

Proposed Changes in Personality and Personality Disorder Assessment and Diagnosis for *DSM-5* Part II: Clinical Application

Andrew E. Skodol

University of Arizona College of Medicine

Donna S. Bender

University of Arizona College of Medicine

John M. Oldham

Baylor College of Medicine

Lee Anna Clark

University of Iowa

Leslie C. Morey

Texas A&M University

Roel Verheul

University of Amsterdam

Robert F. Krueger

University of Minnesota

Larry J. Siever

Mt. Sinai School of Medicine

The four-part assessment of personality psychopathology proposed for *DSM-5* focuses attention on identifying personality psychopathology with increasing degrees of specificity, based on a clinician's available time, information, and expertise. In Part I of this two-part article, we described the components of the new model and presented brief rationales for them. In Part II, we illustrate the clinical application of the model with vignettes of patients with varying degrees of personality psychopathology, selected from the *DSM-IV-TR Casebook*, to show how assessments might be conducted and diagnoses reached.

Keywords: personality disorders, personality, *DSM-5*, assessment, diagnosis, clinical application

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varying degrees of personality psychopathology, selected from the *DSM-IV Casebook* (Spitzer, Gibbon, Skodol, Williams, & First, 2002), to show how assessments might be conducted and diagnoses reached. Cases from the *DSM-IV-TR Casebook* were chosen explicitly so that readers can compare the original discussions based on the *DSM-IV-TR* model to the discussions of the same cases herein and judge their relative clinical utilities.

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Amsterdam, The Netherlands; Robert F. Krueger, Department of Psychology, University of Minnesota; Larry J. Siever, Department of Psychiatry, Mt. Sinai School of Medicine.

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Andrew E. Skodol, Department of Psychiatry, University of Arizona College of Medicine; Donna S. Bender, Department of Psychiatry, University of Arizona College of Medicine; John M. Oldham, Department of Psychiatry, Baylor College of Medicine; Lee Anna Clark, now at Department of Psychology, University of Notre Dame; Leslie C. Morey, Department of Psychology, Texas A&M University; Roel Verheul, Center of Psychotherapy De Viersprong, University of

Correspondence concerning this article should be addressed to Andrew E. Skodol, M.D., Sunbelt Collaborative, 4031 E. Sunrise Drive, Suite 101, Tucson, AZ 85718. E-mail: askodol@gmail.com

To review, the assessment model for personality psychopathology proposed for *DSM-5* identifies core impairments in personality functioning, pathological personality traits, and prominent pathological personality types. A comprehensive personality assessment consists of four components:

(a) Five identified severity levels of personality functioning, based on degrees of impairment in core self and interpersonal capacities;

(b) Five specific personality disorder (PD) types, each defined by impairments in core capacities and a set of pathological personality traits, and one trait-specified type;

(c) Six broad, higher order personality *trait domains*, with 4–10 lower order, more specific *trait facets* within each domain, for a total of 37 specific trait facets;

(d) New general criteria for PD based on severe or extreme deficits in core capacities of personality functioning and extreme levels of pathological personality traits.

The rationale for the proposed changes in personality and PD assessment and diagnosis emanates from the myriad problems with the existing 10-category representation of personality psychopathology in *DSM-IV-TR* (see Skodol et al., this issue). These include an unsubstantiated and nonspecific definition of and general criteria for PD; the lack of a PD-specific, clinically useful, severity measure; excessive comorbidity among *DSM-IV-TR* PDs; limited validity of some existing types; arbitrary diagnostic thresholds; within-disorder heterogeneity; inadequate coverage of the range of PD pathology, and instability of current diagnostic criteria sets. The proposed new model addresses all of the limitations of the PD diagnostic class in *DSM-IV-TR*.

Overview of the *DSM-5* Personality and PD Assessment Method

The new assessment model is designed to be flexible, and to “telescope” clinical attention onto personality pathology by degrees. Even a busy clinician with limited time or expertise in the assessment of personality or PDs should be able to decide whether a personality-related problem exists and how severe it is. Further steps in the assessment of personality problems would be to generally characterize their type according to broad characteristics and to assess

the specific traits that describe the type to generate a corresponding trait profile of the patient. The patient can also be evaluated for the remainder of the traits, a sort of trait-based “review of systems,” in order to identify other important personality characteristics. The levels of functioning and trait profile steps are informative whether or not a patient is believed to have a PD. A trait assessment is also needed to describe the particular, individual trait profile of patients who have sufficient personality psychopathology to receive a PD diagnosis, but do not match one of the five *DSM-5* types. These patients, formerly diagnosed with PD Not Otherwise Specified (PDNOS) in *DSM-IV-TR*, would receive a diagnosis of PD Trait Specified (PDTs) in *DSM-5*. The fourth part of the model, the general criteria for PD, insures that the required inclusion and exclusion criteria have been met.

Assessment of Levels of Personality Functioning

Consideration of the core capacities of personality related to self and interpersonal functioning and determining the severity of any impairment in these areas is accomplished by using the Levels of Personality Functioning Scale (see Appendix A). Any rating above “zero” (i.e., at least a mild level of impairment) indicates personality issues. If not evident from the chief complaint or the history of the presenting problems, a few basic questions about how patients feel about themselves and about the nature of their relationships with others should enable clinicians to say with some confidence whether a personality problem exists. For example, research has shown that a question such as, “Do you ever get the feeling that you don’t know who you really are or what you want out of your life?” has high sensitivity for the kinds of problems with identity and self-concept typically associated with PDs. Similarly, a question such as, “Do you feel close to other people and enjoy your relationships with them” (answered negatively) has high sensitivity for problems with intimacy. Problems with identity and self-concept and with intimacy and interpersonal reciprocity may be the result of another type of mental disorder (i.e., a mood or anxiety disorder), but they are

especially characteristic of personality psychopathology. Preliminary analyses in a sample of 424 psychiatric patients found that a score of greater than 3 (out of 5) on a short 5-item scale depicted in Table 1 had a sensitivity of 79% and a specificity of 54% for a semistructured interview diagnosis of PD (Morey et al., unpublished manuscript).

