The DSM-5 Alternative Model for Personality Disorders:

Rationale and Research

Leslie C. Morey
Department of Psychology
Texas A&M University
Problems with DSM-IV PDs

- Limited diagnostic reliability
- High frequency of comorbidity
- Inadequate coverage, high use of PD-NOS
- Heterogeneity with diagnostic groups
- Arbitrary distinction between normal and abnormal personality functioning
# Bernstein et al. (2007) survey

## TABLE 4. Possible Alternatives to the DSM-IV’s System for Classifying Personality Disorders

<table>
<thead>
<tr>
<th>Questions #13 and #14</th>
<th>Total % agreement</th>
<th>Total % disagreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) ... be a categorical system for PD, just as it is now.</td>
<td>25.0</td>
<td>74.0</td>
</tr>
<tr>
<td>(b) ... be a dimensional system for PD.</td>
<td>55.8</td>
<td>42.1</td>
</tr>
<tr>
<td>(c) ... be a mixed system of categories and dimensions for PD.</td>
<td>69.5</td>
<td>28.4</td>
</tr>
<tr>
<td>(d) ... be a totally dimensional system for both Axis I disorders and PD.</td>
<td>23.2</td>
<td>73.7</td>
</tr>
<tr>
<td>(e) ... be a prototypical system for PD, where patients are rated in terms of how closely they correspond to a prototype for each PD.</td>
<td>50.5</td>
<td>45.3</td>
</tr>
<tr>
<td>(g) keep PD on Axis II, separate from Axis I disorders</td>
<td>76.8</td>
<td>21.1</td>
</tr>
<tr>
<td>(h) ... classify some PD as dimensional/spectrum variants of Axis I disorders.</td>
<td>66.3</td>
<td>31.6</td>
</tr>
<tr>
<td>(i) ... eliminate Axis II, and classify PD as spectrum variants of the Axis I disorders (e.g., schizotypal PD would be grouped with schizophrenia, rather than with the other PD).</td>
<td>13.7</td>
<td>84.2</td>
</tr>
<tr>
<td>(d) eliminate PD from DSM V altogether.</td>
<td>4.2</td>
<td>94.7</td>
</tr>
</tbody>
</table>

*Note. Percentages may not add to one hundred percent, because some respondents answered “uncertain.”*
DSM-5 as a Paradigm Shift?

- DSM-5 (2013)
  - DSM-III represented a major shift to enhance reliability
  - Supposed DSM-5 focus upon enhancing validity of psychiatric diagnosis
  - David Kupfer & Darrel Regier, co-chairs
  - Task Force consisting of chairs of 13 Work Groups, with 10-12 members each
  - “everything is on the table”
Personality and Personality Disorders

ANDREW E. SKODOL, M.D.
Chair

JOHN M. OLDHAM, M.D.
Co-Chair

Robert F. Krueger, Ph.D., Text Coordinator
Renato D. Alarcon, M.D., M.P.H.
Carl C. Bell, M.D.
Donna S. Bender, Ph.D.

Lee Anna Clark, Ph.D.
Leslie C. Morey, Ph.D.
Larry J. Siever, M.D.

1 The members of the Personality and Personality Disorders Work Group are responsible for the alternative DSM-5 model for personality disorders that is included in Section III. The Section II personality disorders criteria and text (with updating of the text) are retained from DSM-IV-TR.
DSM-5 PD proposal: process

• Supported unanimously by the Work Group (after 2 resignations)
• Endorsed unanimously (if grudgingly) by the DSM-5 Task Force and DSM-5 leadership
• Rejected by the American Psychiatric Association’s Board of Trustees
• DSM-IV PDs were retained in “Section II”, the DSM-5 alternative model placed in “Section III”
### SECTION III

**Emerging Measures and Models**

<table>
<thead>
<tr>
<th>Assessment Measures</th>
<th>733</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-Cutting Symptom Measures</td>
<td>734</td>
</tr>
<tr>
<td>DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult</td>
<td>738</td>
</tr>
<tr>
<td>Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Age 6–17</td>
<td>740</td>
</tr>
<tr>
<td>Clinician-Rated Dimensions of Psychosis Symptom Severity</td>
<td>742</td>
</tr>
<tr>
<td>World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)</td>
<td>745</td>
</tr>
<tr>
<td>Cultural Formulation</td>
<td>749</td>
</tr>
<tr>
<td>Cultural Formulation Interview (CFI)</td>
<td>750</td>
</tr>
<tr>
<td>Cultural Formulation Interview (CFI)—Informant Version</td>
<td>755</td>
</tr>
<tr>
<td>Alternative DSM-5 Model for Personality Disorders</td>
<td>761</td>
</tr>
<tr>
<td>Conditions for Further Study</td>
<td>783</td>
</tr>
<tr>
<td>Attenuated Psychosis Syndrome</td>
<td>783</td>
</tr>
<tr>
<td>Depressive Episodes With Short-Duration Hypomania</td>
<td>786</td>
</tr>
<tr>
<td>Persistent Complex Bereavement Disorder</td>
<td>789</td>
</tr>
<tr>
<td>Caffeine Use Disorder</td>
<td>792</td>
</tr>
<tr>
<td>Internet Gaming Disorder</td>
<td>795</td>
</tr>
<tr>
<td>Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure</td>
<td>798</td>
</tr>
<tr>
<td>Suicidal Behavior Disorder</td>
<td>801</td>
</tr>
<tr>
<td>Nonsuicidal Self-Injury</td>
<td>803</td>
</tr>
</tbody>
</table>
Personality disorder in DSM-5: an oral history

P. Zachar¹, R. F. Krueger² and K. S. Kendler³*

¹Department of Psychology, Auburn University Montgomery, Montgomery, AL, USA
²Department of Psychology, University of Minnesota, Minneapolis, MN, USA
³Department of Psychiatry and Department of Human and Molecular Genetics, Virginia Institute of Psychiatric and Behavioral Genetics, Virginia Commonwealth University School of Medicine, Richmond, VA, USA

As the revision process leading to DSM-5 began, the domain of personality disorder embodied the highest aspirations for major change. After an initial prototype-based proposal failed to gain acceptance, the Personality and Personality Disorders Work Group (P&PDWG) developed a hybrid model containing categorical and dimensional components. A clash of perspectives both within the P&PDWG and between the P&PDWG and DSM-5 oversight committees led to the rejection of this proposal from the main body of DSM-5. Major issues included conflicting ways of conceptualizing validation, differences of opinion from personality disorder experts outside the P&PDWG, divergent concepts of the magnitude of evidence needed to support substantial changes, and the disagreements about clinical utility of the hybrid model. Despite these setbacks, the ‘Alternative DSM-5 Model of Personality Disorder’ is presented in Section III of the DSM-5. Further research should clarify its performance relative to the DSM-IV criteria reprinted in the main DSM-5 text.

