any patient’s personality (i.e., not just those with PD). Insofar as personality has been shown to be an important modifier of a wide range of clinical phenomena (Rapee 2002), incorporating a dimensional trait model will strengthen not only PD diagnosis but also DSM-5 as a whole.

Considerable evidence relates current DSM PDs to four broad, higher-order trait domains
of the five-factor model of personality: neuroticism, extraversion, agreeableness, and conscientiousness (O’Connor 2005, Saulsman & Page 2004). As mentioned above, Widiger & Simonsen (2005) 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 PD 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 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 PD (Samuel & Widiger 2008) and that FFM traits tap only the social and interpersonal deficits of STPD 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 psychoticism (formerly called schizotypy) domain forms an important additional factor in analyses of both normal and abnormal personality (Chmielewski & Watson 2008, Harkness et al. 1995, Tackett et al. 2008, Watson et al. 2008). Therefore, an alternative fifth factor was added to the model. Meta-analyses further revealed that OCPD 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 PDs. Therefore, a sixth domain of compulsivity was added to address this otherwise missing element.

Finally, the proposed specific trait facets were selected provisionally as representative of the six domains on the basis of 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 over- 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). Accordingly, we expected that a number of the proposed facets might be highly correlated and so could be combined into a smaller number of somewhat broader facets. It is also possible that some facets were misplaced and would be moved to a different domain; others may be proven unreliable or structurally anomalous and be eliminated. The structural validity of the original trait model was tested in a three-wave community survey (Krueger et al. 2011b; RF Krueger, J Derringer, KE Markon, D Watson, & AE Skodol, unpublished manuscript) and was subsequently revised to yield the five-domain/25-trait model on which the newly proposed diagnostic criteria for PDs are based.

Revised General Criteria for Personality Disorder
The proposal to change the general criteria for PD was based on observations that the DSM-IV-TR criteria were poorly defined, not specific to PD, and were introduced in DSM-IV without theoretical or empirical justification. The rationale for revised general criteria is described earlier in this article in the sections on the Definition of Disorder, the rationale for the Revised Levels of Personality Functioning, and the rationale for the Revised Pathological Personality Traits.

CRITIQUES OF THE PROPOSED MODEL AND THEIR IMPACT ON MODEL EVOLUTION
A number of articles by Work Group members have been published on the proposed model at various stages of its development. Most of these articles have been accompanied by
commentaries or critiques written by prominent members of the PD research and clinical communities. In the sections that follow, these critiques are summarized along with brief accounts of how the critiques have or have not impacted the most recent version of the model as presented above.

Levels of Personality Functioning

Critiques of the original DSM-5 proposed revision generally praised the Levels of Personality Functioning as an advance over DSM-IV (e.g., Ronningstam 2011, Shedler et al. 2010) and suggested that the presence of PD and its severity are the primary distinctions of importance for clinicians (Pilkonis et al. 2011). Some 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). The need for reliability testing was suggested (Pincus 2011). Balancing the need for parsimony for general clinical use against the potential added value of a more complex and potentially redundant set of indicators, the Work Group has simplified rather than elaborated on the Levels. A single global rating of self and interpersonal functioning has been retained, rather than separate ratings, because of evidence of the close developmental and empirical relationships of these components of personality functioning (Luyten & Blatt 2011).

However, further empirical work investigating the validity, reliability, and utility of the new Levels of Personality Functioning, as well as of the other elements of the proposed personality disorder assessment, is needed. Of primary importance will be to test the reliability of the new Levels of Personality Functioning Scale as administered by clinicians to patients during conventional diagnostic evaluations. A formal test-retest reliability study is under way in Phase I of the official DSM-5 Field Trials in 11 large academic settings in the United States and Canada, where two independent clinicians are evaluating patients with and without PDs within a two-week timeframe (Kraemer et al. 2010). Five of the six specific PDs currently proposed for retention in DSM-5 (i.e., antisocial, avoidant, borderline, obsessive-compulsive, and schizotypal) will be represented in substantial numbers (e.g., N = 50) in this field trial so that the specificity of the Levels ratings for personality disorders as opposed to other types of psychopathology and the calibration of the Levels ratings against PDs with varying degrees of severity can be assessed. The feasibility and perceived clinical utility of the Levels ratings will also be assessed at the large academic sites as well as in a representative sample of U.S. psychiatrists and other volunteer mental health clinicians in clinical practice field trials supported by the APA (Kraemer et al. 2010). Other types of validity research should also be conducted in other geographic, cultural, and clinical settings and with other types of subjects (e.g., nontreatment seeking) in order to increase the generalizability of the Levels rating.