A full assessment of impairment in personality functioning, however, is considerably more nuanced. Thus, a 5-point rating scale of functional impairment in the self and interpersonal domains is being proposed for *DSM-5*. The scale ranges from 0 = no impairment to 4 = extreme impairment (see Appendix A), with detailed descriptions of the types of dysfunctions defining each level. Based on a review of existing measures (Bender, Morey, & Skodol, 2011), the assessment of personality functioning is expected to have clinical utility. For example, the more severe the level of impairment, the more likely the person is to have a PD, to have a severe PD, and to receive multiple (more than 1) PD diagnoses according to *DSM-IV* (Bouchard et al., 2008; Loffler-Stastka, Ponocny-Seliger, Fischer-Kern, & Leithner, 2005; Verheul et al., 2008). The severity of impairment in personality functioning has also been shown to be an important predictor of concurrent and prospective general impairment in psychosocial functioning (e.g., Hopwood et al., in press) and to be important in planning treatment and predicting its outcome (e.g., Diamond, Kaslow, Coonerty, & Blatt, 1990; Piper et al., 1991).

Assessment of PD Types

The function of the model's PD type assessment is to generally characterize the type of personality problems a patient exhibits accord-

Table 1
Five-Item Screening Scale for Personality Disorder

1. I can hardly remember what kind of person I was only a few months ago.
2. My feelings about people change a great deal from day to day.
3. Most of the time I don't have the feeling of being in touch with my real self.
4. I drift through life without a clear sense of direction.
5. I have very contradictory feelings about myself.

ing to broad clinically recognizable configurations. The constellation of impairments in personality functioning and characteristics of emotional, cognitive, and behavioral functioning exhibited by a patient is considered to determine the extent to which it matches the five type descriptions proposed for *DSM-5* (antisocial/psychopathic, avoidant, borderline, obsessive-compulsive, or schizotypal) on a 5-point matching scale ranging from 5 = *very good match, patient exemplifies this type*, to 1 = *no match, description does not apply* (see Table 2). Prototype matching often guides diagnostic hypotheses in practice, recognizes that personality pathology occurs on continua, and has been rated very useful by clinicians (Spitzer, First, Shedler, Westen, & Skodol, 2008; Westen, Shedler, & Bradley, 2006). Prototypes also help clinicians structure their assessments of the trait domains and facets proposed for *DSM-5*, by making the meaning of the traits more explicit in the context of a particular kind of patient, that is, by reducing ambiguity (Rottman, Ahn, Sanislow, & Kim, 2009). This in turn facilitates more accurate diagnoses. An assessment that continues through a type rating will often approximate a *DSM-IV-TR* PD diagnosis (unless the patient does not have a specified type), which itself does not require documentation of the specific criteria of the polythetic criteria sets actually met. The *DSM-5* approach also allows the clinician to document heterogeneity within a type, by rating the specific trait profile of each patient.

Assessment of Personality Trait Domains and Facets

Trait ratings are of two kinds: domain ratings and facet ratings (see Appendix B). Trait domains and facets are rated on a 4-point scale: 0 = very little or not at all descriptive; 1 = mildly descriptive; 2 = moderately descriptive; and 3 = extremely descriptive. The six broad trait domains proposed for *DSM-5*—negative emotionality, detachment, antagonism, disinhibition, compulsivity, and schizotypy—are rated to give a “broad brush” depiction of a patient's primary trait structure. Some of these domains are close counterparts to *DSM-IV-TR* PDs. For example, the domain of detachment (DT; and its facet traits) is virtually synonymous with *DSM-IV-TR* schizoid PD and many of the traits of the

Table 2
Obsessive-Compulsive Personality Disorder Type With Matching

Individuals who match this personality disorder type are ruled by their need for order, precision, and perfection. Activities are conducted in super-methodical and overly detailed ways. They have intense concerns with time, punctuality, schedules, and rules. Affected individuals exhibit an overdeveloped sense of duty and obligation, and a need to try to complete all tasks thoroughly and meticulously. The need to try to do things perfectly may result in a paralysis of indecision, as the pros and cons of alternatives are weighed, such that important tasks may not ever be completed. Tasks, problems, and people are approached rigidly, and there is limited capacity to adapt to changing demands or circumstances. For the most part, strong emotions—both positive (e.g., love) and negative (e.g., anger)—are not consciously experienced or expressed. At times, however, the individual may show significant insecurity, lack of self-confidence, and anxiety subsequent to guilt or shame over real or perceived deficiencies or failures. Additionally, individuals with this prototype are controlling of others, competitive with them, and critical of them. They are conflicted about authority (e.g., they may feel they must submit to it or rebel against it), prone to get into power struggles either overtly or covertly, and act self-righteous or moralistic. They are unable to appreciate or understand the ideas, emotions, and behaviors of other people.

Instructions: Rate the patient's personality using the 5-point rating scale shown below. Circle the number that best describes the patient's personality.

5. Very good match: Patient *exemplifies* this type.
4. Good match: Patient *significantly* resembles this type.
3. Moderate match: Patient has *prominent features* of this type.
2. Slight match: Patient has *minor features* of this type.
1. No match: Description does not apply.

domain of antagonism (A) and of negative emotionality (NE) suggest narcissistic PD or (*DSM-IV-TR* Appendix) depressive PD, respectively. The domains figure prominently in the five PD types proposed for *DSM-5*, as well—for example, a combination of traits from the antagonism and the disinhibition (DS) domains make up the trait profile of the antisocial/psychopathic type. Traits from the domains of negative emotionality and of detachment make up the trait profile of the avoidant type. Other types are more complex, however, and have contribution of traits from multiple domains. The most detailed trait profile is obviously derived from the rating of the 37 trait facets. These may be found in myriad combinations and provide the most specific picture of a patient from the personality trait point of view. In addition, the trait domains and facets have the salutary effect of converting a non-specific PDNOS diagnosis into a specific PD Trait Specified diagnosis.

Assessment of the General Criteria for PD

The fourth part of the evaluation is the application of the general criteria for PD. The general criteria are considered last for three reasons: 1) even if a patient does not have a PD, the descriptive information from the other parts of the assessment can be clinically

useful; 2) the assessment of personality problems and of personality traits are needed to rate the general criteria and, so, logically must precede them; and 3) the various exclusion criteria will probably prove to be the most time-consuming and labor intensive parts of the assessment and require the most knowledge about patients and their clinical statuses, and thus should not interfere with an assessment of personality problems, types, and traits, which have clinical utility in their own right. The general criteria for PD were not actually a required rating in *DSM-IV-TR*, but were added to help in the overall conceptualization of what a PD is.

Application to Clinical Case Vignettes

In the next section, we will present three clinical case vignettes drawn from the *DSM-IV-TR Casebook* (Spitzer, Gibbon, Skodol, Williams, & First, 2002). Each vignette will be discussed from the point of view of the proposed *DSM-5* assessment model. For comparison, the reader can consult the *Casebook* for discussions according to *DSM-IV-TR*.