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Key words: DSM-5, history, personality disorder.
DSM-5: Lightning Rod for Controversy

By Dr. Frances, M.D. | February 11, 2010

Dr. Frances was the chair of the DSM-IV Task Force and of the department of psychiatry at Duke University School of Medicine, Durham, NC. He is currently professor emeritus at Duke.

I have previously criticized the DSM-V process—for its unnecessary secrecy, its risky ambitions, its disorganized methods, and its unrealistic deadlines. Now, it is finally time to evaluate the first draft of the recently posted DSM5 product (at www.dsm5.org).

Problematic writing

Perhaps the most obvious problem in DSM-V is the poor and inconsistent writing. Admittedly, early Work Group drafts are often written imprecisely and with varying quality, but it is surprising that the DSM-V leadership has failed to edit for clarity and consistency. It would be a waste of effort, time, and money to conduct field trials before the new criteria are ready.

Higher rates of mental disorder

In terms of content, most concerning are the many suggestions for DSM5 that would dramatically raise the rates of mental illness. They are based on flawed research and wrongheaded assumptions. The suggestion is that we will have to add more than a hundred new disorders to DSM-V to capture new mental illnesses that did not exist when the DSM-IV was written.

Personality Disorders in DSM-5

DSM-5’s proposed format presents a significant shift in the approach to diagnosing personality disorders. The diagnostic criteria outlined in DSM-III and DSM-IV and the introduction of axis II were intended to focus attention on these disorders in clinical practice and to foster research on their diagnosis, epidemiology, psychopathology, clinical course, and treatment. A diagnostic system should be clinically relevant, encompass the spectrum of personality disorders seen in practice, facilitate their recognition, and still be simple enough to be used by busy clinicians, including those who do not specialize in the assessment and treatment of personality. At the same time, the diagnostic scheme must reflect and support progress in research that leads to increased understanding and better treatments of these illnesses. For instance, the proposed system for classifying personality disorders is too complicated, includes a trait-based approach in diagnosis without an adequate clinical definition, and omit personality syndromes that have significant clinical utility.

The proposed DSM-5 diagnostic scheme for personality disorders is an arbitrary compartmentalization of disparate models that cannot happily coexist and raises the likelihood that many clinicians will not have the patience and persistence to make use of it in their practice. The resultant draft criteria encompass 5 levels of personality functioning, 5 personality types, 6 personality trait naming scales, and 49 trait naming subscales or facets per trait naming scale.

We strongly advocate that the...
DSM-5 Hybrid Proposal
(e.g. Skodol et al, 2011)

• Severity/Level of Personality Pathology
• Problematic Personality Traits
• Personality Disorder Types

DSM-5 PD Clinical Survey Field Study

- Web-based study of patients described by 337 clinicians (88 MD/DO, 213 PhD/PsyD; 52% men)
- Solicited via email from membership lists of numerous professional organizations
- 1,829 initial emails sent, 444 clicked to receive more information, 337 participated (76% of those informed, 18% of initial emails)
- Formulation of patient with whom had 5 hours contact (16% no PD, most common PD = 40% borderline PD)
- 3 part instrument
  - Demographic information and various clinical judgments
  - Decisions about all DSM-IV criteria verbatim (in random order), followed by final assigned DSM-IV diagnoses for all PDs, & clinical utility ratings
  - Decisions about all DSM-5 criteria verbatim (in random order), single-item LPF rating, 4-point judgments of 25 DSM-5 pathological traits and higher order trait domains, & clinical utility ratings

Leslie C. Morey, Ph.D.
DSM-5 Hybrid Proposal
(e.g. Skodol et al, 2011)

• Severity/Level of Personality Pathology
• Problematic Personality Traits
• Personality Disorder Types

**DSM-IV Criteria for “Personality Disorder”**

**General diagnostic criteria for a Personality Disorder**

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
3. Interpersonal functioning
4. Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

- No clear specificity (i.e., applies to almost anything chronic)
- No way to assess core construct

Leslie C. Morey, Ph.D.
# Review Measures of Global Personality Pathology

(Bender et al, 2011)

**Table 2.**—Evaluation of measure dimensions

<table>
<thead>
<tr>
<th></th>
<th>QORS</th>
<th>PODF</th>
<th>D-RS</th>
<th>CLS</th>
<th>S-DS</th>
<th>SCORS</th>
<th>RFS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self: Identity integration</strong></td>
<td></td>
<td></td>
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<tr>
<td>Regulation of self-states</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td>X</td>
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<tr>
<td>Boundary delineation (self–other differentiation)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>Meaningful sense of time and personal history</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
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<td></td>
<td>X</td>
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<tr>
<td>Ability to differentiate a unique self from representation of other people</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Self-reflectiveness</td>
<td></td>
<td>X</td>
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<td>X</td>
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<td>X</td>
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<tr>
<td><strong>Self: Integrity of self-concept</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Self-esteem regulation</td>
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<td>X</td>
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<td>X</td>
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<td>Self-respect</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Autonomous agency</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Realistic self-appraisal</td>
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<td></td>
<td>X</td>
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<tr>
<td>Complex and multifaceted self-representation</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Self: Self-directedness</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Establishment of reasonable standards</td>
<td>X</td>
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<tr>
<td>Goal-directedness</td>
<td>X</td>
<td></td>
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<td>X</td>
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<tr>
<td><strong>Interpersonal: Empathy</strong></td>
<td></td>
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<tr>
<td>Ability to mentalize</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity for identifying with others’ experiences</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention to range of others’ perspectives</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding of social causality</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Interpersonal: Intimacy</strong></td>
<td></td>
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<tr>
<td>Depth and duration of connection with others</td>
<td>X</td>
<td></td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Tolerance and desire for closeness</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reciprocity of regard and support</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interpersonal: Complexity and integration of representations of others</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohesiveness, complexity, and integration of mental representations of others</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Use of other representations to regulate self</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

*Note.* QORS = Quality of Object Relations Scale; PODF = Personality Organization Diagnostic Form; D-RS = Differentiation-Relatedness Scale; CLS = Conceptual Level of Descriptions of Self and Other; S-DS = Self-Description Scales; SCORS = Social Cognition and Object Relations Scale; RFS = Reflective Functioning Scale.

Severity/Level of Personality Pathology

DSM-5 Component

**TABLE 1** Elements of personality functioning

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

**Interpersonal:**
1. **Empathy:** Comprehension and appreciation of others’ experiences and motivations; tolerance of differing perspectives; understanding the effects of one’s own behavior on others.
2. **Intimacy:** Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

- Five-point rating scale of impairment
  - Little to None, Some, Moderate, Severe, Extreme
DSM-5 PD Severity

- Characteristics of individuals at different levels described in the "Level of Personality Functioning" scale

- Implicit in describing these dysfunctions is that these reflect failures in developmental and maturational processes
Maturational Continuum As Core Consideration for Personality

Leslie C. Morey, Ph.D.
LPFS rating predicting DSM-IV PD

AUC = .832
SENS = .846, SPEC = .727

FIGURE 1. ROC curve, level of personality functioning relative to any specific DSM-IV PD diagnosis.