Personality Disorder Types

Critiques of the DSM-5 proposal have almost universally been against the deletion of any of the DSM-IV PD 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 PD to be reintroduced into the system (including from the comments posted on the Website) has been for narcissistic PD (e.g., Pincus 2011, Ronningstam 2011), but dependent PD has also had advocates.
(Bornstein 2011), even though the evidence presented for the validity of both of these disorders has often been based on dimensional measures rather than on the diagnostic category. Proponents for narcissistic PD agree, however, that its current representation in DSM-IV is inadequate. Pilkonis et al. (2011) argued for the inclusion in DSM-5 of PD types that have appeared in any DSM since DSM-III.

Work Group members have developed the strong, consensus opinion not to include all of the DSM-IV-TR PDs in the official DSM-5 classification. In fact, some members have persisted in wanting to replace all of the current disorders with a dimensional, trait-based model. The majority of the members believe that there are certain types that have particular clinical salience and evidence of validity and that other PDs with less evidence supporting them can be adequately represented by traits in combination with impairments in personality functioning, i.e., as PD Trait Specified. This convention not only makes the question of inadequate coverage or false negative PD diagnoses moot, but also adds potentially useful clinical information about the nature of personality pathology to the prevalent diagnosis of PDNOS, which in DSM-IV-TR was unspecified. As mentioned above, however, a revised category of narcissistic PD has been reintroduced at the time of this writing, despite some ambiguity in the strength of the rationale for doing so. Criteria sets may be developed for other DSM-IV-TR PDs, using the core impairment/trait hybrid model, for a DSM-5 appendix, in the hope that they will receive greater research attention in the future.

Reaction to the originally proposed shift from criterion-based to prototype-based diagnosis was more mixed. A number of reviewers supported the prototype approach because it is simple and more familiar (types as compared with 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 (First 2010, Shedler et al. 2010); these reviewers have suggested that prototypes replace categories in DSM-5. Questions were 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 PD types, their utility for research was questioned (Widiger 2011a, Zimmerman 2011). The derivation of the type descriptions and their relationships to DSM-IV PD criteria sets have been questioned (Pilkonis et al. 2011), as was the impact of a shift to prototypes on prevalence and comorbidity of PDs (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). 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 PD presence and severity) (Pilkonis et al. 2011); some suggest they be an optional rating on a separate axis (Axis II) (First 2010, Widiger 2011a); and 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). Livesley (2011) recently questioned whether the combination of categorical types and dimensional traits mixed incompatible approaches to classification. Historically, others (e.g., Benjamin 1993) have not seen the inconsistency, and experts in personality disorder have explicitly endorsed such a model (Bernstein et al. 2007). PD types represent the confluence of clinically relevant personality characteristics—impairments in personality functioning and traits—that have come to facilitate communication between
clinicians and have particular developmental, treatment, and prognostic significance.

In the most recent revision of the model, narrative prototypes have been replaced by diagnostic criteria sets, at the request of the DSM-5 Task Force. The new criteria sets incorporate trait ratings (with core impairments) based on empirical data linking traits to types (Samuel & Widiger 2008, Saulsman & Page 2004) and rational methods, which may delight some critics while discouraging others. The narrative prototypes have been used in the DSM-5 Field Trials (with about 1,000 patients out of 3,000 assessed as of this writing). It should be noted that the prototypes were replaced without the benefit of information from these 1,000 patients, since no data have been analyzed. In addition, both the impairment criteria (A) and the trait criteria (B) have been adopted for the criteria sets without any information on the reliability of these ratings in the Field Trials and without any new empirical information on their relationships to the disorders. It remains possible that further revisions of the criteria sets will be indicated. Furthermore, scoring rules for the new criteria and diagnostic algorithms for the disorders need to be developed and their impact on the prevalence and reliability of the disorders assessed.