Case Vignette #1

The patient is a 23-year-old veterinary assistant admitted for her first psychiatric hospital-

ization. She arrived late at night, referred by a local psychiatrist, saying, "I don't really need to be here."

Three months before admission, the patient learned that her mother had become pregnant. She began drinking heavily, ostensibly in order to sleep nights. While drinking she became involved in a series of "one-night stands." Two weeks before admission, she began feeling panicky and having experiences in which she felt as if she were removed from her body and in a trance. During one of these episodes, she was stopped by the police while wandering on a bridge late at night. The next day, in response to hearing a voice repeatedly telling her to jump off a bridge, she ran to her supervisor and asked for help. Her supervisor, seeing her distraught and also noting scars from a recent wrist slashing, referred her to a psychiatrist, who then arranged for her immediate hospitalization.

At the time of her hospitalization, the patient appeared as a disheveled and frail, but appealing, waif. She was cooperative, coherent, and frightened. Although she did not feel hospitalization was needed, she welcomed the prospect of relief from her anxiety and depersonalization. She acknowledged that she had feelings of loneliness and inadequacy and brief periods of depressed mood and anxiety since adolescence. Recently she had been having fantasies that she was stabbing herself or a little baby with a knife. She complained that she was "just an empty shell that is transparent to everyone."

The patient's parents divorced when she was 3, and for the next 5 years she lived with her maternal grandmother and her mother, who had a severe drinking problem. The patient had night terrors during which she would frequently end up sleeping with her mother. At 6 she went to a special boarding school for a year and a half, after which she was withdrawn by her mother, against the advice of the school. When she was 8, her maternal grandmother died, and she recalls trying to conceal her grief about this from her mother. She spent most of the next 2 years living with various relatives, including a period with her father, whom she had not seen since the divorce. When she was 9, her mother was hospitalized with a diagnosis of schizophrenia. From age 10 through college, the patient lived with an aunt and uncle but had ongoing and frequent contacts with her mother. Her school record was consistently good.

Since adolescence she has dated regularly, having an active, but rarely pleasurable, sex life. Her relationships with men usually end abruptly after she becomes angry with them when they disappoint her in some apparently minor way. She then concludes that they were "no good to begin with." She has had several roommates, but has had trouble establishing a stable living situation because of her jealousy about sharing her roommates with others and her manipulative efforts to keep them from seeing other people.

Since college she has worked steadily and well as a veterinary assistant. At the time of admission, she was working a night shift in a veterinary hospital and living alone.¹

Discussion. The young veterinary assistant described in this case has severe problems in self and interpersonal functioning. She described herself as "an empty shell . . . transparent to everyone" and she has felt lonely and inadequate for many years. Though having attempted to hurt herself and harboring suicidal and homicidal fantasies, she is ambivalent about needing help. She dissociates from her body and hears a voice telling her to jump off a bridge. The immediate precipitant for her deterioration is the knowledge that her mother, who has schizophrenia, is pregnant. Thus, the patient has a very fragile and unstable sense of self, influenced by external events, and experiences a lack of identity. Her self-image is simplistic and concrete and she has little ability to self-reflect. Her interpersonal relationships are also unstable. She sees others in terms of their meeting her needs and she seems to have very little understanding or appreciation of their needs (e.g., to see other people) or behavior. When disappointed by men she is dating, she becomes angry, turns on them, and denigrates them. She does not enjoy sexual intimacy. Because of the severity of her problems in identity, self-concept, empathy, and intimacy, she would receive a rating of **3 = serious impairment** on the Levels of Personality Functioning Scale.

The patient's general pattern of personality pathology and pathological personality traits fits the **borderline type** (See Part I, Table 2). She

¹ "Empty Shell." Reprinted with permission from the *DSM-IV-TR Casebook*, (Copyright, 2002). American Psychiatric Association.

has a fragile self-concept that becomes fragmented under stress, a lack of identity and feelings of emptiness, and difficulty maintaining enduring intimate relationships. She has intense and reactive emotions; can become depressed, anxious, and angry, and feels disappointed and mistreated. Her interpersonal relationships are unstable and she appears to have little empathy for others. She engages in black-and-white, all-or-nothing thinking and has dissociated. She is impulsive (drinking, sex), has engaged in self-harm (cutting), and has suicidal ideation in response to her mother's pregnancy. On the "matching" rating scale she warrants a score of **5 = "very good match"** to the borderline type. Although this patient's level of personality functioning is typical for the borderline type, patients with this type may also function either better (i.e., mild or moderate impairment) or worse.

Rating on the traits associated with the borderline type are as follows: emotional lability = **3 (extremely descriptive)**, self-harm = **3**, separation insecurity = **2 (moderately descriptive)**, anxiousness = **2**, low self-esteem = **3**; depressivity = **3**, hostility = **3**; aggression = **0 (very little or not at all descriptive)**, impulsivity = **3**; and dissociation proneness = **2**.

An alternative assessment approach would be to start with an assessment of the trait profile for this patient. Considering the broad trait domains, negative emotionality appears to be **"extremely descriptive"** (rating = **3**), characterized further by emotional lability, depressivity, low self-esteem, self-harm, anxiousness, and separation insecurity. She would also receive ratings of **"moderately descriptive"** on the disinhibition domain (for her impulsivity) and for the trait of recklessness (not currently listed as an associated trait for the borderline type), because she engages in dangerous and risky behaviors (e.g., one night stands, wandering about late at night). She might also receive a rating of **"mildly"** or **"moderately descriptive"** on the antagonism domain (for her hostility). If her episodes of depersonalization were recurrent, then the domain of schizotypy would be considered **"mildly descriptive,"** because of the trait facet of dissociation proneness. Although the patient reports an auditory hallucination one night, there is no evidence that this is a recurrent experience, therefore the trait of unusual perceptions, connoting a tendency toward these

experiences, would not apply. A clinician might also be tempted to rate the trait facet cognitive dysregulation in the schizotypy domain because of the patient's tendency toward black-and-white, all-or-nothing thinking, but the current definition of cognitive dysregulation does not include these particular thought processes characteristic of the borderline patient.