Global Severity and PD Diagnosis/Comorbidity

Number of PD Diagnoses

Convergent Validity: LPF rating

TABLE 2. Correlations Between DSM-5 LPFS Ratings and Indicators of Personality Pathology

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample</th>
<th>European-American (n = 252)</th>
<th>Non-European-American (n = 85)</th>
<th>Female (n = 192)</th>
<th>Male (n = 145)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self/interpersonal functioning composite</td>
<td>0.723</td>
<td>0.711</td>
<td>0.761</td>
<td>0.722</td>
<td>0.729</td>
</tr>
<tr>
<td>Identity problems</td>
<td>0.531</td>
<td>0.547</td>
<td>0.506</td>
<td>0.554</td>
<td>0.527</td>
</tr>
<tr>
<td>Self-direction problems</td>
<td>0.514</td>
<td>0.504</td>
<td>0.537</td>
<td>0.510</td>
<td>0.518</td>
</tr>
<tr>
<td>Empathy problems</td>
<td>0.495</td>
<td>0.465</td>
<td>0.587</td>
<td>0.491</td>
<td>0.499</td>
</tr>
<tr>
<td>Intimacy problems</td>
<td>0.563</td>
<td>0.558</td>
<td>0.589</td>
<td>0.608</td>
<td>0.513</td>
</tr>
<tr>
<td>Personality Functioning Scale (Morey et al., 2011)</td>
<td>0.722</td>
<td>0.702</td>
<td>0.774</td>
<td>0.751</td>
<td>0.685</td>
</tr>
<tr>
<td>DSM-IV total PD symptoms</td>
<td>0.506</td>
<td>0.490</td>
<td>0.550</td>
<td>0.501</td>
<td>0.517</td>
</tr>
<tr>
<td>DSM-5 Criterion A sum</td>
<td>0.558</td>
<td>0.514</td>
<td>0.666</td>
<td>0.559</td>
<td>0.564</td>
</tr>
<tr>
<td>Social functioning composite</td>
<td>0.471</td>
<td>0.494</td>
<td>0.408</td>
<td>0.494</td>
<td>0.446</td>
</tr>
<tr>
<td>Risk composite</td>
<td>0.385</td>
<td>0.428</td>
<td>0.285</td>
<td>0.398</td>
<td>0.371</td>
</tr>
<tr>
<td>Prognosis rating</td>
<td>0.480</td>
<td>0.448</td>
<td>0.551</td>
<td>0.475</td>
<td>0.481</td>
</tr>
<tr>
<td>Level of care rating</td>
<td>0.353</td>
<td>0.386</td>
<td>0.275</td>
<td>0.312</td>
<td>0.390</td>
</tr>
</tbody>
</table>

All correlations are statistically significant, p < 0.001. No significant differences (Fisher’s Z test, p < 0.05) were observed between correlations related to ethnicity or sex.

LPFS vs. DSM-IV PDs: Clinical Judgments


### TABLE 3. Comparison of Predictions of Clinical Judgments, DSM-5 LPFS Rating vs. DSM-IV Categorical PD Diagnoses

<table>
<thead>
<tr>
<th></th>
<th>DSM-5 LPF</th>
<th>10 DSM-IV Categories</th>
<th>Hotelling’s $t$ Test, PRESS $r$’s</th>
<th>DSM-IV Increment DSM-5 LPF</th>
<th>DSM-5 LPF Increment DSM-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial functioning composite</td>
<td>0.471** (0.461**)</td>
<td>0.409** (0.344**)</td>
<td>2.35**</td>
<td>0.167**</td>
<td>0.363**</td>
</tr>
<tr>
<td>Risk composite</td>
<td>0.385** (0.373**)</td>
<td>0.632** (0.599**)</td>
<td>4.77**</td>
<td>0.530**</td>
<td>0.184**</td>
</tr>
<tr>
<td>Prognosis rating</td>
<td>0.480** (0.470**)</td>
<td>0.468** (0.410**)</td>
<td>1.24</td>
<td>0.246**</td>
<td>0.346**</td>
</tr>
<tr>
<td>Level of care rating</td>
<td>0.353** (0.337**)</td>
<td>0.381** (0.300**)</td>
<td>0.67</td>
<td>0.188**</td>
<td>0.246**</td>
</tr>
</tbody>
</table>

Values in parentheses are PRESS-corrected multiple correlations.

**$p < 0.01.$

- Single-item LPF as good or better at predicting 3 of 4 clinical judgments than the combination of 10 DSM-IV PD categorical diagnoses
- Single-item LPF significantly increments 10 DSM-IV diagnoses in 4 of 4 judgments
Difficult to Use?

Undergraduates using LPFS

AUC = .909

SENS = .898, SPEC = .808

Diagonal segments are produced by ties.

DSM-5 Dimensional Proposal
(e.g. Skodol et al, 2011)

- Severity/Level of Personality Pathology
- **Problematic Personality Traits**
- Personality Disorder Types

Problematic Personality Traits
Five broad domains (25 lower order facets)

• **Negative Emotionality** (emotional lability, anxiousness, submissiveness, separation insecurity, perseveration, depressivity*, suspiciousness*)

• **Detachment** (withdrawal, restricted affectivity*, anhedonia, intimacy avoidance)

• **Antagonism** (callousness, manipulativeness, grandiosity, attention-seeking, hostility*, deceitfulness)

• **Disinhibition** (impulsivity, distractibility, risk-taking, irresponsibility) vs. **Compulsivity** (rigid perfectionism)

• **Psychoticism** (unusual beliefs and experiences, eccentricity, cognitive and perceptual dysregulation)
DSM-5 Trait Model

- Trait definitions for higher order domains and lower order facets are provided
- Implicit in describing these traits is that they reflect temperamental, biobehavioral individual differences

Table 5: Definitions of DSM-5 personality disorder trait domains and facets

<table>
<thead>
<tr>
<th>Domain (Pole Opposite)</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Affectivity</td>
<td>Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt, shame, anger, and fear) and the tendency to experience and express these emotions in a socially inappropriate manner.</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>Frequent worry about the negative effects of past interpersonal experiences and future negative possibilities, feeling vulnerable and apprehensive about uncertainty, expecting the worst to happen.</td>
</tr>
<tr>
<td>Antagonism</td>
<td>Persistent or frequent angry feelings, anger or hostility in response to minor rights and insults, mean, angry, or vengeful behavior, lack of Antagonism.</td>
</tr>
<tr>
<td>Anhedonia</td>
<td>Lack of interest in, enjoyment of, or ability to experience pleasure or enjoyment in social activities or close relationships.</td>
</tr>
<tr>
<td>Bipolar Affectiveness</td>
<td>Emotional lability, instability of attention, and mood; emotions that are easily aroused, intense, and out of proportion to events and circumstances.</td>
</tr>
<tr>
<td>Antisociality</td>
<td>Inability to control impulses and desires; persistent and repeated failure to conform to social norms.</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>Inability to control impulses and desires; persistent and repeated failure to conform to social norms.</td>
</tr>
<tr>
<td>Submissiveness</td>
<td>Adaptation (toward Behavior to the societal or personal interests and demands of others) so that it is not attributed to one’s own willful behavior.</td>
</tr>
<tr>
<td>Healthy</td>
<td>Persistent or frequent angry feelings, anger or hostility in response to minor rights and insults, mean, angry, or vengeful behavior, lack of Antagonism.</td>
</tr>
</tbody>
</table>

Leslie C. Morey, Ph.D.
Dimensional Traits as Core Elements of Personality

Leslie C. Morey, Ph.D.

