An Integrative Conceptual Framework for Assessing Personality and Personality Pathology

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As a contribution to the ongoing debate over the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5, we present a framework for jointly conceptualizing personality and personality pathology. The key element is an explicit distinction between personality description (which is the realm of basic personality psychology) and personality evaluation (which is the realm of clinical personality psychology). Previous diagnostic systems did not acknowledge this crucial distinction. We created a sample diagnostic system, to illustrate how a practical application of our conceptual framework may look like. The system comprises two ingredients: First, a list of personality dispositions that may become problematic. These are described at a “basic level” of abstraction (i.e., the level at which patients and clinicians intuitively communicate about personality problems). Second, a list of negative consequences that are used to evaluate the extent to which a patient’s personality pattern is “problematic.” A sample of therapists used the system for describing actual patients and found it to be better than the International Classification of Diseases (ICD)-10 and DSM-IV. Based on our conceptual deliberations, we analyze the DSM-5 proposal for personality and personality disorders. The proposal contains three different sets of “higher-order concepts” (personality traits, personality types, and levels of personality functioning). Only the first of these is sufficiently supported by empirical evidence, including analyses of our own set of personality dispositions.

Keywords: DSM-5, personality, personality disorders, diagnosis

The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is currently undergoing its fourth major revision, with DSM-5 expected to be published in 2013, or later. Of the various syndromes that are described in DSM, the “personality disorders” (PDs) are among those that are likely to undergo radical changes, because numerous problems were found to be associated with the current version (e.g., Bornstein, 1998; Clark, 2007; Livesley, 1998; Sheets & Craighead, 2007; Trull & Durrett, 2005; Westen & Shedler, 1999a; Widiger & Trull, 2007). For example, in summarizing the weaknesses of the existing DSM–IV PD categories, Widiger and Trull (2007) referred to diagnostic comorbidity, inadequate coverage of the relevant clinical phenomena, arbitrary and unstable boundaries with normal personality functioning, heterogeneity among persons sharing the same categorical diagnosis, and inadequate empirical support. The new system for assessing personality disorders in DSM-5 is supposed to overcome these limitations.

In the present article, we present a joint conceptual framework for assessing personality and personality problems, as a contribution to the ongoing debate over DSM-5. Our primary goal in developing this framework is to achieve a better integration of basic and clinical personality psychology. For decades, researchers interested in normal personality variation and researchers interested in clinically relevant personality phenomena were largely segregated from each other, as each community had its own meetings, journals, and jargon (for an exception see Strack, 2006). The present article is based on the conviction that this segregation is superfluous, and that personality and personality pathology may easily be described within one common conceptual framework. The key to a better conceptual integration is an explicit distinction between personality description and personality evaluation. After introducing our new conceptual framework, we demonstrate how an implementation of our deliberations into clinical practice may look like, and compare our own approach to the current version (June 21st, 2011) of the proposal by the DSM-5 Work Group on personality and personality disorders.

Throughout the present article, we will try to adhere to three important principles. Two of these are also endorsed by most other authors in the field: First, a system for diagnosing personality and personality problems should reflect the current state of research evidence. Second, the system should be clinically useful, that is, it should help clinicians do their everyday work with their patients. The third principle, parsimony, is just as important, but seems to have been neglected somewhat in the course of the debate so far: A diagnostic system should not only be as complex as necessary, but also as simple as possible. With regard to this latter requirement, the proposal by the DSM-5 Work Group leaves much to be desired. Throughout the article, we will try to explain how the solutions that we propose incorporate these principles.
Conceptual Deliberations

Separating Description From Evaluation

Our primary objective in the present article is to achieve a better integration of basic and clinical personality science. Doing so is easier than it may seem at first, if one acknowledges the fundamental difference between these two research fields. Whereas basic personality science is mainly descriptive, clinical personality science has to be evaluative (Leising & Müller-Plath, 2009). Researchers interested in normal personality variation focus on describing how and explaining why people differ from each other, in terms of cognition, emotion, and behavior. We will call such differences between people “dispositions” in the following. In contrast, researchers interested in clinically relevant personality phenomena have to compare how people think, feel and behave with an image of how people should think, feel, and behave. This is because it is logically impossible to identify personality “problems” without comparing a person’s habitual pattern of thought, feeling, and behavior with patterns that would be less problematic (Leising, Rogers, & Ostner, 2009; Wakefield, 1992, 1999).

The two steps (description and evaluation) are conceptually distinct, and the distinction is very important and highly consequential, as we will try to demonstrate. People may agree perfectly in judging how a person typically behaves, but differ completely in how they evaluate that behavior. For example, people may agree that a person tends to make decisions on his own (= description). But whereas some people (e.g., the person himself) may see this disposition as a strength, others may find it problematic (= evaluation), because it undermines collaborative processes. Basic personality psychology uses the terms “substance” (= what is actually there) and “style” (= how it is seen or presented) when referring to this important distinction (McCrae & Costa, 1983). However, the existing diagnostic systems for assessing personality pathology do not acknowledge the distinction and often mix up description and evaluation to a considerable degree. For example, criterion nine of the narcissistic PD category in DSM–IV requires that a person “shows arrogant, haughty behaviors or attitudes.” It is needless to say that “arrogant” and “haughty” are highly evaluative terms, and whether it is appropriate to use them in describing a target’s behavior lies in the eye of the beholder to a large extent. Most target persons would probably not use these terms in describing themselves. Likewise, people who are loyal to a target (e.g., friends, spouse) would not use these terms either (Leising, Erbs, & Fritz, 2010). Rather, the target’s confidants may describe the very same behaviors in more positive terms (e.g., “he is very self-confident,” “he picks his conversation partners carefully”). Obviously, what a person does and what people think about it is not the same thing.

In order to better integrate basic and clinical personality science, we need to explicitly separate description from evaluation: “This is what the person does, and this why it is a problem.” In accordance with this approach, personality problems may be defined as recurrent, or chronic, patterns of thought, feeling, and behavior, which cause, or have the potential to cause, significant impairments to the individual, or to the individual’s social environment. This definition incorporates both a descriptive and an evaluative component: The phrase “recurrent, or chronic, patterns of thought, feeling, and behavior” is essentially referring to personality, that is, stable individual differences between people. The remainder of the definition refers to the clinical relevance of those individual differences.

There are different ways of determining whether personality features are problematic. In a previous article (Leising et al., 2009), we have addressed some of this in detail: For example, the “problemness” of a personality disposition may be determined by referring to the standards of the culture in which a person currently lives, or the standards of the culture in which the person was raised, or a universal image of “natural” functioning that is rooted in evolutionary thinking (cf. Wakefield, 1992, 1999). In the present article, we suggest operationalizing the problemness of a person’s personality pattern in terms of that pattern’s negative consequences. That is because it seems impossible to diagnose a person as having a personality problem if one is unable to name at least one (possible) negative consequence of the person’s habitual pattern of thought, feeling, and behavior. Even if a person “does X” frequently and with great intensity, we would hardly consider X clinically relevant unless it causes, or at least has the potential to cause, the person or other people any harm or trouble. In other words, negative consequences seem to be a necessary condition for diagnoses of personality problems. In this sense, we use negative consequences as a specification of the term “impairment” (cf. Leising et al., 2009; Zachar & Kendler, 2010).

To conclude, what is needed in a joint diagnosis of personality and personality pathology is an analysis of a target person’s dispositions (i.e., stable tendencies to think, feel, and behave in certain ways), and an analysis of whether and which negative consequences (may) follow from these dispositions. The first component reflects “personality,” the second reflects “problemness.” Simply put, we conceptualize personality pathology in additive terms: Personality problems = personality + problems (Leising & Müller-Plath, 2009). The diagnostic system that will be presented below explicitly incorporates these two components.