Finally, the clinician considers the general criteria for PD. In this case, the serious impairment in both self and interpersonal functioning, and the extreme levels of a number of pathological personality traits leave little doubt that criteria A and B (see Part I, Table 4) are met. Although there has been a recent deterioration in this young woman's condition, there is some evidence that these difficulties are chronic, have been exhibited in a number of situations, and clearly began in adolescence. She may have had diagnosable episodes of major depressive disorder, alcohol abuse (most likely), depersonalization disorder, or a psychotic disorder (NOS), but these in and of themselves do not seem sufficiently chronic to account for her longstanding impairments in personality functioning. There is no evidence of an etiologically relevant general medical condition. Thus, she meets the general criteria for PD.

Summary of Case Vignette #1 Assessment

Levels of personality functioning. 3 (serious impairment).

Type. Borderline (5 = very good match).

Clinically significant traits. Trait domains: negative emotionality, disinhibition. Trait facets: emotional lability, self-harm, low self-esteem, depressivity, hostility, impulsivity, separation insecurity, anxiousness, dissociation proneness.

PD general criteria met? Yes.

Case Vignette # 2

Dr. Wilson, a 34-year-old psychiatrist, is 15 minutes late for his first appointment. He has recently been asked to resign from his job in a mental health center because, according to his boss, he is frequently late for work and meetings, has missed appointments, has forgotten about assignments, is late with his statistics, refused to follow instructions, and seems unmotivated. Dr. Wilson was surprised and resent-

ful—he thought he had been doing a particularly good job under trying circumstances and experienced his boss as excessively obsessive and demanding. Nonetheless, he reports a long-standing pattern of difficulties with authority.

The patient had a childhood history of severe and prolonged temper tantrums that were a legend in his family. He had been a bossy child who demanded that other kids “play his way” or else he wouldn’t play at all. With adults, particularly his mother and female teachers, he was sullen, insubordinate, oppositional, and often unmanageable. He had been sent to an all-boys preparatory school that had primarily male teachers, and he gradually became more subdued and disciplined. He continued, however, to stubbornly want things his own way and to resent instruction or direction from teachers. He was a brilliant but erratic student, working only as hard as he himself wanted to; he “punished” teachers he didn’t like by not doing their assignments. He was argumentative and self-righteous when criticized, and claimed that he was not being treated fairly.

Dr. Wilson is unhappily married. He complains that his wife does not understand him and is a “nitpicker.” She complains that he is unreliable and stubborn. He refuses to do anything around the house and often forgets to complete the few tasks he has accepted as within his responsibility. Tax forms are submitted several months late; bills are not paid. The patient is sociable and has considerable charm, but friends generally become annoyed at his unwillingness to go along with the wishes of the group (e.g., if a restaurant is not his choice, he may sulk all night or “forget” to bring his wallet).²

Discussion. This psychiatrist displays a lifelong pattern of oppositional behavior in play, school, work, and interpersonal relationships that seems to be a textbook case of passive-aggressive PD, with narcissistic features. Passive-aggressive PD was relegated to an appendix in *DSM-IV-TR* for “criteria sets and axes provided for further study.” Neither passive-aggressive PD nor narcissistic PD is a type currently included in the proposed model for *DSM-5*. How can this patient’s personality psychopathology be represented in the new system?

The first step is again to determine if the patient has impairments in self and interpersonal functioning. In the realm of the self, this patient clearly has problems in identity integration, self-concept, and self-direction. He has

difficulties maintaining boundaries between himself and those around him. Although it is he who has been late for work, missed appointments, forgotten assignments, been late with statistics, and refused to follow instructions, he blames his failings on his boss, who is “excessively . . . demanding.” When criticized for deliberately not doing assignments, he believes that he is being “treated unfairly.” That he is surprised when asked to resign his job and thinks that he is doing a good job, is evidence that he has a distorted self-appraisal. His lack of self-awareness indicates impairment in his capacity to self-reflect. Despite having pursued a high level of education to attain a professional degree and career, he has undermined it with his refusal to meet the standards expected from someone in his position. On the interpersonal side, he seems to have considerable lack of empathy for his wife and friends and does not attempt to develop other than superficial relationships with them. These impairments in personality functioning warrant a rating of **2 = moderate impairment** on the proposed Levels of Personality Functioning Scale.

In turning to the types, it may be possible to consider the obsessive–compulsive type (see Table 2) because of the patient’s resistance to authority, manifest in his proneness to get into power struggles, his self-righteousness, and his general rigidity. Missing, however are a need for order, precision, and perfection; detail-orientation; and concerns with time and punctuality, duty and obligation, thoroughness and meticulousness. If anything, this patient exhibits the opposite pattern. Furthermore, his impairments in self and interpersonal functioning are more severe than those generally observed in patients with the obsessive–compulsive type. He does not show the periodic insecurity, self-doubt, and anxiety or guilt over his deficiencies or failures of the individual with an obsessive–compulsive personality type. Thus, at most, a rating of **2 = slight match** (minor features of the type) would apply. The antisocial/psychopathic type (see Table 3) might be considered because the patient seems arrogant and self-centered, and is manipulative, irresponsible, su-

² “Stubborn Psychiatrist.” Reprinted with permission from the *DSM-IV-TR Casebook*, (Copyright, 2002). American Psychiatric Association.

Table 3
Antisocial/Psychopathic Personality Disorder Type With Matching

Individuals who match this personality disorder type are arrogant and self-centered, and feel privileged and entitled. They have a grandiose, exaggerated sense of self-importance and they are primarily motivated by self-serving goals. They seek power over others and will manipulate, exploit, deceive, con, or otherwise take advantage of others, in order to inflict harm or to achieve their goals. They are callous and have little empathy for others' needs or feelings unless they coincide with their own. They show disregard for the rights, property, or safety of others and experience little or no remorse or guilt if they cause any harm or injury to others. They may act aggressively or sadistically toward others in pursuit of their personal agendas and appear to derive pleasure or satisfaction from humiliating, demeaning dominating, or hurting others. They also have the capacity for superficial charm and ingratiation when it suits their purposes. They profess and demonstrate minimal investment in conventional moral principles and they tend to disavow responsibility for their actions and to blame others for their own failures and shortcomings.

Individuals with this personality type are temperamentally aggressive and have a high threshold for pleasurable excitement. They engage in reckless sensation-seeking behaviors, tend to act impulsively without fear or regard for consequences, and feel immune or invulnerable to adverse outcomes of their actions. Their emotional expression is mostly limited to irritability, anger, and hostility; acknowledgement and articulation of other emotions, such as love or anxiety, are rare. They have little insight into their motivations and are unable to consider alternative interpretations of their experiences.