Cattell
Costa
McCrae
Eysenck
Galton
Cloninger
Wiggins
Goldberg
Millo
Tellegen
Allport
Jung
Christal

Leslie C. Morey, Ph.D.
Factor Structure of DSM-5 §3 Trait Ratings

- Investigating hierarchical structure using Goldberg’s strategy
- Replication of Wright et al., 2012 *J.Abn.Psych.*


Leslie C. Morey, Ph.D.
Factor Structure of DSM-5 §3 Clinician Ratings

Comparing factor structure for Wright et al.’s self-report, nonclinical vs. Morey et al.’s clinician ratings of patients

For 4 of 5 higher order factors, average congruence coefficient = .880

Largest difference: clinicians do not seem to conceptualize “compulsive” personality as the opposite of “disinhibition” (i.e., conscientiousness, constraint)

DSM-5 Dimensional Proposal
(e.g. Skodol et al, 2011)

• Severity/Level of Personality Pathology
• Problematic Personality Traits
• Personality Disorder Types

DSM-IV Personality Disorder Types

- “Cluster A”
  - Paranoid
  - Schizoid
  - Schizotypal

- “Cluster B”
  - Borderline
  - Antisocial
  - Narcissistic
  - Histrionic

- “Cluster C”
  - Avoidant
  - Dependent
  - Obsessive-Compulsive

- “Criteria Sets Provided for Further Study” (appendix)
  - Passive-Aggressive
  - Depressive

- Personality Disorder Not Otherwise Specified

Leslie C. Morey, Ph.D.
Roughly a dozen discrete personality types as core differences in personality
Personality Disorder Types

DSM-5 Component

• Proposal includes 7 PD “types”
  – Borderline
  – Antisocial
  – Schizotypal
  – Avoidant
  – Obsessive-compulsive
  – Narcissistic (reinstated after controversy)
  – PD, Trait-Specified

• Disorder types reflect specific combinations of global PD pathology and problematic traits
Personality Disorder Types

Why retain them?

- Continuity for clinical use
- Research base
- Empirically supported treatments
References to DSM-IV PDs
Scientific Literature, 1994-2010

Data gathered by L. C. Morey, October, 2010.
Personality Disorder Types

Borderline Personality Example

• Disorder types reflect “hybrid” of global PD pathology (Criterion A) and problematic traits (Criterion B)

Borderline Personality Disorder
Typical features of borderline personality disorder are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domain of Negative Affectivity, and also Antagonism and/or Disinhibition.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

1. **Identity**: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.

2. **Self-direction**: Instability in goals, aspirations, values, or career plans.

3. **Empathy**: Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.

4. **Intimacy**: Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternation between overinvolvement and withdrawal.

B. Four or more of the following seven pathological personality traits, at least one of which must be (6) Impulsivity, (7) Risk taking, or (7) Hostility:

1. **Emotional lability** (an aspect of Negative Affectivity): Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.

2. **Anxiousness** (an aspect of Negative Affectivity): Intense feelings of nervousness, tension, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.

3. **Separation Insecurity** (an aspect of Negative Affectivity): Fears of rejection by—and/or separation from—significant others, associated with fears of excessive dependency and complete loss of autonomy.

4. **Depressivity** (an aspect of Negative Affectivity): Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.

5. **Impulsivity** (an aspect of Disinhibition): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.

6. **Risk taking** (an aspect of Disinhibition): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one’s limitations and denial of the reality of personal danger.

7. **Hostility** (an aspect of Antagonism): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.
Borderline Personality in §3 Model Space

Leslie C. Morey, Ph.D.
PD-Trait Specified

Personality Disorder—Trait Specified

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by difficulties in two or more of the following four areas:
   1. Identity
   2. Self-direction
   3. Empathy
   4. Intimacy

B. One or more pathological personality trait domains OR specific trait facets within domains, considering ALL of the following domains:
   1. Negative Affectivity (vs. Emotional Stability): Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, anger), and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations.
   2. Detachment (vs. Extraversion): Avoidance of socioemotional experience, including both withdrawal from interpersonal interactions, ranging from casual, daily interactions to friendships to intimate relationships, as well as restricted affective experience and expression, particularly limited hedonic capacity.
   3. Antagonism (vs. Agreeableness): Behaviors that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both unawareness of others’ needs and feelings, and a readiness to use others in the service of self-enhancement.
   4. Disinhibition (vs. Conscientiousness): Orientation toward immediate gratification, leading to impulsive behavior driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences.
   5. Psychoticism (vs. Lucidity): Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception, dissociation) and content (e.g., beliefs).

• No more PD-NOS!
• Resembles ICD-11 PD Proposal, as well as NIH’s RDoC

Leslie C. Morey, Ph.D.
ICD-11 PD Proposal

Panel 2: Proposed category names and essential features of personality disorders in International Classification of Diseases (ICD-11)

Personality disorder
- A pervasive disturbance in how an individual experiences and thinks about the self, others, and the world, manifested in maladaptive patterns of cognition, emotional experience, emotional expression, and behavior.
- The maladaptive patterns are relatively inflexible and are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships.
- The disturbance is manifested across a range of personal and social situations (it is not limited to specific relationships or situations).
- The disturbance is relatively stable over time and is of long duration. Most commonly, personality disorder has its first manifestations in childhood and is clearly evident in adolescence.

Late onset qualifier
- If the disturbance has its origin in adulthood, the qualifier for “late onset” may be added. The “late onset” qualifier should be used for cases in which, by history, there is no evidence of personality disorder or its early manifestations prior to age 35 years.

Mild personality disorder
There are notable problems in many interpersonal relationships and the performance of expected occupational and social roles, but some relationships are maintained and some roles are carried out.
- Examples: Able to maintain, and has some interest in maintaining, a few friends, interpersonal or frequent, minor conflicts with peers, co-workers, and/or supervisors; alternatively, exhibits withdrawn, isolative behavior but, in either case, is capable of sustaining and willing to sustain employment, given appropriate employment opportunities. His meaningful relationships with some family members but typically avoids or has conflict with others.