### Personality Traits

Published critiques of the originally proposed trait system were predominantly negative. According to Gunderson (2010), the six-factor/37-facet trait system would be unfamiliar to clinicians and unlikely to be used because the traits lacked an experiential or empirical basis for clinical salience. Although it may represent a factor structure that is scientific, he believed there was 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 PDs, a consensus on the optimal number of traits and their definitions, and their use for making clinical inferences (Gunderson 2010). The traits were also criticized for being (a) nonspecific in that the same trait may apply to many types (First 2010, Paris 2011), (b) inherently ambiguous, static (as opposed to dynamic) representations of personality, difficult to incorporate into coding systems, and (c) 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, and by Clarkin & 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 PD 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 PD were too narrow, believed that some trait definitions were confounded with interpersonal elements, and noted 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 PD types. The recommendation from First (2010) is that a variable-centered trait approach should not replace categories in DSM-5 but could be on a separate axis (Axis II). Costa & McCrae (2010) argued that the notion of personality dimensions as adjuncts to PD types is supported and that traits should be assessed in all patients, not just those with PDs.

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 PD and its severity. They also found the new trait system and the diagnosis of PD 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 PDs 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 was much redundancy in some of the proposed trait facets whereas 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 do not map onto biological systems and ignore the emergent properties of cognitive, affective, and behavioral systems in PDs.

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,b). The lack of bipolarity to the traits leads to the omission of clinically relevant traits and misplaced (within domains) traits (Pilkonis et al. 2011; Widiger 2011a,b). Several authors argue that the proposed trait structure does not correspond to the consensus “big four” and that the domains of compulsion and schizotypy are not needed (Pilkonis et al. 2011; Widiger 2011a,b).

Several authors also argue for the importance of including both normal and abnormal traits in DSM-5 and believe that the FFM does a better job at representing important personality variation than the proposed new model (Costa & McCrae 2010; Widiger 2011a,b). Finally, limitations and ambiguities in factor analytic methods to derive trait structures were mentioned by several authors (Clarkin & Huprich 2011, Hallquist & Pilkonis 2010).

The overall structure of the revised five-domain/25-facet system does correspond to the “big four” domains characterizing other trait models, with compulsion representing the opposite pole of a bipolar domain of disinhibition. Evidence for a psychoticism (formerly called schizotypy) domain has been mentioned above. That there are differences between extant models (including the DSM-5 model) at the facet level should come as no surprise since there is little consensus on the facet structure of trait domains. Problems with the narcissistic trait representation have been addressed with the new criteria, which combine core narcissistic impairments in identity, self-direction, empathy, and intimacy that include both inflated and deflated expressions and a revised trait of grandiosity that refers to either overt or covert manifestations. PDs are not represented solely by extreme traits in the revised model, since all of the disorder criteria, including those for PDTS, require impairments in personality functioning as well as the presence of pathological personality traits.

The scoring of traits and diagnostic criteria are open issues. Within the criteria, it is possible that ratings of trait domains will supersede rating of trait facets for diagnostic purposes and that facet ratings will be more fine-grained descriptions. In the Field Trials, raters are asked first to rate domains, and only when a domain is rated as relevant are the component facets rated.