Individuals with this disorder often engage in unlawful and criminal behavior and may abuse alcohol and drugs. Extremely pathological types may also commit acts of physical violence in order to intimidate, dominate, and control others. They may be generally unreliable or irresponsible about work obligations or financial commitments and often have problems with authority figures.

Instructions: Rate the patient's personality using the 5-point rating scale shown below. Circle the number that best describes the patient's personality.

5. Very good match: Patient *exemplifies* this type.
4. Good match: Patient *significantly* resembles this type.
3. Moderate match: Patient has *prominent features* of this type.
2. Slight match: Patient has *minor features* of this type.
1. No match: Description does not apply.

perfidiously charming, and unempathic. Missing here, however, are the extreme levels of callousness and exploitativeness, the overt aggression, the recklessness, and the unlawful and criminal behavior characteristic of this type. A rating of **3 = moderate match** (prominent features of the type) would apply.

For a patient who has impaired personality functioning, but who does not match significantly to a proposed type, the assessment becomes more purely trait driven. From the trait perspective, the major relevant trait domain in the case of this psychiatrist would be antagonism. A rating of **2 = moderately descriptive** would apply. Oppositionality (rating = **3**), narcissism (**3**), irresponsibility (**3**), manipulativeness (**2**), hostility (**2**), and perhaps even callousness (**1**) could be noted. Looking at the *DSM-IV-TR* to *DSM-5* Crosswalk (see Part I, Table 3), *DSM-IV-TR* passive-aggressive PD is represented by the traits of oppositionality, hostility, and guilt/shame. The current patient has two of these three traits. Narcissistic PD is represented by the traits of narcissism, manipulativeness, histrionism, and

callousness. The patient has two or perhaps three of these traits. The crosswalk shows that personality pathology (even according to *DSM-IV-TR* constructs) that is not represented by a *DSM-5* type can be described in trait terms. It also illustrates, however, the lack of clear boundaries between *DSM-IV-TR* PDs, and the trait heterogeneity within them.

In considering whether this patient meets the general criteria for a PD according to the newly proposed system, his poorly delineated interpersonal boundaries and low, or at least conflicted, self-directedness noted above in the assessment of levels of functioning suggest an impaired sense of self or identity (criterion A1) and the lack of empathy for and intimacy with others suggest impairment in effective interpersonal functioning (criterion A2). Most striking, however, is his lifelong inability to cooperate with others (A2iii). He exhibits extreme levels of several pathological personality traits (criterion B). He has had this pattern of maladaptive personality functioning stretching back to childhood and it has affected his relationships with peers, teachers,

bosses, friends, and his spouse. So, criterion C is clearly met. There is no evidence in this case of either another mental disorder or a substance or general medical condition that could account for his personality problems. In sum, the general criteria for PD are met.

Summary of Case Vignette #2 Assessment

Levels of personality functioning. 2 (moderate impairment).

Type. Antisocial/psychopathic (3 = moderate match); Obsessive–compulsive (2 = slight match).

Clinically significant traits. Trait domain: antagonism. Trait facets: oppositionality, narcissism, irresponsibility, manipulativeness, hostility.

PD general criteria met? Yes.

Case Vignette # 3

A 28-year-old junior executive was referred by a senior psychoanalyst for “supportive” treatment. She had obtained a master’s degree in business administration and moved to California 1½ years earlier to begin work in a large firm. She complained of being “depressed” about everything: her job, her husband, and her prospects for the future.

She had extensive psychotherapy previously. She had seen an “analyst” twice a week for 3 years while in college, and a “behaviorist” for 1½ years while in graduate school. Her complaints were of persistent feelings of depressed mood, inferiority, and pessimism, which she claims to have had since she was 16 or 17. Although she did reasonably well in college, she consistently ruminated about those students who were “genuinely intelligent.” She dated during college and graduate school, but claimed that she would never go after a guy she thought was “special,” always feeling inferior and intimidated. Whenever she saw or met such a man, she acted stiff and aloof, or actually walked away as quickly as possible, only to berate herself afterward and then fantasize about him for many months. She claimed that her therapy had helped, although she still could not remember a time when she didn’t feel somewhat depressed.

Just after graduation, she married the man she was going out with at the time. She thought of him as reasonably desirable, though not “special,” and married him primarily because she felt she

“needed a husband” for companionship. Shortly after their marriage, the couple started to bicker. She was very critical of his clothes, his job, and his parents; he, in turn, found her rejecting, controlling, and moody. She began to feel that she had made a mistake in marrying him.

Recently she has also been having difficulties at work. She is assigned the most menial tasks at the firm and is never given an assignment of importance or responsibility. She admits that she frequently does a “slipshod” job of what is given her, never does more than is required, and never demonstrates any assertiveness or initiative to her supervisors. She views her boss as self-centered, unconcerned, and unfair, but nevertheless admires his success. She feels that she will never go very far in her profession because she does not have the right “connections,” and neither does her husband; yet she dreams of money, status, and power.

Her social life with her husband involves several other couples. The man in these couples is usually a friend of her husband’s. She is sure that the women find her uninteresting and unimpressive and that the people who seem to like her are probably no better off than she.

Under the burden of her dissatisfaction with her marriage, her job, and her social life, feeling tired and uninterested in “life,” she now enters treatment for the third time.³

Discussion. This young executive complains of pervasive depression in all aspects of her life, dating back to adolescence. In *DSM-IV-TR*, her problems would have most likely been characterized as dysthymic disorder, although criteria for depressive PD were included in the appendix for criteria sets and axes provided for further study. It is controversial whether a depressive PD can be distinguished from dysthymic disorder and whether it would make a difference to either the clinician or the patient, but the criteria for depressive PD emphasized cognitive, interpersonal, and intrapsychic personality traits, as opposed to physical symptoms of depression, which were more prominent in the criteria for dysthymic disorder. Other clinicians might conceptualize her problems as a self-defeating PD (an appendix diagnosis in *DSM-III-R*).

³ “Junior Executive.” Reprinted with permission from the *DSM-IV-TR Casebook*, (Copyright, 2002). American Psychiatric Association.

The patient's pervasive feelings of inferiority and low self-esteem are indicators of problems with the regulation of self-states consistent with a problem in personality functioning. Although she dreams of "money, status, and power," she does the minimum required of her at work, and a poor job of it at that, and lacks assertiveness and initiative, preferring to blame others for her lack of success. This suggests significant problems in self-direction, as well. Her simultaneous self-defeating patterns of behavior and attempts to diminish others, while also envying them and dreaming of their success, suggests the construct of covert narcissism, an important variant of narcissism that is not well represented in *DSM-IV-TR*. She has little capacity for appreciating others experiences, little understanding of processes of social causality, and little regard even for her husband. The combination of these problems in self and interpersonal functioning warrant a rating of **2 = moderate impairment** on the Levels of Personality Functioning Scale.