Moderate personality disorder
There are marked problems in most interpersonal relationships, and in the performance of expected occupational and social roles across a wide range of situations that are sufficiently extensive that most are compromised to some degree.
- Examples: Able to maintain very few friends or has little interest in maintaining friendships. Irregular conflict with peers, coworkers, and/or supervisors or marked withdrawal and isolative behavior that interferes with the ability to function constructively at work or with others. May exhibit little interest in and/or efforts toward sustained employment when appropriate employment opportunities are available. May have a history of frequently changing employment as a result. Has conflict, or a marked absence of, relationships with actual or perceived stressors.

Moderate personality disorder often is associated with a past history and future expectation of harm to self or others, but not to a degree that causes long-term damage or has endangered life.
- Examples: Recurrent suicidal ideation or suicide attempts without a clear expectation of death, recurrent episodes of self-harm without clear lethality, recurrent hostile and confrontational behavior, or occasional violent episodes that involve only minor destruction of property (e.g., breaking things) or interpersonal aggression such as pushing, shoving, or slapping that is not sufficient to cause lasting injury to others.

Severe personality disorder
There are severe problems in interpersonal functioning affecting all areas of life. The individual's general social dysfunction is profound and the ability and/or willingness to perform expected occupational and social roles is absent or severely compromised.
- Examples: Has no friends but may have some associates. Unwilling or unable to sustain regular employment due to lack of interest or effort, interpersonal difficulties, or inappropriate behavior (e.g., irresponsibility, fits of temper, impulsiveness). Even when appropriate employment opportunities are available, conflict with withdrawal from peers and coworkers. Family relationships are absent (despite having living relatives) or marred by significant conflict.

Severe personality disorder usually is associated with a past history and future expectation of severe harm to self or others that has caused long-term damage or has endangered life.
- Examples: Suicide attempts with a clear expectation of death, episodes of self-harm that permanently injure, disfigure or deform the individual, episodes of serious property destruction such as burning down someone’s house in anger, or episodes of violence sufficient to cause lasting injury to others.

Panel 3: Domain traits in the proposed International Classification of Diseases (ICD-11) classification of personality disorders

Negative affective features
The negative affectivity trait domain is characterized primarily by the tendency to manifest a broad range of distressing emotions including anxiety, anger, self-soothing, irritability, vulnerability, depression, and other negative emotional states, often in response to even relatively minor actual or perceived stressors.

Dissocial features
The core of the dissocial trait domain is disregard for social obligations and conventions and the rights and feelings of others. Traits in this domain include callousness, lack of empathy, hostility and aggression, ruthlessness, and inability or unwillingness to maintain prosocial behavior, often manifested in an overly positive view of the self, entitlement, and a tendency to be manipulative and exploitative of others.

Features of disinhibition
The disinhibition trait domain is characterized by a persistent tendency to act impulsively in response to immediate internal or environmental stimuli without consideration of longer term consequences. Traits in this domain include irresponsibility, impulsivity without regard for risks or consequences, distractibility, and recklessness.

Anankastic features
The core of the anankastic trait domain is a narrow focus on the control and regulation of one’s own and others’ behavior to ensure that things conform to the individual’s particularistic ideal. Traits in this domain include perfectionism, perseveration, emotional and behavioral restraint, stubbornness, deliberativeness, onedimensionality, and concern with following rules and meeting obligations.

Features of detachment
The core of the detachment trait domain is emotional and interpersonal distance, manifested in marked social withdrawal and indifference to people, isolation with very few or no attachment figures, including avoidance of not only intimate relationships but also close friendships. Traits in the detachment domain include aloofness or coldness in relation to other people, reserve, passivity and lack of assertiveness, and reduced expression and experience of emotion, especially positive emotions, to the point of a diminished capacity to experience pleasure.


Leslie C. Morey, Ph.D.
Calibrating PD Type Diagnostic Rules

Table 4. Potential DSM-5 diagnostic decision rules for avoidant personality disorder

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Prevalence</th>
<th>DSM-IV-TR kappa</th>
<th>ASPD</th>
<th>AVPD</th>
<th>OCPD</th>
<th>BPD</th>
<th>NPD</th>
<th>STPD</th>
<th>Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM-IV-TR</td>
<td>26.3%</td>
<td>n/a</td>
<td>−0.196</td>
<td>0.673</td>
<td>0.146</td>
<td>0.212</td>
<td>−0.069</td>
<td>0.209</td>
<td>−0.096</td>
</tr>
<tr>
<td>DSM-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>13.8%</td>
<td>0.472</td>
<td>−0.163</td>
<td>0.624</td>
<td>0.139</td>
<td>0.130</td>
<td>−0.106</td>
<td>0.118</td>
<td>−0.087</td>
</tr>
<tr>
<td>3</td>
<td>25.7%</td>
<td>0.596</td>
<td>−0.150</td>
<td>0.795</td>
<td>0.212</td>
<td>0.238</td>
<td>−0.084</td>
<td>0.251</td>
<td>−0.101</td>
</tr>
<tr>
<td>2</td>
<td>36.2%</td>
<td>0.580</td>
<td>−0.156</td>
<td>0.850</td>
<td>0.214</td>
<td>0.341</td>
<td>0.005</td>
<td>0.279</td>
<td>−0.155</td>
</tr>
<tr>
<td>1</td>
<td>46.4%</td>
<td>0.510</td>
<td>−0.122</td>
<td>0.839</td>
<td>0.224</td>
<td>0.451</td>
<td>0.062</td>
<td>0.310</td>
<td>−0.207</td>
</tr>
<tr>
<td>Require 1 from NA and 1 from DET</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No min</td>
<td>32.0%</td>
<td>0.560</td>
<td>−0.160</td>
<td>0.799</td>
<td>0.203</td>
<td>0.339</td>
<td>−0.021</td>
<td>0.196</td>
<td>−0.131</td>
</tr>
<tr>
<td>3 or more</td>
<td>23.4%</td>
<td>0.584</td>
<td>−0.164</td>
<td>0.760</td>
<td>0.187</td>
<td>0.242</td>
<td>−0.102</td>
<td>0.208</td>
<td>−0.105</td>
</tr>
</tbody>
</table>

*aCorrelation of applied diagnosis with dimensional DSM-5 criterion count for antisocial PD