An assessment tool for rating DSM-5 personality traits by self-report has been developed: the Personality Inventory for DSM-5 (Krueger et al. 2011; RF Krueger, J Derringer, KE Markon, D Watson, & AE Skodol, unpublished manuscript). This 220-item questionnaire was developed in a three-wave community survey and is currently being tested by a number of research groups across the country. It remains to be seen, however, whether clinicians can rate these traits (and the disorders based on them) reliably and whether clinicians regard them as useful. Both of these questions are being addressed in the Field Trials. Undoubtedly, training and familiarity will improve reliability. Finally, the clinical salience and utility of pathological personality traits continues to be a topic of debate. Certainly, broad personality trait domains, such as neuroticism (negative affectivity in the DSM-5 proposal) have strong relationships to adverse physical health outcomes (Lahey 2009), and neuroticism, (dis)agreeability (antagonism in DSM-5),
(un)conscientiousness (disinhibition), and extraversion predict both negative and positive psychosocial (Ozer & Benet-Martinez 2006, Roberts et al. 2007) outcomes. Studies of hybrid models of personality disorders (see above) also show that traits increment disorders (and vice versa) in predicting important antecedent, concurrent, and predictive variables. The clinical value of assessing specific trait facets is less established, though theoretically appealing (Verheul 2005).

**General Criteria for Personality Disorder**

As indicated previously, feedback received on the initial Website posting 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 impairment in personality functioning were integrated with pathological personality traits into the new general and specific criteria sets. For all PDs, severity in core impairments can vary on the continuum of the Levels of Personality Functioning Scale. For PDTS, significant impairment is required, and a threshold on the Levels is being studied in the Field Trials.

Integration of the general criteria for PD into the diagnostic process has been viewed as an advance, by distinguishing normality and abnormality separately from describing individual differences (Pincus 2011). The constructs embedded in the proposed general criteria for DSM-5 are consistent with research and many theories of PD but will require training to be rated reliably. Costa & McCrae (2010) believed that the originally proposed definitions of impairment in self-identity, which emphasized the instability of borderline functioning, contradicted data on the internal consistency and stability of self-reported personality traits. All levels of personality functioning are now represented in the A criterion of the general criteria for PD.

Pilkonis and colleagues agreed that PDs should be defined by impairments in functioning and adaptation (not by extreme traits) but thought that the originally proposed criteria were too esoteric, inferential, and narrow (Pilkonis et al. 2011). They advocated for including constructs of agency, community, autonomy, achievement, self-definition (identity versus confusion), capacity for attachment (intimacy versus isolation), generativity, and prosocial engagement. Their proposal for general criteria would reflect (a) failure to achieve autonomy and self-direction (with objective markers) and inability to develop consistent and realistic representation of self, (b) failures in interpersonal relatedness manifest by inability to develop and maintain close relationships and general social integration, and (c) 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 PD. Clarkin & 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. As in the case of the Levels of Personality Functioning, which now constitute the core impairments central to the personality disorder definition and are represented by the A criteria in the new general and specific diagnostic criteria, the majority of critics favored a simplified, rather than a more elaborated, definition, and the empirical support for the four core self and interpersonal elements selected for the revised model has been described above.

**CONCLUSIONS**

Scientific principles were articulated for guiding DSM-5 more than a decade ago. These principles have influenced the development of
proposed changes for the assessment and diagnosis of personality psychopathology. Their application to the process has not been straightforward, however. Principles were left ambiguous and became open to interpretation, debate, and controversy among Work Group members. In some instances, contradictory messages were sent. Deliberations have been hampered by unclear decision-making processes.

Although widespread dissatisfaction with the current DSM-IV-TR categorical classification of PDs has long pervaded the field, little consensus exists on the preferred alternative. The P&P Work Group members have labored in a systematic and diligent manner to improve the DSM-5 approach to personality and personality disorders in order to make the classification more valid and more clinically useful. They have attempted to be responsive to the array of diverse and sometimes contradictory suggestions made by other members of the PD research and clinical communities. The current model continues to be a work in progress. The next steps will include the review of data from the Field Trials on the reliability, feasibility, and acceptability of each element of the assessment. Further changes are expected as a result of the process.

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The author is Chair of the DSM-5 Personality and Personality Disorder Work Group, an unpaid position. The author is unaware of any other affiliation, funding, or financial holdings that might be perceived as affecting the objectivity of this review.

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