This patient also does not appear to bear a close resemblance to any of the five proposed PD types for *DSM-5*. The "flavor" of her personality pathology, therefore, needs to be described in terms of her trait profile. The predominant trait domain in her case is negative emotionality. An appropriate rating might be a **2 = moderately descriptive**, primarily because the traits she exhibits in this domain are mostly limited to traits that describe her depressive personality style. She would receive ratings of **3 = extremely descriptive** on the trait facets of depressivity, pessimism, and low self-esteem. Other traits of the NE domain (e.g., anxiousness) are not notable. She also exhibits some less characteristic traits from the detachment (e.g., anhedonia, restricted affectivity) and antagonism (e.g., hostility) domains.

In applying the general criteria for PD, an impaired sense of self or identity is manifested almost exclusively by problems in self-directedness, that is, her difficulty in setting and achieving (and the disconnect between these) satisfying and rewarding personal goals. The degree of identity disintegration and deficient integrity of self-concept described in the currently proposed general criteria for PD are at a level of dysfunction that does not fit this case. Impaired empathic capacity and capacity for intimate interpersonal relationships also suggest a PD. Depressive traits are clearly extreme, longstanding, and exhibited

across interpersonal contexts. As stated at the outset of this case discussion, whether and why a PD diagnosis should be made in a patient who meets criteria for dysthymic disorder is controversial. It would be hard to argue that this woman's personality trait characteristics are independent of her dysthymic disorder (the criteria for which include depressed mood, low self-esteem, and feelings of hopelessness), so a PD diagnosis would not be made. The information about her impairments in personality functioning, however, would nonetheless be useful to the clinician in formulating a treatment plan that should include psychotherapy, in forming an alliance in that treatment, and in considering likely treatment outcomes.

Summary of Case Vignette #3 Assessment

Levels of personality functioning. 2 (moderate impairment).

Type. None.

Clinically significant traits. Trait domain: negative emotionality. Trait facets: depressivity, pessimism, low self-esteem.

PD general criteria met? No.

Conclusions

The four-part assessment of personality psychopathology proposed for *DSM-5* focuses attention on identifying personality psychopathology with increasing degrees of specificity, based on a clinician's available time, information, and expertise. In Part II, of this two-part article, we have illustrated the clinical application of the model with vignettes of patients with varying degrees of personality psychopathology, selected from the *DSM-IV Casebook*, to show how assessments might be conducted and diagnoses reached.

Impairments in personality functioning are often evident in a patient's clinical presentation. A global rating of the level of personality functioning can be elicited by a few basic, and presumably routine, questions that all mental health providers can ask and understand. If this is as far as an assessment can go, it will nevertheless provide information that is predictive of more formal diagnoses of PDs and give guidance to treatment planning and outcome. In some instances, a referral will need to be made for a more thorough evaluation by a clinician experienced in personality

and PD assessment, or conversely, a more thorough exam can be conducted as treatment or follow-up proceeds with the initially evaluating clinician.

Further characterization of personality types and traits are the next steps. Certain PD types (e.g., borderline, antisocial) have implications for treatment approaches with the greatest likelihoods of success, as well as highlight the specific therapeutic challenges associated with alliance building (Bender, 2009). Personality traits, at least at the domain level, have been shown to predict physical health and psychosocial outcomes, overall mental health treatment effectiveness, as well as components of effectiveness, such as treatment compliance (Krueger & Eaton, in press). Thus, each step in the evaluation of personality and personality disorders according to *DSM-5* is expected to add clinically relevant information, to be pursued as much as time, information, and expertise will allow.

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(Appendices follow)

Appendix A

Levels of Personality Functioning

Personality psychopathology fundamentally emanates from disturbances in thinking about self and others. Because there are greater and lesser degrees of disturbance of the self and interpersonal domains, individual patients should be assessed using the following continuum comprised of *levels of self and interpersonal functioning*.

Each level is characterized by typical functioning in the following areas:

Self

1. Identity integration. Regulation of self-states; coherence of sense of time and personal history; ability to experience a unique self and to identify clear boundaries between self and others; capacity for self-reflection.

2. Integrity of self-concept. Regulation of self-esteem and self-respect; sense of autonomous agency; accuracy of self-appraisal; quality of self-representation (e.g., degrees of complexity, differentiation, and integration).

3. Self-directedness. Establishment of internal standards for one's behavior; coherence and meaningfulness of both short-term and life goals.

Interpersonal

1. Empathy. Ability to mentalize (create an accurate model of another's thoughts and emotions); capacity for appreciating others' experiences; attention to range of others' perspectives; understanding of social causality.

2. Intimacy and cooperativeness. Depth and duration of connection with others; tolerance and desire for closeness; reciprocity of regard and support and its reflection in interpersonal/social behavior.

3. Complexity and integration of representations of others. Cohesiveness, complexity and integration of mental representations of others; use of other-representations to regulate self.

As with the General Diagnostic Criteria for Personality Disorder, in applying these dimensions diagnostically, self and interpersonal difficulties must:

A. Be multiple years in duration.

B. Not be solely a manifestation or consequence of another mental disorder.

C. Not be due solely to the direct physiological effects of a substance or general medical condition.

D. Not be better understood as a norm within an individual's cultural background.

Self and Interpersonal Functioning Continuum

Please indicate the level of personality functioning that most closely characterizes the patient:

_____ 0 = No impairment.

_____ 1 = Mild impairment.

_____ 2 = Moderate impairment.

_____ 3 = Serious impairment.

_____ 4 = Extreme Impairment.

Definitions of Levels

0 = No Impairment

Self. There is awareness of having a unique identity, grounded in personal history, along with continuity in self states and the ability to think about and make sense of internal experience. Identity remains intact and alive in the context of relationships. The self-concept is associated with a relatively consistent and self-regulated level of positive self-esteem and self-respect, and self-appraisal is accurate. The self representation is complex and multifaceted, with a sense of appropriate autonomy and agency, and the ability to set and aspire to reasonable personal goals and behavior standards, and to attain a sense of fulfillment in life.