*bCorrelation with dimensional DSM-5 criterion count for avoidant PD

*cCorrelation with dimensional DSM-5 criterion count for obsessive-compulsive PD

*dCorrelation with dimensional DSM-5 criterion count for borderline PD

*eCorrelation with dimensional DSM-5 criterion count for narcissistic PD

*fCorrelation with dimensional DSM-5 criterion count for schizotypal PD

*gCorrelation with composite psychosocial functioning rating

### DSM-IV/DSM-5 §3 PD Type Correspondence

same patients diagnosed under 2 systems

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>DSM-IV Prevalence</th>
<th>DSM-5 §3 Prevalence</th>
<th>Kappa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline</td>
<td>39.80%</td>
<td>38.90%</td>
<td>.643</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>14.40%</td>
<td>14.70%</td>
<td>.506</td>
</tr>
<tr>
<td>Antisocial</td>
<td>11.40%</td>
<td>11.70%</td>
<td>.516</td>
</tr>
<tr>
<td>Avoidant</td>
<td>26.30%</td>
<td>23.40%</td>
<td>.584</td>
</tr>
<tr>
<td>Obs-Compulsive</td>
<td>9.00%</td>
<td>7.20%</td>
<td>.436</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>9.30%</td>
<td>8.70%</td>
<td>.561</td>
</tr>
</tbody>
</table>

#### TABLE 1. Diagnostic Convergence Between DSM-III and DSM-III-R for 291 Patients With Personality Disorder

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Percent of Patients With Diagnosis</th>
<th>Kappa</th>
<th>Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline</td>
<td>32.0 DSM-III 33.3 DSM-III-R 0.969*</td>
<td>62.43</td>
<td>4.56</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>6.2 DSM-III 22.0 DSM-III-R 0.378*</td>
<td>4.56</td>
<td>11.83</td>
</tr>
<tr>
<td>Histrionic</td>
<td>21.6 DSM-III 21.6 DSM-III-R 0.656*</td>
<td>8.06</td>
<td>6.43</td>
</tr>
<tr>
<td>Antisocial</td>
<td>5.8 DSM-III 6.2 DSM-III-R 0.726*</td>
<td>8.10</td>
<td>8.10</td>
</tr>
<tr>
<td>Avoidant</td>
<td>11.3 DSM-III 27.1 DSM-III-R 0.447*</td>
<td>5.39</td>
<td>6.43</td>
</tr>
<tr>
<td>Dependent</td>
<td>14.1 DSM-III 22.3 DSM-III-R 0.543*</td>
<td>5.39</td>
<td>8.10</td>
</tr>
<tr>
<td>Compulsive</td>
<td>8.9 DSM-III 7.9 DSM-III-R 0.531*</td>
<td>5.39</td>
<td>8.10</td>
</tr>
<tr>
<td>Passive-aggressive</td>
<td>8.2 DSM-III 12.4 DSM-III-R 0.407*</td>
<td>5.39</td>
<td>4.12</td>
</tr>
<tr>
<td>Paranoid</td>
<td>7.2 DSM-III 22.0 DSM-III-R 0.327*</td>
<td>5.39</td>
<td>3.82</td>
</tr>
<tr>
<td>Schizoid</td>
<td>1.4 DSM-III 11.0 DSM-III-R 0.091*</td>
<td>5.39</td>
<td>0.60</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>17.2 DSM-III 9.3 DSM-III-R 0.602*</td>
<td>5.39</td>
<td>8.24</td>
</tr>
<tr>
<td>Atypical, mixed</td>
<td>29.2 DSM-III 22.3 DSM-III-R 0.581*</td>
<td>5.39</td>
<td>10.11</td>
</tr>
</tbody>
</table>

*p<0.001.


Leslie C. Morey, Ph.D.

A “Hybrid” Model
Applied to CLPS Longitudinal Data

- Bifactor CFA model of general and specific personality disorder dimensions, estimated from baseline, 2-year, 4-year, 6-year, and 10-year CLPS assessments
- Model fit: RMSEA = .048; CFI = .96; TLI = .92; SRMR = .036.
- All disorders EXCEPT BORDERLINE can be modeled as combination of general PD and specific traits
- Borderline PD appears to largely reflect general PD

Static and dynamic elements of PD?

Source of Resistance?

Commentary

Personality Disorders in DSM-5

DSM-5 in its proposed form presents a significant shift in the approach to diagnosing personality disorders. The diagnostic criteria outlined in DSM-III and DSM-IV and the introduction of axis II were intended to focus attention on these syndromes in

A diagnostic system should be clinically relevant, encompass the spectrum of personality syndromes seen in practice, facilitate their recognition, and still be simple enough to be used by busy clinicians, including those who do not specialize in the assessment and treatment of personality. At the same time, the diagnostic scheme needs to reflect and support progress in research that leads to increased understanding and better treatment of these illnesses. Regrettably, the proposed system for classifying personality disorders is too complicated, includes a trait-based approach to diagnosis without an adequate clinical rationale, and omits personality syndromes that have significant clinical utility.

PETER FONAGY, PH.D.
GLEN O. GABBARD, M.D.
JOHN GUNDERSON, M.D.
OTTO KERNBERG, M.D.
ROBERT MICHELS, M.D.
DREW WESTEN, PH.D.

This commentary grew out of conversations between Glen Gabbard, Jonathan Shedler, and Robert Michels in February 2010. It reflects the views of all of the authors, and each has contributed to it. Dr. Shedler played the primary role in drafting the commentary; others are listed in alphabetical order. Address correspondence and reprint requests to Dr. Michels, Department of Psychiatry, Cornell University, 418 East 71st Street, Suite 41, New York, NY 10021; rmichels@med.cornell.edu (e-mail). Commentary accepted for publication June 2010 (doi: 10.1176/appi.ajp.2010.10050746).

Leslie C. Morey, Ph.D.
Clinical Utility Ratings for different parts of DSM-5 §3

Leslie C. Morey, Ph.D.

Adapted from Samuel & Widiger, 2006 J Abn Psych

<table>
<thead>
<tr>
<th>Question</th>
<th>DSM-IV criteria</th>
<th>DSM-5 level</th>
<th>DSM-5 criteria</th>
<th>DSM-5 traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>How easy do you feel it was to apply these concepts to this individual?</td>
<td>3.25 (0.920)</td>
<td>3.02+++ (0.965)</td>
<td>3.11+ (0.942)</td>
<td>3.54 *** (0.897)</td>
</tr>
<tr>
<td>How useful do you feel these concepts would be for communicating information about this individual with other mental health professionals?</td>
<td>3.32 (1.026)</td>
<td>3.08+++ (1.003)</td>
<td>3.15++ (1.002)</td>
<td>3.48 * (0.950)</td>
</tr>
<tr>
<td>How useful do you feel these concepts would be for communicating information about the individual to him or herself?</td>
<td>2.69 (1.133)</td>
<td>2.81 (1.083)</td>
<td>2.83* (1.016)</td>
<td>3.21*** (1.047)</td>
</tr>
<tr>
<td>How useful are these concepts for comprehensively describing all the important personality problems the individual has?</td>
<td>2.77 (1.062)</td>
<td>2.89 (1.051)</td>
<td>3.01*** (1.013)</td>
<td>3.26*** (1.027)</td>
</tr>
<tr>
<td>How useful would these concepts be for helping you to formulate an effective intervention for this individual?</td>
<td>2.91 (1.103)</td>
<td>2.98 (1.039)</td>
<td>3.00 (1.041)</td>
<td>3.26 *** (1.006)</td>
</tr>
<tr>
<td>How useful were these concepts for describing the individual’s global personality?</td>
<td>2.89 (1.081)</td>
<td>2.98 (1.044)</td>
<td>3.00 (1.053)</td>
<td>3.32*** (1.031)</td>
</tr>
</tbody>
</table>