A better distinction between description and evaluation would help us address a number of tricky issues that plague the field of personality pathology: For example, the term “ego-syntonicity” denotes the tendency of many people with personality problems, especially those of the more externalizing kind, to see their own “problems” as healthy adaptations (e.g., as reactions to other people’s bad behaviors). A patient and a therapist may agree relatively well in determining the patient’s most typical dispositions, but arrive at very different evaluations of those dispositions. In many cases it may be useful to systematically assess such discrepancies between a patient’s own views of his or her behaviors, and other people’s (e.g., the clinician’s) views of the same behaviors (cf. Clifton, Turkheimer, & Oltmanns, 2004; McCullough, 2000). For example, one may rate each problematic personality feature in terms of how aware the patient is of its negative consequences. Such an assessment may be important for treatment planning, and useful in tracking therapeutic improvement (OPD Task Force, 2008). Another relevant phenomenon is “niche seeking”: Many people display personality dispositions that make them prone to experiencing negative consequences, but do not experience any such consequences (yet), because their current life circumstances do protect them. For example, a man who strongly depends on other people’s approval and admiration may function very well as long as his career (e.g., as an actor) goes well. However, if his star starts to fade (e.g., no good roles...
anymore), the same man may become suicidal, because he is unable to regulate his sense of self-esteem without constant and massive support from other people. According to our view, it would constitute a major step forward if a diagnostic system enabled an assessment of such “vulnerable spots” early on, even before they have led to obvious negative consequences. To that end, a clearer distinction between personality dispositions and their consequences would be necessary.

It should be noted that, whereas the mere presence of some personality disposition or consequence may be assessed with relatively good objectivity, the question of whether the consequence of a disposition “is actually negative” is of a different nature. How “negative” a consequence is judged to be will always depend on which values the judge endorses (cf. Leising et al., 2009). For example, it is relatively easy to assess whether a person fails to honor agreements and obligations (= disposition), and whether the person tends to get fired from his or her jobs (= consequence), but the assumption that getting fired is something “bad” is not empirically verifiable. Rather, it reflects an acceptance of certain values.

Level of Abstraction

Personality dispositions may be described in terms of person effects or in terms of person by situation interaction effects (Leising & Müller-Plath, 2009). The term “person effect” refers to stable individual differences that broadly generalize across various contexts. Person by situation interactions, in contrast, refer to habitual patterns of thought, feeling and behavior, whose occurrence is reliably linked to particular situational circumstances. Some researchers prefer analyses of personality in terms of person effects, whereas others (e.g., Mischel & Shoda, 1995, 1998) focus on interaction effects. Both approaches certainly have their merits. Both kinds of personality dispositions also feature in the DSM-IV. For example, criterion 7 of the schizoid PD category (“shows emotional coldness, detachment, or flattened affectivity”) clearly represents a person main effect, whereas criterion 5 of the avoidant PD category (“is inhibited in new interpersonal situations because of feelings of inadequacy”; emphasis added) represents an interaction effect. When we took the time to independently classify the DSM-IV PD criteria according to this distinction, the vast majority (Leising: 75.6%, Zimmermann: 83.3%) turned out to reflect person main effects. Interrater agreement between the two authors was \( \kappa = .69, p < .001 \) for this classification (with 89.7% identical classifications). In the development of our own diagnostic system (see below) we also focused on person main effects, but we do acknowledge that a different approach would be possible.

Regardless of which approach one favors, descriptions of people’s habitual thoughts, feelings and behaviors may range from very specific to very broad. For example, it may be stated that (a) “Ed assumes other people will not keep their word,” and that (b) “Ed assumes other people may try to hurt him.” On a higher level of abstraction, we may express the commonality between these two characteristics by stating that Ed “doesn’t trust others.” Furthermore, if Ed also has a hard time making compromises, and finds it difficult to forgive others, we may express the commonality of all of Ed’s personality dispositions on an even higher level of abstraction, by stating that Ed “is not very agreeable.” In other words, people’s personalities may be described at different levels of abstraction. If we want to design a diagnostic system that is clinically useful, we should use a level of abstraction that helps clinicians do their everyday diagnostic and therapeutic work. It is interesting that the items of most of the existing measures of personality pathology (American Psychiatric Association [APA], 2000; Horowitz, Rosenberg, Baer, Uren˜o, & Villaseñor, 1988; Westen & Shedler, 1999a, 1999b, 2007; Livesley & Jackson, 2009; Clark, 1993; Simms & Clark, 2006; Widiger, Costa & McCrae, 2002) describe personality characteristics at a similar, relatively low level of abstraction. This level, which is also similar to the middle level of abstraction in our example (“doesn’t trust others”) may be considered the “basic level” of abstraction, because it seems to be the level that patients, therapists and researchers use intuitively when communicating about problematic personality features (cf. Blashfield & Flanagan, 2005).

In determining whether two personality dispositions (A, B) should be merged, or rather be kept separate from each other, in a diagnostic system, the following considerations may be helpful: (a) Could disposition A and disposition B—each by itself—have negative consequences for the patient or anybody else? (b) Could each of the two dispositions be considered a treatment focus by itself, that is, would it be possible to address disposition A while ignoring disposition B for a moment? (c) Could disposition A persist if disposition B vanished (or vice versa); and (d) could each disposition be used as a separate indicator of treatment success (i.e., if both dispositions vanished, would the treatment be considered more successful than if only one disposition vanished)? The more “yes” answers are given to these questions, the better it would be to keep the two dispositions separate from each other in a diagnostic system. In designing our own diagnostic system (see below), we applied these criteria.

Most PD scholars advocate the use of “higher-order concepts” in diagnosing personality problems. “Higher-order concepts” are superordinate labels that denote “clusters” of basic level personality problems, such that personality problems within a cluster “belong together” more closely than personality problems in different clusters. The DSM–IV personality disorder categories (e.g., paranoid, schizotypal, etc.) were examples of such higher-order concepts. At first sight, the task in creating higher-order concepts seems simple: Find a common name for a set of basic level elements. Of course, such a common name should in some way be useful, that is, the higher-order concept should add some utility to the diagnosis that would not be present if only the basic level personality problems were reported. If we assign a superordinate label (e.g., “borderline”) to some configuration of basic level personality features, we should be able to answer the question: “What are we supposed to gain by doing so?” Unfortunately, in most of the existing diagnostic systems, this question is not explicitly addressed. It is also not addressed in the proposal by the DSM-5 Work Group on personality and personality disorders.

There are two major ways of interpreting higher-order concepts. The first is to see them as being mainly descriptive. A descriptive higher-order concept would simply reflect the “common denominator” of the basic level elements, by emphasizing their shared features, and neglecting the more unique ones. For example, if Ed does not trust others, has a hard time making compromises and hardly ever forgives others, we may say that he displays “low agreeableness,” because all of these dispositions would make it difficult for Ed to get along with other people (which is what agreeableness is about). Descriptive higher-order concepts are
typically derived by analyzing empirical covariation patterns of basic level elements (e.g., using factor analysis). A problem with descriptive higher-order concepts is that they do not suggest any concrete intervention steps (see Krueger & Eaton, 2010, p. 100, and Clark, 2007, p. 236, for similar arguments). It will be of little help for a therapist to know that her patient should “become more agreeable.” Rather, the therapist would probably address each of the patient’s more specific dispositions (lack of trust, inability to make compromises, unwillingness to forgive), regardless of which descriptive superordinate label is used for them. If the therapist thought of the patient mainly in terms of a descriptive higher-order concept, instead of the more concrete basic level personality dispositions, he or she would essentially lose important information, but not gain anything. However, incorporating a set of broad, descriptive, empirically supported personality factors into the diagnostic system may still be advisable, because studies suggest that such factors may independently shape the presentation of Axis I disorders, and even predict the course and outcome of various forms of (e.g., psychotherapeutic) treatment (e.g., Bagby et al., 2008; Blatt, Zuroff, Hawley, & Auerbach, 2010; Cain, Fincus, & Holtforth, 2010; Dinger & Schauenburg, 2010; Kennedy, Farvolden, Cohen, Bagby, & Costa, 2005; Quilty et al., 2008).

