Rationale for a Revised "A" Criteria for Personality Disorders and the Levels of Personality Functioning

The general criteria for personality disorder (PD) were introduced into DSM-IV without an empirical basis and have been generally considered too non-specific for a definition of PD. Incorporation of personality dimensions into DSM-5 necessitates the use of 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 also predispose to mental disorders other than PDs. Thus, the Personality and Personality Disorders Work Group set out to develop a new definition and set of general criteria that would be more specific and empirical. In addition, consideration of the possibility of more clearly demarcated boundaries between the manifestations of psychopathology and its consequences at the Task Force level has led to discussion of the discrimination of "disability" – the impairments in functioning that are the consequences of disorders – from "dysfunction," which relates to the 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 personality disorders, because impairment in "interpersonal functioning" is inherent to their conceptualization.
With respect to functional domains, strengths and impairments can be arrayed along cognitive, self, emotional, behavioral, physical, interpersonal, occupational, and recreational dimensions. 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 were deemed by the Work Group to be most characteristic of personality disorders.

Revision of General Criteria for Personality Disorder

The originally proposed general criteria for PD as posted on the DSM-5 Web site (see Skodol et al., 2011a, Table 4) were based on the theoretical model of adaptive failure of Livesley (1998), which included the failure to develop coherent sense of self or identity and chronic interpersonal dysfunction. Although these criteria accurately represented core impairments in personality functioning central to PDs, feedback received on the Website posting suggested that they 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 sufficiently integrated with the other parts of the proposed model.

Since its original posting on the APA's DSM-5 Web site, the general criteria for PD have been simplified, streamlined, and integrated with the Levels of Personality Functioning in response to comments received. In its current iteration, two assessments combine to comprise the essential criteria for a personality disorder: 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, the core impairment assessment now has an empirical basis, can be represented in gradations of severity, and is sensitive to change.

Development and Refinement of 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 personality disorders (PDs) are optimally characterized by a generalized personality severity continuum with additional specification of 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 level is essential to any dimensional system for assessing 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, Morey, & Skodol (in press) 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 that 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. Most of the measures, however, were designed for use by researchers and require extensive training to implement. Thus, it is not practical to simply adopt any individual measure for clinical use in DSM-5. At the same time, 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., 2011a; 2011b). This version was posted in February 2010 on the APA's DSM-5 Web site.

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 to refine the Levels: 1) a secondary data analysis; 2) a reduction in the number of elements by retaining only the most reliable ones from the various measures surveyed for the Levels development; 3) a synthesis of 1 and 2 into a revised proposed Levels of Personality Functioning, and 4) a further simplification and reorganization of the Levels into a tabular format, with a revised 5-point numerical scale of severity.

To determine empirically the validity of the core dimension of personality pathology based on deficits in representations of self and others, Morey et al. (in press) 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 (SIPP; Verheul et al., 2008) and the General Assessment of Personality Disorder (GAPD; Livesley, unpublished manuscript). The instruments measuring DSM-IV personality disorder diagnoses were the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II: First, Spitzer, Williams & Gibbon, 1997) and the Structured Interview for DSM-IV Personality (SIDP-IV: Pfohl, Blum, & Zimmerman, 1997). In summary, specific items in the SIPP and GAPD were identified as reliable and discriminating markers of the dimensions identified above in the preliminary Levels of Personality Functioning. 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 any personality disorder diagnosis, as well as to the likelihood of receiving multiple personality disorder diagnoses. Morey et al. (in press) concluded that, "indicators of this dimension involve important functions related to self (e.g., identity integration, integrity of self-concept) and interpersonal relatedness (e.g., capacity for empathy and intimacy)."

In response to suggestions from the DSM-5 Web site posting, a second step in refining the model involved identifying the most reliable dimensions among those found in the measures considered in the Bender, Morey, & Skodol (in press) review. A threshold of .75 was established. Dimensions that met this criterion were retained. Further in response to commentary, because certain terms, such as "mentalize" and "complexity of representations," were regarded to be too unfamiliar or to rely excessively on a particular theoretical jargon, adjustments were made to the original Levels version. Identity Integration and Integrity of Self-concept were viewed as substantially overlapping concepts and so were combined to

form one facet called Identity. The following components were eliminated based reliability or complexity considerations – regulation of self-states, sense of autonomous agency and quality of self-representation – and the capacity for a range of emotional experience and its regulation was added to the Identity domain to capture an affect component that was deemed important. For the Interpersonal domain, the Complexity and Integration of Representations of Others facet was eliminated, and the term "mentalize" was dropped. Based on all of these considerations, a revised proposal for the definition of the key elements for the Levels of Personality Functioning was formulated as follows:

Self:
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.
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:
Empathy: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding of the effects of own behavior on others.
Intimacy: Depth and duration of positive connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

In summary, DSM-IV had no provision for delineating severity of impairment specific to personality functioning. The Personality and Personality Disorders Work Group demonstrated with a literature review that dimensional measures of personality psychopathology based on representations of self and interpersonal relations hold significant clinical utility, particularly in identifying the presence and extent of personality psychopathology, for treatment planning, as information for alliance-building, and in studying treatment course and outcome. From these measures, the Levels of Personality Functioning continuum has been derived for use in assessing personality functioning in DSM-5. Secondary data analyses have provided empirical support for this continuum. The proposed severity dimension captures variability, not only across, but also within personality disorder types.

Impairment in self and interpersonal functioning is consistent with multiple theories of personality disorder and their research bases, including cognitive/behavioral, interpersonal, psychodynamic, attachment, developmental, social cognitive, and evolutionary theories, and to be key aspects of personality pathology in need of clinical attention (Clarkin & Huprich, 2011; Pincus, 2011). Furthermore, the Levels of Personality Functioning constructs align well with the NIMH Research Domain Criterion (RDoC) of "social processes" (Sanislow et al., 2010). The interpersonal dimension of personality pathology has been related to attachment and affiliative systems regulated by neuropeptides (Stanley & Siever, 2010), and 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 (MPFC) and other cortical midline structures (CMS) -- the sites of brain's so-called "default network" (Fair et al., 2008; Northoff et al., 2006; Preston et al., 2007).

Further Development of the Levels of Personality Functioning
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 underway in Phase I of the official DSM-5 Field Trials in 11 large academic settings in the U.S. and Canada, where two independent clinicians are evaluating patients with and without personality disorders within a two-week timeframe (Kraemer, Kupfer, Narrow, Clarke, & Regier, 2010). Five of the 6 specific personality disorders currently proposed for retention in DSM-5 (i. e., antisocial/psychopathic, 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 personality disorders 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., non-treatment seeking) in order to increase the generalizability of the Levels rating.

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 six specific PDs, as well as the category of PD Trait Specified, which is intended to replace PDNOS in DSM-5. The six disorders include the five originally proposed for retention in DSM-5 (Skodol et al., 2011c) and narcissistic PD, which Web site feedback suggested was the specific PD with the most clinical utility slated for deletion. 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 PD not otherwise specified (NOS). That is, when the presentation does not neatly resemble a specific PD type, the clinician has the option of diagnosing PD, and tailoring the description of the PD to fit the specific patient, using the specific features encoded by pathological traits.

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