Leslie C. Morey, Ph.D.
Clinical Utility in Action: 
DSM-5 §3 & Treatment Decisions

Table 3
Multiple regression prediction of 11 clinical treatment decisions using variables of DSM-IV and DSM-5-III PD diagnostic constructs.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>DSM-IV model (&gt; Diagnostic threshold)</th>
<th>DSM-5-AM model (Traits and level)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Model R</td>
<td>95% CI</td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td>.15</td>
<td>(.04-.25)</td>
</tr>
<tr>
<td>Exploratory Therapy</td>
<td>.33**</td>
<td>(.23-.42)</td>
</tr>
<tr>
<td>Supportive Therapy</td>
<td>.28**</td>
<td>(.18-.38)</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>.20</td>
<td>(.10-.30)</td>
</tr>
<tr>
<td>Anxiolytics</td>
<td>.31**</td>
<td>(.21-.40)</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>.37**</td>
<td>(.27-.46)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>.31**</td>
<td>(.21-.40)</td>
</tr>
<tr>
<td>Anti-seizure</td>
<td>.17</td>
<td>(.06-.27)</td>
</tr>
<tr>
<td>Mood-Stabilizers</td>
<td>.35**</td>
<td>(.25-.44)</td>
</tr>
<tr>
<td>Long-Term Prognosis</td>
<td>.47**</td>
<td>(.38-.55)</td>
</tr>
<tr>
<td>Optimal Treatment Level</td>
<td>.38**</td>
<td>(.28-.47)</td>
</tr>
</tbody>
</table>

* p ≤ .05 ** p ≤ .01.

average multiple correlations for the DSM-5-AM exceeded those for the DSM-IV for both the model multiple correlations (t(10) = 8.75, p < .001, d = 1.55) and the PRESS multiple correlations (t(10) = 3.90, p < .003, d = 0.68).

Closing Arguments for the DSM-5 §3 Model

- Describing **PD Severity** provides a more specific conceptualization of PD conveying considerable information about current functioning, yet is likely treatment-sensitive.
- Describing **Problematic Traits** provides precision in specifying PD variants as well as considerable predictive information, and is an approach that clinicians tend to find more clinically useful.
- Describing **PD Types** provides continuity with DSM-IV, and begins to characterize particular regions of the “hybrid space”.
- Providing greater specificity in describing core dysfunctions and trait structures likely will provide better targets for etiological and treatment research relating to developmental and biobehavioral mechanisms of PD and more insight into enduring vs. dynamic elements of the disorders.

Leslie C. Morey, Ph.D.
Divining the future.....
Thank You
CLPS Methodology Overview
(c.f. Gunderson et al, 2000)

- Longitudinal study, n = 668
- Targeted PDs as well as a non-PD, MDD comparison group
- Completion rate ~80% at Year 10
- Administration of:
  - DIPD: DSM-IV diagnostic interview
  - NEO-PI-R: Five factor model questionnaire
  - SNAP: “normal and abnormal” trait questionnaire
  - numerous other instruments

DSM-IV Model

"Cluster A"
- Paranoid
- Schizoid
- Schizotypal

"Cluster B"
- Borderline
- Antisocial
- Narcissistic
- Histrionic

"Cluster C"
- Avoidant
- Dependent
- Obsessive-Compulsive

Leslie C. Morey, Ph.D.
Five-Factor Model
(c.f. Costa & Widiger, 1994, 2001)

Neuroticism
- Anxiety
- Hostility
- Depression
- Self-Conscious
- Impulsive
- Vulnerable

Extroversion
- Warmth
- Gregarious
- Assertive
- Activity
- Excitement Seeking
- Positive Emotions

Openness to Experience
- Fantasy
- Aesthetics
- Feelings
- Actions
- Ideas
- Values

Agreeableness
- Trust
- Straightforward
- Altruism
- Compliance
- Modesty
- Tenderminded

Conscientiousness
- Competence
- Order
- Dutifulness
- Achievement Striving
- Self-Discipline
- Deliberation

Leslie C. Morey, Ph.D.
SNAP (Nonadaptive & Adaptive Personality) Model
(c.f. L.A. Clark, 1990)

Negative Affectivity
- Mistrust
- Dependency
- Aggression
- Eccentric Perceptions
- Self-Harm
- Manipulative

Positive Affectivity
- Exhibitionism
- Entitlement
- Detachment

Disinhibition
- Impulsivity
- Propriety
- Workaholism

Leslie C. Morey, Ph.D.
Model Construct Validity
Overview of Validation Strategy

• Diagnostic Models
  – FFM (5 domains / 30 facets), SNAP (15 dimensions), DSM-IV (11 categories / 11 criterion counts)

• Longitudinal Intervals
  – Concurrent validity (baseline), follow up at least every two years for 10 years

• Validating Variables
  – GAF
  – Social functioning (self-report & interview)
  – Work functioning (self-report & interview)
  – Recreational functioning (self-report & interview)
  – Number of Axis I disorders
  – Number of current psychotropic medications
  – PAI depression
  – IIP interpersonal problems
  – # Suicide attempts
  – # Psychiatric hospitalizations
## Average $r^2$ Upon Cross-Validation Across Validating Domains

**Five Diagnostic Model Variants**

<table>
<thead>
<tr>
<th></th>
<th>DSM-C</th>
<th>DSM-D</th>
<th>SNAP</th>
<th>NEO-5</th>
<th>NEO-30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent$^1$</td>
<td>9.87%</td>
<td>16.11%</td>
<td>17.33%</td>
<td>12.00%</td>
<td>11.22%</td>
</tr>
<tr>
<td>Predictive - 2 year$^1$</td>
<td>7.32%</td>
<td>11.64%</td>
<td>11.82%</td>
<td>9.36%</td>
<td>4.73%</td>
</tr>
<tr>
<td>Predictive - 4 year$^1$</td>
<td>4.11%</td>
<td>7.45%</td>
<td>10.27%</td>
<td>9.00%</td>
<td>5.55%</td>
</tr>
<tr>
<td>Predictive - 10 year$^2$</td>
<td>3.39%</td>
<td>5.43%</td>
<td>8.21%</td>
<td>5.25%</td>
<td>4.84%</td>
</tr>
</tbody>
</table>

Categories always led to appreciable loss of information

SNAP pathological trait model consistently explained most variance in outcome

---


Leslie C. Morey, Ph.D.
### Table 3. Part correlations of PRESS-derived predicted scores with outcomes