An alternative way of interpreting higher-order labels is explanatory in nature. In ancient Greece, for example, the typical behaviors of a “hysterical” woman were attributed to a common cause: her womb (hystera) was supposedly wandering through her body, in search for semen. Many of the higher-order concepts that psychodynamically oriented therapists use today are also explanatory. For example, imagine a patient who asserts his own interests too little, submits to others too much, makes too many compromises, and makes too few decisions on his own. A psychodynamically oriented therapist may hypothesize that this patient is (unconsciously) afraid of growing-up, that is, of becoming an autonomous person with a will and a responsibility of his own. In contrast to purely descriptive higher-order concepts, such an explanatory concept could actually be useful for therapy, because it would suggest a focus of treatment. For example, based on his psychodynamic hypothesis, the therapist may try to help the patient confront the biographic origins of his fear of autonomy. Just like in diagnoses of many somatic illnesses (e.g., a stroke), explanatory higher-order concepts suggest an underlying “missing link” that accounts for the basic level phenomena, and thereby provides additional information that may be useful, even decisive, in helping a patient. The underlying assumption is that, if we address the common cause of the basic level personality problems properly, they may go away.

It should be noted that, from a methodological point of view, empirical covariation of basic level phenomena is not a necessary condition for establishing explanatory higher-order concepts. For example, people who experience (a) headaches and/or (b) nausea rarely have (c) bradycardia (low resting heart rate) at the same time. The correlation between these symptoms (a or b with c) in the general population is negligible. However, a patient who displays all three symptoms at once has an increased likelihood of having a brain tumor. The scientific evidence that this common factor may cause these three symptoms to co-occur justifies mentioning them (cause and symptoms) together in a diagnostic manual. Thus, in establishing explanatory higher-order concepts one has to go beyond the empirical covariations of basic level phenomena and present evidence of a common etiological pathway. Unfortunately, psychology is far from being able to name the causes and symptoms of personality pathology that way. Similar patterns of problematic behavior may be fueled by quite different constellations of underlying motives, fears, expectations, and early relationship experiences (Horowitz et al., 2006). For example, the typical behaviors that are subsumed under the “narcissism” label are sometimes interpreted as the result of a patient’s lack of experience with boundaries and limitations, that is, the patient was “pampered” too much as a child (Millon, 1981), and sometimes as a patient’s attempt to compensate for a very fragile sense of self-esteem (Morf & Rhodewalt, 2001; cf., Cramer, 2011). Therapists with different theoretical orientations (e.g., psychodynamic vs. cognitive–behavioral) may use quite different explanations for one and the same pattern of problematic personality dispositions. According to our view, it is unlikely that we will soon see the creation of an integrative system of explanatory higher-order concepts of personality pathology that will be accepted by even only the majority of clinicians. For these reasons, explanatory higher-order concepts should not become part of the DSM-5 personality disorder section. Rather, if higher-order concepts are to be incorporated in DSM-5, they would have to be descriptive, and we would have to turn to empirical covariations of basic level elements in establishing them.

### A Sample Diagnostic System

We will now present an attempt to incorporate our conceptual deliberations into a system for diagnosing personality and personality problems. It should be noted that this is only intended to serve as an illustration of the guiding principles that we consider important. The system is neither supposed to be a rival measure for the many different assessment methods that already exist for personality problems, nor is it supposed to be entered directly into DSM-5.

#### Part 1: A List of Potentially Problematic Personality Dispositions

A system for diagnosing personality problems should be comprehensive, that is, it should cover a broad range of personality dispositions that may become clinically relevant. A wealth of measures of personality pathology already exists. The DSM–IV (APA, 2000) lists 78 problematic personality characteristics (i.e., the individual PD criteria), the Shedler-Westen Assessment Procedure (Westen & Shedler, 1999a, 1999b, 2007) lists 200, the Dimensional Assessment of Personality Pathology (Livesley & Jackson, 2009) lists 290, and the Schedule for Nonadaptive and Adaptive Personality (Clark, 1993; Simms & Clark, 2006) lists 375. A list of 146 personality problems that refers explicitly to the Five Factor Model of personality was presented by Widiger, Costa, and McCrae (2002), who expanded on earlier work by McCrae (1994), and Trull and Widiger (1997).

The overlap in content among these different measures is considerable. For example, interpersonal problems such as submissiveness or mistrust can be found in highly similar phrasings in any of the lists. Thus, different authors seem to agree relatively well with regard to the relevant phenomena that constitute the domain.
of personality pathology. However, most measures comprise too large a number of items to be used routinely in everyday clinical practice. Therefore, extracting the “common core” from the existing measures, and keeping the number of items within a range that would be acceptable from a clinician’s point of view, should be a primary objective in creating the DSM-5 section on personality problems.

In devising our diagnostic system, we first created a list of personality dispositions that may become problematic. Note that this list essentially constitutes a measure of personality, not personality pathology. Our goal in construing the list of personality dispositions was to cover this domain as comprehensively as possible, by including interpersonal behavior, emotional experience and emotional expression, self-regulation and self-esteem, as well as subjective representations of the self, others, and their interrelatedness. The initial version of the list was based on the basic and clinical research literature, as well as our own clinical experience. We then compared our own list of potentially problematic personality dispositions with various other lists, among which were the DSM-IV personality disorder criteria (APA, 2000), the first proposed set of DSM-5 trait facets (Skodol et al., 2011a), the SWAP-200 items (Westen & Shedler, 1999a), as well as the items of Axis II (relationship) and Axis IV (structure) of the Operationalized Psychodynamic Diagnosis Manual (OPD Task Force, 2008). Based on these comparisons we revised the list several times, adding new items while removing or merging others, and taking into account our four criteria (a–d) for an optimal level of abstraction (see above). We also tried to phrase the dispositions as neutrally as possible, in order to clearly separate description from evaluation.

The final version comprised 94 basic level dispositions, which are displayed in Table 1. In order to test the applicability of the items, and check for possible redundancies between them, the list of dispositions was presented to a convenience sample of 255 university students (75.6% female, age: M = 21.6, SD = 3.4). The students were asked to describe a target person of their own choice whom they knew relatively well, by rating how much the person displayed each disposition, using a 5-point scale ranging from 1 (very little) to 5 (very much). The dispositions were presented with a bipolar response format, implying that both extremely high and extremely low levels of the same disposition may become problematic (cf. Horowitz, 2004; OPD Task Force, 2008; Samuel, 2011; Widiger & Mullins-Sweatt, 2009). The main advantage of bipolarity is parsimony: Instead of presenting an unwieldy list of 188 unipolar items, we were able to represent the full spectrum of potentially problematic personality dispositions with 94 bipolar items.