(Appendices continue)

Interpersonal. The capability to understand and appreciate the full range of others' experiences is intact and there is ongoing awareness of others' perspectives. The effect of personal actions on others is readily comprehended, and the response to a range of others' ideas, emotions and behaviors is flexible. There is desire for and engagement in multiple affiliative and reciprocal relationships. Others are viewed as complex, multifaceted, autonomous individuals, and contradictions and shortcomings are adequately reconciled. Representations of others are used for constructive self-regulation.

1 = Mild Impairment

Self. A sense of a unique, historical identity is relatively intact, but there may be some variation in self states and interpersonal boundaries due to strong emotions. There is the ability to reflect upon internal experiences, but possible overemphasis on a single (e.g., intellectual, emotional) type of self-knowledge rather than integrating all types. Typical self-representation is multifaceted, and self-esteem is moderately well-regulated, although self-criticism may be too strong or too weak. There is an appropriate sense of autonomy and agency, but goal-directedness may be excessive or somewhat maladaptive. Conversely, there may be conflicts among goals or goal-inhibition related to an unrealistic or socially inappropriate set of personal standards. Satisfaction in some aspects of life is attainable.

Interpersonal. The ability to appreciate and understand others' experiences is somewhat compromised, and others may be seen as having unreasonable expectations or a wish for control. Awareness of the effect of personal behavior on others is inconsistent. There is the capacity and desire to form affiliative relationships, but expression of this may be inhibited or constrained by any intense emotion or conflict. The ability to respond to the full range of others' ideas, emotions and behaviors is somewhat limited, as is the capacity for understanding one's own contributions to ongoing relationships. Others are viewed as multifaceted, autonomous individuals, with some ability to reconcile contra-

dictions and shortcomings. Representations of others can be used for self-regulation if not under internal or perceived external pressure.

2 = Moderate Impairment

Self. The regulation of self-states often depends on context, and there is impaired capacity to think about internal experience. A tendency toward strong identifications with others may be manifested in a somewhat less differentiated sense of uniqueness, and an inconsistent personal history. Self-esteem is controlled by exaggerated attention to external evaluation, with a wish for approval and admiration from other people. A sense of incompleteness or inferiority may be present, and self-appraisal is based on perceptions of external appraisals rather than on internal assessment. Reactions may take the form of overidentification with negative appraisals—deflation of self-esteem—or compensation via an overt sense of self-importance or entitlement. Goals are often context-dependent, pursued to gain approval. Personal standards may be unreasonably high (e.g., with a constructed self-view as “special” or in response to internal or perceived external expectations), or low (i.e., not consonant with prevailing social values). Personal fulfillment is compromised by a sense of lack of authenticity.

Interpersonal. There is a considerable inability to consider multiple points of view, and extreme attention to the views of others, but only with respect to perceived self-relevance. A capacity and desire to form relationships is present, but connections may be superficial and limited to meeting self-regulatory and self-esteem needs, and there is a general unawareness of the effect of personal behavior on others. The ability to respond appropriately to others is compromised and reciprocity is lacking; conversely there is an unrealistic expectation of being magically and perfectly understood by others. Views of others are limited and relatively simple, based primarily on need-fulfillment. Representations of others are necessary, but sometimes insufficient, means of self-regulation.

(Appendices continue)

3 = Serious Impairment

Self. Self-states are poorly regulated and unstable, accompanied by confusion or lack of continuity in personal history. Boundary definition is poor or rigid, there may be overidentification with others, overemphasis on independence from others, or vacillation between these. The ability to think about one's mental processes is significantly compromised. Self-concept is very fragile, easily influenced by events and circumstances, and lacking coherence. The sense of agency is weak and the experience of lack of identity or emptiness is common. Self-appraisal is characterized by self-loathing, self-aggrandizing, or an illogical, unrealistic combination of these. Self-representations are simplistic and concrete, focused primarily on negative or positive attributes, or shifting between extremes. There is difficulty establishing and/or achieving personal goals. Internal standards for behavior are unclear, contradictory, and/or circumstantial. Life is often felt to be meaningless or dangerous.

Interpersonal. The ability to understand the thoughts, feelings, and behavior of other people is significantly limited, and there is confusion or unawareness of social causality, including the impact of one's actions on others. However, very specific aspects of others' experience may be focused upon, particularly vulnerabilities and shortcomings. The ability to consider multiple points of view is greatly impaired. Relationships are based on a strong belief in the absolute need for intimate other(s), and/or expectations of abandonment and/or abuse. Feelings about intimate involvement with others alternate between fear or rejection and desperate desire for connection. Relationships are minimally reciprocal; others are conceptualized primarily in terms of how they affect the self (negatively or positively). Ideas about others are focused on others' capacity for need fulfillment or abuse, and thus may vacillate between idealization and denigration. Extreme and unstable representations of others undermine self-regulation.

4 = Extreme Impairment

Self. There is a profound inability to think about one's experience. Self-states are virtually unregulated and may go unnoticed and/or be experienced as external to self. Experience of a unique identity is virtually absent, as is any sense of continuity of personal history. Boundaries with others are confused or lacking. Self-concept is diffuse, and prone to significant distortions in self-appraisal. Self-representation is impoverished and concrete, and a sense of agency/autonomy is virtually absent, or is organized around perceived external persecution. Thoughts and actions are poorly differentiated, so goal-setting ability is severely compromised. Goals often are unrealistic, and goal-setting is incoherent. Internal standards for behavior are virtually lacking. Genuine fulfillment is elusive and virtually inconceivable, and extensive engagement in fantasy may be used to compensate.

Interpersonal. The ability to consider and understand others' experience and motivation is significantly impaired, and attention to others' perspectives is virtually absent (attention is hypervigilant, focused on need-fulfillment and harm avoidance). Social interactions can be confusing and disorienting. Desire for affiliation is limited because of expectation of harm. Engagement with others is detached, disorganized or consistently negative. Relationships are conceptualized primarily as power based, and considered in terms of their ability to provide comfort or inflict pain and suffering. Social/interpersonal behavior is not reciprocal; rather, it represents basic approach (e.g., need fulfillment) and avoidance (e.g., escape from pain) tendencies. Representations of others are vague, global, and typically dominated by negative and persecutory images. Preoccupation with painful ideas about others is destructive to self-regulation.

(Appendices continue)

Appendix B

DSM-5 Clinicians' Personality Trait Rating Form

On the following pages are descriptive definitions of six broad personality *trait domains*, followed by definitions of specific *trait facets* that comprise each domain.⁴ All individuals' trait levels fall somewhere on these dimensions, ranging from "not at all descriptive" to "extremely descriptive."