<table>
<thead>
<tr>
<th></th>
<th>DSM controlling for</th>
<th>SNAP controlling for</th>
<th>FFM controlling for</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SNAP</td>
<td>FFM</td>
<td>DSM</td>
</tr>
<tr>
<td>6-year follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAF</td>
<td>0.21</td>
<td>0.32</td>
<td>0.23</td>
</tr>
<tr>
<td>LIFE social functioning</td>
<td>0.19</td>
<td>0.21</td>
<td>0.19</td>
</tr>
<tr>
<td>LIFE work functioning</td>
<td>0.17</td>
<td>0.19</td>
<td>0.11</td>
</tr>
<tr>
<td>8-year follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAF</td>
<td>0.17</td>
<td>0.32</td>
<td>0.35</td>
</tr>
<tr>
<td>LIFE social functioning</td>
<td>0.22</td>
<td>0.27</td>
<td>0.21</td>
</tr>
<tr>
<td>LIFE work functioning</td>
<td>0.13</td>
<td>0.15</td>
<td>0.13</td>
</tr>
<tr>
<td>10-year follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAF</td>
<td>0.16</td>
<td>0.30</td>
<td>0.35</td>
</tr>
<tr>
<td>LIFE social functioning</td>
<td>0.20</td>
<td>0.23</td>
<td>0.18</td>
</tr>
<tr>
<td>LIFE work functioning</td>
<td>0.10</td>
<td>0.09</td>
<td>0.04</td>
</tr>
</tbody>
</table>

The DSM-D DID significantly increment the SNAP.

The NEO-5 did not significantly increment the SNAP.


Leslie C. Morey, Ph.D.
Personality Disorder Comorbidity

Rule rather than the Exception

<table>
<thead>
<tr>
<th>Diagnostic System</th>
<th>Axis II multiple diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DSM-III</strong>¹</td>
<td>51.4%</td>
</tr>
<tr>
<td><strong>DSM-III-R</strong>¹</td>
<td>66.8%</td>
</tr>
<tr>
<td><strong>DSM-IV</strong>²</td>
<td>61.1%</td>
</tr>
</tbody>
</table>


# Internal consistency of ALL DSM PD Criteria

<table>
<thead>
<tr>
<th>Study</th>
<th>System</th>
<th>Sample</th>
<th>Coefficient Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morey, 1988</td>
<td>DSM-III-R</td>
<td>Clinical</td>
<td>.81</td>
</tr>
<tr>
<td>Morey et al., 2002</td>
<td>DSM-IV</td>
<td>Student</td>
<td>.96</td>
</tr>
<tr>
<td>CLPS (e.g. Morey et al., 2007)</td>
<td>DSM-IV</td>
<td>Clinical</td>
<td>.94</td>
</tr>
<tr>
<td>DSM-5 Field Study (e.g., Morey &amp; Skodol, 2013)</td>
<td>DSM-IV</td>
<td>Clinical</td>
<td>.90</td>
</tr>
<tr>
<td>Butcher et al., 1989</td>
<td>MMPI-2 Clinical scales (avg)</td>
<td>Community men</td>
<td>.66</td>
</tr>
<tr>
<td>Butcher et al., 1989</td>
<td>MMPI-2 Clinical scales (avg)</td>
<td>Community women</td>
<td>.65</td>
</tr>
</tbody>
</table>


Leslie C. Morey, Ph.D.
Global Severity and Diagnostic Overlap

Articulating Global Personality Pathology

DSM-5 Data Reanalysis Project (Morey et al, 2011)

• Had PD WG members identify item responses from GAPD (Livesley) and SIPP (Verheul) indicative of global personality pathology

• Refined subsequent item set with EFA to identify single factor

• Conducted IRT analyses to:
  – Estimate “theta” for study participants & relate to PD diagnoses
  – Identify indicators of global pathology at different levels of severity
Core Personality Pathology
Sample Items and IRT Parameters (Morey et al, 2011)

Table 1.—Item response theory parameters for example GAPD/SIPP–118 items discriminating at different levels of a core personality pathology continuum.

<table>
<thead>
<tr>
<th>Item</th>
<th>Discrimination</th>
<th>SE</th>
<th>Threshold</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe that it does not help to try to work together with people.</td>
<td>1.15</td>
<td>0.24</td>
<td>−1.28</td>
<td>0.2</td>
</tr>
<tr>
<td>I can hardly remember what kind of person I was only a few months ago.</td>
<td>1.61</td>
<td>0.24</td>
<td>−0.53</td>
<td>0.12</td>
</tr>
<tr>
<td>I can’t make close ties with people.</td>
<td>1.29</td>
<td>0.22</td>
<td>−0.47</td>
<td>0.14</td>
</tr>
<tr>
<td>My feelings about people change a great deal from day to day.</td>
<td>2.01</td>
<td>0.31</td>
<td>−0.23</td>
<td>0.09</td>
</tr>
<tr>
<td>Sometimes I think that I am a fake or a sham.</td>
<td>1.91</td>
<td>0.26</td>
<td>−0.16</td>
<td>0.09</td>
</tr>
<tr>
<td>I worry that I will lose my sense of who I really am.</td>
<td>2.40</td>
<td>0.33</td>
<td>0.02</td>
<td>0.08</td>
</tr>
<tr>
<td>My feelings about other people are very confused.</td>
<td>1.61</td>
<td>0.24</td>
<td>0.29</td>
<td>0.11</td>
</tr>
<tr>
<td>I drift through life without a clear sense of direction.</td>
<td>2.76</td>
<td>0.41</td>
<td>0.48</td>
<td>0.08</td>
</tr>
<tr>
<td>I have very contradictory feelings about myself.</td>
<td>2.23</td>
<td>0.32</td>
<td>0.95</td>
<td>0.11</td>
</tr>
<tr>
<td>I mostly have the feeling that my true self is hidden.</td>
<td>2.05</td>
<td>0.33</td>
<td>0.96</td>
<td>0.11</td>
</tr>
</tbody>
</table>

*Note.* GAPD = General Assessment of Personality Disorder, SIPP–118 = Severity Indices of Personality Problems.

Correlations: “Theta” and PD Severity Indicators

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sample</th>
<th>Correlations with Estimated Theta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PD criteria, SIDP&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Clinical (Netherlands)</td>
<td>.51</td>
</tr>
<tr>
<td>Baseline Total PD criteria sum, DIPD&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Clinical (CLPS: US)</td>
<td>.69</td>
</tr>
<tr>
<td>Year 10 Total PD criteria sum, DIPD&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Clinical (CLPS: US)</td>
<td>.42</td>
</tr>
<tr>
<td>Total PD Criteria, PDQ&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Student (Texas)</td>
<td>.69</td>
</tr>
<tr>
<td>PAI-BOR score&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Student (Texas)</td>
<td>.79</td>
</tr>
</tbody>
</table>


Severity vs. Stylistic Features of PD

Predictive Validity at Follow-up, CLPS Study