To maximize variability, the students were arbitrarily assigned to one of four conditions: They were to either select a target person (a) “who has problems with him-/herself” (n = 61), or a person (b) “who has problems with others” (n = 50), or a person (c) “with whom others have problems” (n = 113), or a person (d) “who is at ease with himself and others” (n = 31). We used these different instructions in order to obtain ratings of persons with internalizing and externalizing personality pathology, persons with high and low levels of subjective distress, and persons with no apparent personality pathology. Across conditions, the target persons that the participants chose to describe were 24.8 years old on average (SD = 9.2), and 54.8% of them were female. Items were applicable in the vast majority of cases: The mean proportion of valid responses (other than “don’t know” or missing) per item was 93.8%. The level of redundancy between the items was low: Of the 4,371 correlations between individual items, only 5.5% were equal to or exceeded 1 r | r = .40.

We also asked 30 psychotherapists (19 female; age: M = 33.2, SD = 6.4) to describe one of their actual patients who had personality problems, by means of the new system. The goal of involving the therapists was to investigate the clinical applicability of the system. For the therapists’ descriptions of their patients, we modified the 5-point rating scale, such that it ranged from 1 (too little), to 5 (too much). Note that this reflects the important conceptual step from merely describing to actually evaluating the targets’ personalities. The therapists were told that using the end points of the scale would only be appropriate if the particular disposition contributed to a problematic personality pattern (i.e., a pattern that has negative consequences). These negative consequences should then be separately reported (see below). For four items (89, 90, 92, 93) the assumption of bipolarity seemed unreasonable with regard to negative consequences, thus we removed the first two response options (1–2). We also asked the therapists about their impressions of the clinical relevance and utility of the diagnostic system (cf. Spitzer, First, Shedler, Westen, & Skodol, 2008), and whether they thought any important content areas were missing.

The therapists’ most common theoretical orientation was cognitive–behavioral (73%), followed by psychodynamic or psychoanalytic (20%), and integrative or systemic (7%). On average, they had 5.2 years of therapeutic experience (SD = 4.7). The patients had a mean age of 35.7 years (SD = 11.4). Twenty-four patients were female. By far the most prevalent Axis I diagnosis reported by the therapists was depressive disorder (n = 19), followed by anxiety disorder (n = 8). The most prevalent DSM–IV PD diagnoses were borderline (n = 8), avoidant (n = 6), narcissistic (n = 4), and obsessive–compulsive PD (n = 3). At the time the therapists completed the questionnaire, hours of therapeutic contact with the patients had ranged from 3 to 300, with 50% of the patients having had more than 20.

The following findings from the therapist sample were particularly noteworthy: First, the items of the personality dispositions list were very well applicable in the clinical setting. Mean valid response rate per item was 97.1%, and all items had at least 90%. Second, all 94 dispositions received either a “too much” or a “too little” rating in at least one case, implying that an extreme level of the respective disposition contributed to a problematic personality pattern. In other words, all dispositions were clinically relevant. Third, for 66 items, both poles of the scale were used, indicating that the choice of the bipolar response format was appropriate in the majority of cases.

Part 2: A List of Negative Consequences

We also created a list of possible negative consequences of people’s personality dispositions. For doing so, we collected various life events and life circumstances that are viewed as negative by most cultures, and that may necessitate intervention. The collection was mainly based on the literature regarding functional impairment, life failure, and problems in living associated with PD (e.g., Mullins-Sweatt & Widiger, 2010; Skodol et al., 2005; Smith
After revising the list several times, the final version contained 23 items which are presented in Table 2. The list of negative consequences was only presented to the 30 therapists, who used it for reporting the negative consequences of their patients' patterns of personality dispositions. As we wanted to assess negative consequences that had already occurred, as well as negative consequences that were likely to occur in the future, we let the therapists use a 4-point rating scale ranging from “not at all,” to “possibly,” to “probably,” to “certainly.” All 23 negative consequences were rated as “probable” or “certain” in at least three cases, which underscores their clinical relevance. In almost all cases, the therapists believed that it was probable or certain that a personality pattern caused a patient to “suffer” (n = 29), “develop an Axis I disorder” (n = 28), and to be “chronically stressed out” (n = 27). These findings are unsurprising, given that our patient sample only comprised persons who had actively sought treatment. Other consequences were only seen as relevant for roughly half of the patients, for example, that the patient “does not exhaust his or her career potential” (n = 15) or that his or her “sex life is unsatisfactory” (n = 15). Yet other

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
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<th>Item</th>
<th>Factor</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Influences others</td>
<td>D</td>
<td>48</td>
<td>Experiences shame</td>
<td>N</td>
</tr>
<tr>
<td>2</td>
<td>Competes with others</td>
<td></td>
<td>49</td>
<td>Experiences envy</td>
<td>N</td>
</tr>
<tr>
<td>3</td>
<td>Asserts his/her own interests</td>
<td>D</td>
<td>50</td>
<td>Experiences joy</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Attacks others</td>
<td>−A</td>
<td>51</td>
<td>Experiences fear</td>
<td>N</td>
</tr>
<tr>
<td>5</td>
<td>Submits to others</td>
<td>−D</td>
<td>52</td>
<td>Experiences sadness</td>
<td>N</td>
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<tr>
<td>6</td>
<td>Fits into groups</td>
<td>A</td>
<td>53</td>
<td>Experiences separation anxiety</td>
<td>N</td>
</tr>
<tr>
<td>7</td>
<td>Trusts others</td>
<td>A, E</td>
<td>54</td>
<td>Experiences love / affection</td>
<td>A</td>
</tr>
<tr>
<td>8</td>
<td>Delegates responsibility to others</td>
<td>E</td>
<td>55</td>
<td>Experiences intimacy / security</td>
<td>A</td>
</tr>
<tr>
<td>9</td>
<td>Seeks support from others</td>
<td>E</td>
<td>56</td>
<td>Has trust in his/her own abilities</td>
<td>D</td>
</tr>
<tr>
<td>10</td>
<td>Opens up to others</td>
<td>E</td>
<td>57</td>
<td>Sees him/herself as lovable</td>
<td>E</td>
</tr>
<tr>
<td>11</td>
<td>Shows others his/her affection</td>
<td>A</td>
<td>58</td>
<td>Has a clear image of him/herself vs. others</td>
<td>D</td>
</tr>
<tr>
<td>12</td>
<td>Acknowledges others</td>
<td>A</td>
<td>59</td>
<td>Feels that he/she belongs to at least one group</td>
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<td>13</td>
<td>Seeks contact with others</td>
<td>E</td>
<td>60</td>
<td>Feels accepted by others</td>
<td>D, E</td>
</tr>
<tr>
<td>14</td>
<td>Flirts with others</td>
<td>E</td>
<td>61</td>
<td>Has a stable self-image</td>
<td>D</td>
</tr>
<tr>
<td>15</td>
<td>Sets boundaries to others</td>
<td>−E</td>
<td>62</td>
<td>Sees him/herself as a victim</td>
<td>N</td>
</tr>
<tr>
<td>16</td>
<td>Makes compromises</td>
<td>A</td>
<td>63</td>
<td>Is aware of his/her own weaknesses</td>
<td>A</td>
</tr>
<tr>
<td>17</td>
<td>Forgive others</td>
<td>A</td>
<td>64</td>
<td>Accepts his/her own body</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Honors agreements and obligations</td>
<td>C</td>
<td>65</td>
<td>Sees others as independent persons</td>
<td>A</td>
</tr>
<tr>
<td>19</td>
<td>Is considerate to others</td>
<td>A</td>
<td>66</td>
<td>Has relatively stable images of other people</td>
<td>A</td>
</tr>
<tr>
<td>20</td>
<td>Respects others' autonomy</td>
<td>A</td>
<td>67</td>
<td>Sees others in a differentiated manner</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Tells the truth, is honest</td>
<td>A</td>
<td>68</td>
<td>Sees others as being critical and evaluating</td>
<td>N</td>
</tr>
<tr>
<td>22</td>
<td>Carries out conflicts openly</td>
<td>D</td>
<td>69</td>
<td>Sees others as being dangerous</td>
<td>N</td>
</tr>
<tr>
<td>23</td>
<td>Expresses him/herself clearly</td>
<td>D</td>
<td>70</td>
<td>Holds others to high standards</td>
<td>N</td>
</tr>
<tr>
<td>24</td>
<td>Admits his/her own mistakes, apologizes</td>
<td>A</td>
<td>71</td>
<td>Sees others as lovable</td>
<td>A</td>
</tr>
<tr>
<td>25</td>
<td>Is critical of others</td>
<td>D, N</td>
<td>72</td>
<td>Sees others in terms of their usefulness</td>
<td>−A</td>
</tr>
<tr>
<td>26</td>
<td>Opposes others</td>
<td>D</td>
<td>73</td>
<td>Copes with setbacks and defeats</td>
<td>D</td>
</tr>
<tr>
<td>27</td>
<td>Withdraws from others</td>
<td>−E</td>
<td>74</td>
<td>Is motivated/interested</td>
<td>C</td>
</tr>
<tr>
<td>28</td>
<td>Commits to relationships with others</td>
<td>A</td>
<td>75</td>
<td>Accepts risks</td>
<td>D</td>
</tr>
<tr>
<td>29</td>
<td>Accuses others</td>
<td>−A, N</td>
<td>76</td>
<td>Completes tasks that he/she has begun</td>
<td>C</td>
</tr>
<tr>
<td>30</td>
<td>Seeks others’ attention</td>
<td>E</td>
<td>77</td>
<td>Anticipates consequences of his/her behaviour</td>
<td>A, C</td>
</tr>
<tr>
<td>31</td>
<td>Cares for others</td>
<td>A</td>
<td>78</td>
<td>Sets personal goals for him/herself</td>
<td>C</td>
</tr>
<tr>
<td>32</td>
<td>Cooperates with others</td>
<td>A</td>
<td>79</td>
<td>Deals with tasks efficiently, sets priorities</td>
<td>C</td>
</tr>
<tr>
<td>33</td>
<td>Shares with others</td>
<td>A</td>
<td>80</td>
<td>Learns from his/her mistakes</td>
<td>A</td>
</tr>
<tr>
<td>34</td>
<td>Protects him/herself from others</td>
<td>N</td>
<td>81</td>
<td>Has his/her impulses under control</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Stands up for his/her own group</td>
<td>A</td>
<td>82</td>
<td>Makes decisions on his/her own</td>
<td>D</td>
</tr>
<tr>
<td>36</td>
<td>Shows his/her anger openly</td>
<td>D</td>
<td>83</td>
<td>Accepts his/her own weaknesses and imperfections</td>
<td>A</td>
</tr>
<tr>
<td>37</td>
<td>Avoids being alone</td>
<td>E</td>
<td>84</td>
<td>Maintains daily routines</td>
<td>C</td>
</tr>
<tr>
<td>38</td>
<td>Is sexually active</td>
<td>E</td>
<td>85</td>
<td>Knows his/her own limits</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Profits from others</td>
<td>E</td>
<td>86</td>
<td>Takes the initiative</td>
<td>D</td>
</tr>
<tr>
<td>40</td>
<td>Makes demands on others</td>
<td>N</td>
<td>87</td>
<td>Gives room to feelings</td>
<td>A</td>
</tr>
<tr>
<td>41</td>
<td>Is self-confident when with others</td>
<td>D</td>
<td>88</td>
<td>Provides relaxation/recovery time for him/herself</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Is aware of his/her own feelings</td>
<td></td>
<td>89</td>
<td>Has „strange“ views or perceptions</td>
<td>−A</td>
</tr>
<tr>
<td>43</td>
<td>Expresses his/her feelings openly</td>
<td>A</td>
<td>90</td>
<td>Shows „odd“ behaviors</td>
<td>−A</td>
</tr>
<tr>
<td>44</td>
<td>Experiences emotional ups and downs</td>
<td>N</td>
<td>91</td>
<td>Weights risks carefully</td>
<td>C</td>
</tr>
<tr>
<td>45</td>
<td>Experiences anger</td>
<td>N</td>
<td>92</td>
<td>Intentionally harms him/herself</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Experiences feelings of guilt</td>
<td>N</td>
<td>93</td>
<td>Threatens or tries to kill him/herself</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Experiences jealousy</td>
<td>N</td>
<td>94</td>
<td>Values being sexually attractive</td>
<td>E</td>
</tr>
</tbody>
</table>

Note. Capital letters indicate markers item (|r| > .40) for the five factors Agreeableness (A), Dominance (D), Neuroticism (N), Extraversion (E), and Conscientiousness (C). Negative loadings are signed with minus (−).
consequences were reported only rarely, for example, that the patient "commits a crime" (n = 4), "is in danger of dying" (n = 4), or "becomes the victim of a crime" (n = 3). Note that, by summing up all the negative consequences of a person's personality pattern, it would be possible to obtain a broad measure of overall personality-related impairment, or general severity.

After the therapists had used the lists of dispositions and consequences to describe their patients, we asked them: "How would you judge the clinical utility of this system for diagnosing personality pathology, as compared to that of the DSM–IV or ICD-10?"

The therapists gave the new system an average score of M = 3.50 (SD = 0.86) on a 5-point scale (1 = much worse, 2 = worse, 3 = about equal, 4 = better, and 5 = much better), which is significantly better than the "about equal" response option, r(29) = 3.18, p = .003. The effect size was quite substantial (d = .58). This finding is in line with previous studies reporting that the clinical utility of dimensional ratings of personality pathology is superior to the current DSM–IV system (Lowe & Widiger, 2009; Samuel & Widiger, 2006; Widiger & Mullins-Sweatt, 2010). What is most important to note, however, is that the therapists found the new system only incorporated basic level dispositions and negative consequences. No higher-order labels (e.g., borderline, histrionic) whatsoever were used, but the therapists did not seem to miss them. The therapists also had only very few suggestions for additional item content, indicating the new system’s relatively comprehensive coverage of the personality pathology domain.

It seems that, with our lists of personality dispositions and their possible negative consequences, we created a system that would already enable an assessment of personality pathology. However, for administrative purposes, some sort of more general diagnostic category may be needed. We suggest using a single superordinate category for all sorts of personality problems. This category may be named “significant personality-related impairment” (SPRI). Note that the SPRI category would be free of any specific content regarding the patient’s personality. Its function would simply be to signal that the patient’s pattern of personality problems is, by itself, severe enough to require intervention, treatment, or special consideration. This is—inevitably—a categorical decision (e.g., most therapists we know would not recommend that a patient should begin therapy “somewhat” or “a little”). In making the decision as to whether SPRI is present, the most relevant source of information would be the number and severity of negative consequences that are associated with a person’s personality dispositions.

In a way, the suggested SPRI category is similar to the “PDNOS” (personality disorder not otherwise specified) category in DSM-IV, and to the “PDTS” (personality disorder trait specified) category in the DSM-5 proposal, which are used to describe patients who do not fit any of the more circumscribed PD patterns. Several studies have shown that PDNOS may in fact be the DSM-IV PD category that is used most often in clinical practice (Verheul, Bartak, & Widiger, 2007; Verheul & Widiger, 2004), implying that most patients show some relatively unique pattern of personality-related impairment. Our suggestion to use a single superordinate category for all kinds of personality-related impairment is just a way of taking these empirical findings seriously.

Comparison With the DSM-5 Proposal

The first proposal of the DSM-5 Work Group on personality and personality disorders was posted online on the DSM website on February 10th, 2010, and was subsequently explained and justified in several publications (e.g., Skodol et al., 2011a; 2011b). It was also heavily debated in special issues of relevant journals, mainly receiving critical responses (e.g., Pilkonis, Hallquist, Morse, & Stepp, 2011; Pincus, 2011; Shedler et al., 2010; Widiger, 2011; Zimmerman, 2011). In the meantime, a revised proposal has been posted (June 21st, 2011), accompanied by a series of new publications (e.g., Bender, Morey, & Skodol, 2011; Morey et al., 2011; Krueger, Eaton, Derringer, Markon, Watson, & Skodol, 2011). In the remainder of this article, we will discuss this proposal in terms of the conceptual framework that we outlined above, supplementing arguments with data from our own sample measure.

Basic Level Elements

The personality dispositions in our diagnostic system are described at a rather low (“basic”) level of abstraction. This is necessary, from our point of view, to match the level of abstraction at which most of therapists’ everyday clinical work with their patients takes place. It also roughly matches the level of abstraction at which personality pathology is described by the items of most measures (see above). The component of the DSM-5 proposal that approaches the basic level most closely is the list of 25 “personality trait facets.” It should be noted, however, that these facets are considerably broader than the basic level items of all other PD measures we know. The average number of items in the measures we listed above was M = 217.8. Our own sample diagnostic system comprises 94 personality dispositions and 23 negative consequences. The number of trait facets in the current
version of the DSM-5 proposal is much smaller than that. If the number of items is reduced so significantly, it is inevitable that the content of the individual items will become broader, as long as one still intends to cover the domain of personality pathology comprehensively. As a consequence, many of the proposed DSM-5 trait facets (e.g., anxiousness, depressivity) may be too broad and abstract to be clinically useful (see above).

Higher-Order Concepts

Trait domains. The DSM-5 proposal contains three different sets of higher-order concepts: “personality traits,” “personality types,” and “levels of personality functioning.” Only the first of these is sufficiently supported by empirical data (cf. Clark, Livesley, Schroeder, & Irish, 1996; Markon, Krueger, & Watson, 2005; Rossi, Elklit, & Simonsen, 2010; Trull & Durett, 2005; Watson, Clark, & Chmielewski, 2008; Widiger, Livesley, & Clark, 2009). Wiggins and Pincus (1989) were among the first to demonstrate that a considerable proportion of personality pathology variance may be accounted for by the Big Five personality factors (Goldberg, 1993; John, 1990; McCrae & Costa, 1990). Since then, evidence that at least a “Big Four” model—comprising neuroticism (negative affectivity), extraversion (positive affectivity), conscientiousness (constraint), and agreeableness—may be the most appropriate framework for jointly conceptualizing normal and pathological personality variation on a higher level of abstraction has steadily grown (Livesley, Jang, & Vernon, 1998; Saulsman & Page, 2004; Widiger, 1998; Widiger & Samuel, 2005). Openness to experience, the fifth of the Big Five factors, has come to be regarded more or less irrelevant for describing personality pathology (but see Piedmont, Sherman, Sherman, Dy-Liacco, & Williams, 2009, as well as Widiger, 2011, for different views on this issue). The DSM-5 Work Group’s proposal contains five broad personality trait domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism), each of which is further subdivided into several “facets” (Krueger et al., 2011). The first four trait domains represent the “pathological” variants of neuroticism, (low) extraversion, (low) agreeableness, and (low) conscientiousness. Psychoticism represents the cognitive peculiarities (e.g., magical thinking, ideas of reference, unusual beliefs) that were associated with schizotypal PD in DSM-IV (APA, 2000). This latter trait is not part of the Big Five model of personality, but empirical research has demonstrated that a separate factor may be necessary to cover this domain (Watson et al., 2008).

In order to determine the factor structure of our own measure, we conducted a principal components analysis (PCA) of the 94 personality dispositions, using the student sample (N = 255). The Kaiser-Meyer-Olkin measure of sampling adequacy (Kaiser, 1970) was good (.83). Scree test and parallel analysis (Horn, 1965; O’Connor, 2000) unequivocally suggested extracting five components, which explained 40.4% of the total variance. We used Varimax rotation, and applied an arbitrary threshold of |r| > .40 for identifying “marker items.” In Table 1, the personality factors for which the individual items were markers are indicated by capital letters. Seventy-six items were markers for exactly one of the five factors. Six items were markers for two factors. Based on the pattern of loadings, the factors were easily interpretable: The first (15.9% explained variance) was agreeableness, the third (6.2%) was neuroticism (or negative affectivity), the fourth (4.3%) was extraversion, and the fifth (2.8%) was conscientiousness. Thus, like many studies before, our own study replicated the “Big Four” factors very well. As we had compiled our item set with no particular factor structure in mind, but only based on considerations of clinical relevance, comprehensiveness, and parsimony, the finding clearly speaks to the validity of these four factors. Note that we gave our factors the traditional names of the corresponding factors from the Five Factor Model. This was appropriate because these were descriptive personality factors, and thus conceptually independent of negative consequences.

The second factor (11.2%), however, represented a content area that does not map directly on the Big Four/Five framework. Based on the loadings of the items on this factor, we interpreted it as dominance (assertiveness/self-confidence). Dominance is one of the two basic dimensions of the Interpersonal Circumplex model (Kiesler, 1983; Leary, 1957; Wiggins, 1979), which has also been used as a descriptive higher-order framework for personality problems (Pincus & Wiggins, 1990; Pincus, Lukowitsky, & Wright, 2010). It may be somewhat surprising to see dominance emerge as a factor of its own in our analysis, given that dominance and extraversion tend to be substantially correlated (Traupman et al., 2009; Wiggins & Broughton, 1991). However, some authors (e.g., Wiggins, 1979) use the term “extraversion” in a narrower sense, referring more specifically to sociability (McCrae & Costa, 1989), that is, a tendency to enjoy and seek contact with other people, which does not necessarily imply assertiveness or striving for status. Our own dominance and extraversion factors conformed very well with this approach. Notably, the detachment factor (= problematically low extraversion) that is used in the DSM-5 proposal also has no implications of high or low status.

Other findings of our PCA were noteworthy as well: First, whereas most items were clearly associated with one (or two) of the five factors (|r| > .40), some (N = 12) were not. Among these were some with particularly important content, such as self-harm (item 92) and suicidality (item 93). This finding emphasizes once more the need to assess personality pathology at a relatively low level of abstraction. It will always be important to know whether a patient is at risk of intentionally harming or killing himself or herself, regardless of which other problematic personality dispositions the patient shows, or how the patient’s overall pattern of personality problems may be named on a higher level of abstraction. Second, the neuroticism factor clearly had a component pertaining to strained relationships with others (mainly in terms of negative images of others), but submissive interpersonal behavior was not part of the neuroticism factor. This suggests that the DSM-5 Work Group may have to reassess its decision to list submissiveness as a facet of negative affectivity. We found a high negative loading of submissive behavior (item 5) on the dominance factor, which is perfectly congruent with the Interpersonal Circumplex model. Third, attention seeking seems to be ill represented as a facet of antagonism (= problematically low agreeableness) in the DSM-5 proposal. Our findings suggest that mapping it as a facet of low detachment (= problematically high extraversion) may be more appropriate. Similar arguments have been made by others (e.g., Gore, Tomiatti, & Widiger, 2011; Pincus & Wiggins, 1990; Saulsman & Page, 2004; Wiggins & Pincus, 1989). Fourth, dispositions referring to the psychoticism dimension from the DSM-5 proposal were clearly underrepresented in our item set. There is an ongoing debate as to whether this content domain
should be removed completely from the PD section of DSM, and integrated with the Axis-I section on psychotic disorders (Huprich, 2011; Hyman, 2007). Doing so may be quite reasonable, from our point of view, as representing this content domain separately at two different places in the diagnostic manual would clearly contradict the principle of parsimony.

The results of the PCA were also relevant with regard to the issue of bipolarity, which is heavily debated in the personality assessment literature these days (Block, 2008; Pilkonis et al., 2011; Samuel, 2011; Weston & Shedler, 2007; Widiger et al., 2009; Widiger, 2011; Wood, Garb, Nezworski, & Koren, 2007). With respect to the basic level of abstraction, we had argued that both extremely high and extremely low levels of most personality dispositions may become problematic (cf. Horowitz, 2004; OPD Task Force, 2008; Widiger & Mullins-Sweatt, 2009). This assumption was corroborated by the fact that, within the therapist sample, both poles of the bipolar response format (“too much” or “too little”) were used for more than two thirds of the items (see above). Our study makes it possible to also investigate the issue of bipolarity with regard to higher-order traits. The clinical relevance of dispositions that relate to high and low levels of dominance, extraversion, and conscientiousness, as well as high levels of neuroticism and low levels of agreeableness, is already well supported by empirical evidence. More research is needed, however, to clarify whether dispositions that relate to high agreeableness or low neuroticism may be relevant in diagnosing personality pathology as well (Lowe, Edmundson, & Widiger, 2009; Lynam & Widiger, 2007; Widiger et al., 2009; Widiger, 2011). Preliminary evidence regarding this issue comes from our therapist sample: For 22 of the 31 marker items of agreeableness, both poles of the bipolar response format were used; the same was true for 16 of the 17 marker items of neuroticism. This means that, from the perspective of the therapists, extremely high or low levels of most dispositions that relate to agreeableness or neuroticism may become problematic under certain circumstances. A prominent example was item 45 (“experiences anger”), which was exclusively associated with the neuroticism factor. Five patients (16.7% of the sample) were rated by their therapists as experiencing anger to a problematic low extent.

To conclude, we found a very well interpretable pattern of five descriptive personality factors that could be used to organize basic level personality dispositions at a higher level of abstraction. Four of these factors were the well-established Big Four (with extraversion being interpreted mainly as sociability), whereas the remaining factor was interpretable as dominance, assertiveness, or self-confidence. If a higher-order framework is to be incorporated into DSM-5, it should be some variant of the Big Four (possibly complemented by a separate dominance factor), because this set of personality factors has by far the strongest empirical support. If the description and the evaluation of personality features are distinguished from each other, as in the diagnostic system that we created, it would easily be possible to keep the traditional labels of the personality factors (e.g., agreeableness, conscientiousness) instead of using new ones that imply strong evaluations (e.g., antagonism, disinhibition). Keeping the traditional labels would certainly enhance the compatibility of basic and clinical personality science. The personality factors would only be used to organize the basic level dispositions at a higher level of abstraction, whereas the problemness of the dispositions would be assessed independently, in terms of negative consequences.

**Levels of personality functioning.** The second framework of higher-order concepts in the DSM-5 proposal is called “levels of personality functioning.” The underlying idea for this framework is that of a unidimensional “general severity” continuum of self and interpersonal impairments, which according to Hopwood et al. (in press) is a powerful predictor of future social, occupational, and leisure dysfunction. Various theoretical accounts highlight the importance of disturbances in self–other representations for the assessment of personality pathology (e.g., Clarkin, Levy, & Ellison, 2011; Horowitz, 2004; Kernberg & Caligor, 2005; Luyten & Blatt, 2011; Meyer & Pilkonis, 2005; OPD Task Force, 2008; PDM Task Force, 2006). The levels of personality functioning scale is supposed to reflect this content domain. In the current version of the DSM-5 proposal, the continuum is to be assessed by means of a 5-point scale. In scoring the scale, two domains of self-functioning (identity and self-direction), and two domains of interpersonal functioning (empathy and intimacy) are to be considered (Bender et al., 2011; Morey et al., 2011).

The problems with this framework are manifold: First, each individual level of the scale is described in terms of three short paragraphs. Some of these incorporate a level of abstraction that is similar to the one we used in our own list of personality dispositions (e.g., “tends not to view relationships in reciprocal terms, and cooperates predominantly for personal gain”). Most, however, are very complex and highly inferential (e.g., “Vulnerable self-esteem controlled by exaggerated concern about external evaluation, with a wish for approval. Sense of incompleteness, or inferiority, with compensatory inflated, or deflated self-appraisal”). It is likely that, because of this high level of inference, such items will be associated with low interrater agreement (Hoyt & Kerns, 1999). This is even more likely as not one, but three paragraphs are to be considered at the same time, in deciding whether a particular scale level should be assigned to a particular individual. In fact, the DSM-5 proposal requires users to simultaneously consider four different domains (identity, self-direction, empathy, intimacy), each of which comprises five scale levels, each of which comprises three short paragraphs, in judging a patient’s overall level of personality functioning. A direct rating of overall severity on a single 5-point scale, based on such comparisons, may require too much abstract inference to be reliably and routinely used in clinical practice (cf. Pincus, 2011).

In this regard, it may be instructive to consider the results of a multicenter study (Cierpka, Grande, Rudolf, von der Tann, & Stasch, 2007) that investigated the interrater reliability of Axis IV of the Operationalized Psychodynamic Diagnosis (OPD Task Force, 2001). This measure is very similar to the proposed levels of personality functioning scale, as it assesses a patient’s overall level of “structural integration” on a 7-point scale, using short paragraphs to describe the individual scale levels. Note that the authors of the system recommend that raters should have at least 2 years of clinical experience, plus a 60-hr training course, before they may use the system in a reliable manner (OPD Task Force, 2001, 2008). Under research conditions, interrater reliability was relatively good (average weighted \( \kappa > .70 \)). But under conditions of clinical routine (i.e., when interviews were conducted rather pragmatically and with time constraints), weighted kappa values were lower than .50. We expect that the proposed levels of per-
sonality functioning scale will suffer from similar reliability problems when it is used in everyday clinical decision-making. Second, there is a considerable level of conceptual fuzziness associated with the construct of “general severity” as currently proposed. Terms like “impairment,” “pathology,” “dysfunction,” and “severity” are used at various points in the proposal, and in the research articles related to it, but their meaning is never explicitly defined. One possible understanding of these terms would invoke an image of “natural personality development” with which a person’s actual level of development may be compared. This understanding is close to Wakefield’s (1992) concept of “dysfunction” (i.e., a mechanism does not perform the function that it was selected for in the course of evolution), which is also invoked occasionally by the DSM-5 Work Group (e.g., Krueger, Skodol, Livesley, Shrout, & Yueqin, 2007, p. 70). However, as Leising et al. (2009) pointed out, we do not have a sufficient, empirically based understanding of “natural personality development” to enable such comparisons at present (see also Zachar & Kendler, 2010). Rather, most of the detailed accounts of normal and abnormal personality development in the literature (cf. Bender et al., 2011; Livesley, 1998; Parker et al., 2002) are essentially theoretical in nature, with little or no empirical support. Another possible understanding would refer to how successfully a person, given his or her specific set of personality dispositions, deals with the demands and challenges of his or her social environment (e.g., interpersonal relationships, occupational settings, etc.). This understanding is the one that we advocate when defining “impairment” in terms of negative consequences in the present article.

So “severity” may be interpreted in terms of deviations from the natural course of personality development, or in terms of the negative consequences that may be brought about by a person’s personality dispositions. However, this fundamental conceptual difference is not reflected in any of the existing measures of personality pathology. As most measures seem to conflate the two approaches to some extent, it is likely that some of the correlations between PD variables that are reported in the literature contain an element of predictor–criterion contamination. For example, the correlation between “severity of personality disorder” and “impaired functioning” (Hopwood et al., in press) may partly reflect an overlap in content between these two variables.

Third, even if ordering patients along a general severity continuum is reasonable (e.g., for deciding whether and what kind of treatment the patient needs), this does not lend support for the specific composition of the scale levels in the current DSM-5 proposal. The “rationale” section on the DSM-5 website discusses at length how important it is to consider representations of the self and others in assessing personality pathology (to which we agree), but gives no empirical justification for the specific compositions of the scale levels. We are not aware of empirical analyses demonstrating that the individual criteria listed in the levels of personality functioning scale actually covary as suggested by the DSM-5 Work Group. Establishing higher-order concepts without sufficient empirical basis was one of the primary mistakes that were made in creating the DSM–IV section on personality disorders. We would suggest not making that mistake again. Instead, overall severity should be assessed in terms of the (weighted) sum of all negative consequences of a person’s personality pattern. This overall severity may then be used to decide whether a diagnosis of SPRI is warranted, and what kind of treatment setting (e.g., inpatient vs. outpatient, frequency of therapeutic contact) would be appropriate. Individual disturbances of self- and other-representations should be assessed at a basic level of abstraction. Our list of personality dispositions contains several items referring to this content domain.

**Personality disorder types.** The third framework of higher-order concepts in the DSM-5 proposal recombines elements of the first two: Each of six personality types (narcissistic, schizotypal, borderline, obsessive-compulsive, antisocial, and avoidant) is described in terms of (a) characteristic impairments of personality functioning (using elements of the levels of personality functioning scale) and (b) pathological personality traits and trait facets. The diagnostician’s task is to judge whether, or to which extent a given patient matches each type (the exact scoring procedures are currently under development). As the types are essentially composed of the same lower-level elements as the levels of personality functioning scale and the personality traits, there is a considerable level of redundancy in the proposal. Recombining elements of two higher-order frameworks to form a third higher-order framework is clearly at odds with the principle of parsimony. This is particularly problematic because the DSM-5 proposal does not present a compelling rationale for why these alternative combinations are necessary, and because the types that are presented are, again, lacking empirical support.

The prototype approach (Rosch, 1975) implies that in everyday judgments of objects, category-membership is often a matter of degree, rather than a matter of necessary and sufficient conditions. The prototype is the member of a category that is most typical for all members of the category. Accordingly, an object’s category membership may be defined in terms of its similarity to various prototypes. In personality research, prototypes are often derived by asking a group of people (e.g., clinicians) which features they consider to be most characteristic of a given concept (e.g., borderline). The similarity between a given person’s personality profile and the prototype may then be assessed in terms of (e.g.) a profile correlation (for an exemplary study using this approach see Westen & Shedler, 1999a). The problem with this approach, however, is that higher-order concepts are not automatically valid only because people can use them with good agreement. In their clinical training, psychotherapists learn about the (supposed) existence of certain personality types, and about the typical features of those types. The fact that, unsurprisingly, trained therapists are able to reproduce these algorithms in a study does not mean that the concepts themselves reflect reality (i.e., sufficiently distinct clusters of personality features that actually covary with each other). The only way to avoid the bias that may be introduced by learning about personality theories before rating the personalities of actual patients is to use untrained persons as raters. Most personality disorder types that are established this way (i.e., by analyzing typical configurations of basic level personality problems using exploratory techniques and data from untrained raters) do not resemble the six prototypes in the DSM-5 proposal much, and are not replicable across samples (Eaton, Krueger, South, Simms, & Clark, 2011). In fact, lack of replicability across samples and informants is one of the most prominent arguments against personality types in basic personality psychology research (Ashton & Lee, 2009; De Fruyt, Mervielde, & Van Leeuwen, 2002; McCrae, Terracciano, Costa, & Ozer, 2006; Rammstedt, Riemann, Angleitner, & Borkenau, 2004).
Our criticism of questionable higher-order concepts like “borderline” is not meant to imply that we regard the basic level personality dispositions that are thought to contribute to these and other personality disorder types as irrelevant. For example, emotional ups and downs (item 44), separation anxiety (item 53), lack of impulse control (item 81), self-harm (item 92), and suicidal gestures (item 93) are, of course, clinically relevant. However, an analysis of the empirical covariations of these phenomena in our student sample reveals that, whereas self-harm is in fact strongly associated with suicidality, \( r(228) = .54, p < .001 \), it is only weakly associated with separation anxiety, \( r(193) = .20, p = .006 \), and unrelated to impulse control, \( r(185) = -.09, p = .187 \). Thus, putting self-harm and impulsivity together into the same type (“borderline”) does not reflect the empirical covariations of these dispositions.

**Summary and Outlook**

We presented a joint conceptual framework for assessing personality and personality pathology. In this framework, the explicit distinction between personality description and personality evaluation is of crucial importance. Based on this distinction, we presented a sample diagnostic system that comprises two parts: First, a list of personality dispositions that reflect a person’s tendencies to think, feel, and behave in certain ways. These dispositions constitute the personality component of the system. They are phrased as neutrally as possible, and on a basic level of abstraction, in order to be clinically useful. Second, a list of negative consequences which are used to evaluate the extent to which the person’s pattern of personality dispositions is problematic. The overall amount of negative consequences may be used to determine whether the person should be considered “a case” (= “significant personality-related impairment”), and what kind of treatment setting (e.g., inpatient vs. outpatient, frequency of therapeutic contact) would be appropriate.

A sample of therapists rated actual patients by means of the system, in order to provide data regarding its clinical utility. The therapists judged the system as being somewhat better than DSM–IV or ICD-10, despite the fact that it did not contain any higher-order concepts (i.e., labels denoting clusters of basic level elements that presumably “go together”). We also let a sample of students describe acquaintances by means of the personality dispositions, in order to establish their factor structure. Using principle components analysis we found four factors that were easily identifiable as the “Big Four,” plus an additional dominance factor. If a framework of higher-order concepts is wanted for DSM-5, it should be a version of the Big Four model, because this framework has by far the best empirical support. By separating description from evaluation, it would be possible to keep the traditional names (e.g., agreeableness) of the personality traits, which would greatly enhance the compatibility between basic and clinical personality psychology. Assessing broad descriptive personality traits is not really necessary in diagnosing personality problems, because therapists’ everyday clinical work takes place at a lower level of abstraction. However, assessing such traits may still be useful, because studies have shown that they may independently predict the course of all kinds of (e.g., psychotherapeutic) treatment. The other two frameworks of higher-order concepts in the DSM-5 proposal (personality types, levels of personality functioning) are conceptually flawed and/or lack empirical support, and thus should not be incorporated in DSM-5.

**References**


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