Some personality traits are easily summarized by a single label, whereas others are more complex. Therefore, we have defined each trait dimension, rather than simply providing labels. The extent to which a patient has each defined trait is rated using the scale shown below. The example shown is the second broad trait domain, *Introversión*. Please read the domain definition, think about the patient you are rating, and decide the extent to which the defining characteristics describe the patient.

Depending on the role of personality in patients' clinical pictures, you may rate their traits in one of three ways:

(1) just the six broad trait domains for a *personality overview*,

(2) all trait facets for a *comprehensive personality profile*, or

(3) the six trait domains, followed by the component trait facets comprising each of those domains for which the characteristics describe the patient "2 – Moderately" or "3 – Extremely" well.

Please rate patients' *usual* personality, what they are like *most of the time*.

Example: Detachment⁵ Domain

Withdrawal from other people, ranging from intimate relationships to the world at large; restricted affective experience and expression; limited hedonic capacity.

_____ 0 = Very little or not at all descriptive.

_____ 1 = Mildly descriptive.

_____ 2 = Moderately descriptive.

_____ 3 = Extremely descriptive.

For this trait, rate the extent to which the patient shows (1) detachment from other people across the range of relationships from intimate to the world at large, (2) restricted affective experience and expression, and (3) limited hedonic capacity. If the definition describes the patient very little or not at all, or is just mildly descriptive, rate a 0 or a 1, respectively, whereas if the definition describes the patient moderately or extremely well, rate a 2 or 3, respectively.

The six trait domains and the specific trait facets comprising the domains follow:

_____ **Negative emotionality.** Experiences a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, etc.), and the behavioral and interpersonal manifestations of those experiences.

Trait facets. Emotional lability, anxiousness, submissiveness, separation insecurity, pessimism, low self-esteem, guilt/shame, self-harm, depressivity, suspiciousness.

_____ **Detachment.** Withdrawal from other people, ranging from intimate relationships to the world at large; restricted affective experience and expression; limited hedonic capacity.

Trait facets. Social withdrawal, social detachment, restricted affectivity, anhedonia, intimacy avoidance.

_____ **Antagonism.** Exhibits diverse manifestations of antipathy toward others, and a correspondingly exaggerated sense of self-importance.

⁴ The proposed set of trait domains and facets is being tested for structural validity and is subject to change depending on the analytic results.

⁵ In the Work Group's original proposal, this domain was named *introversión*, but in response to comments posted on the DSM-5 website, we are proposing changing it to *detachment*. This increases the consistency of labeling, because all of the other domain names reflect the high, typically maladaptive, end of the dimension, and the new label does so as well.

(Appendices continue)

Trait facets. Callousness, manipulativeness, narcissism, histrionic style, hostility, aggression, oppositionality, deceitfulness.

_____ **Disinhibition.** Diverse manifestations of being present- (vs. future- or past-) oriented, so that behavior is driven by current internal and external stimuli, rather than by past learning and consideration of future consequences.

Trait facets. Impulsivity, distractibility, recklessness, irresponsibility.

_____ **Compulsivity.** The tendency to think and act according to a narrowly defined and unchanging ideal, and the expectation that this ideal should be adhered to by everyone.

Trait facets. Perfectionism, perseveration, rigidity, orderliness, risk aversion.

_____ **Schizotypy.** Exhibits a range of odd or unusual behaviors and cognitions, including both process (e.g., perception) and content (e.g., beliefs).

Trait facets. Unusual perceptions, unusual beliefs, eccentricity, cognitive dysregulation, dissociation proneness.

Full Rating Scale

Negative emotionality. Experiences a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, etc.), and the behavioral and interpersonal manifestations of those experiences.

_____ **Emotional liability.** Having unstable emotional experiences and frequent, large mood changes; having emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.

_____ **Anxiousness.** Having frequent, persistent, and intense feelings of nervousness/tenseness/being on edge; worry and nervousness about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and threatened by uncertainty.

_____ **Submissiveness.** Subservience and unassertiveness; advice and reassurance

seeking; lack of confidence in decision-making; subordination of one's needs to those of others; adaptation of one's behavior to the interests and desires of others.

_____ **Separation insecurity.** Having fears of rejection by, and/or separation from, significant others; feeling distress when significant others are not present or readily available; active avoidance of separation from significant others, even at a cost to other areas of life.

_____ **Pessimism.** Having a negative outlook on life; focusing on and accentuating the worst aspects of current and past experiences or circumstances; expecting the worst outcome.

_____ **Low self-esteem.** Having a poor opinion of one's self and abilities; believing that one is worthless or useless; disliking or being dissatisfied with one's self; believing that one cannot do things or do them well.

_____ **Guilt/shame.** Having frequent and persistent feelings of guilt/shame/blame-worthiness, even over minor matters; believing one deserves punishment for wrongdoing.

_____ **Self-harm.** Engaging in thoughts and behaviors related to self-harm (e.g., intentional cutting or burning) and suicide, including suicidal ideation, threats, gestures, and attempts.

_____ **Depressivity.** Having frequent feelings of being down/miserable/depressed/hopeless; difficulty "bounding back" from such moods; belief that one is simply a sad/depressed person.

_____ **Suspiciousness.** Mistrust of others; expectations of and hyperalertness to signs of interpersonal ill-intent or harm; having doubts about others' loyalty and fidelity; feelings of persecution.

_____ **Detachment.** Withdrawal from other people, ranging from intimate relationships to the world at large; restricted affective experience and expression; limited hedonic capacity.

_____ **Social withdrawal.** Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.

(Appendices continue)

_____ **Social detachment.** Indifference to or disinterest in local and worldly affairs; disinterest in social contacts and activity; interpersonal distance; having only impersonal relations and being taciturn with others (e.g., solely goal- or task-oriented interactions).

_____ **Intimacy avoidance.** Disinterest in and avoidance of close relationships, interpersonal attachments, and intimate sexual relationships.

_____ **Restricted affectivity.** Lack of emotional experience and display; emotional reactions, when evident, are shallow and transitory; unemotional, even in normally emotionally arousing situations.

_____ **Anhedonia.** Lack of enjoyment from, engagement in, or energy for life's experiences; deficit in the capacity to feel pleasure or take interest in things.

_____ **Antagonism.** Exhibits diverse manifestations of antipathy toward others, and a correspondingly exaggerated sense of self-importance.

_____ **Callousness.** Lack of empathy or concern for others' feelings or problems; lack of guilt or remorse about the negative or harmful effects of one's actions on others; exploitativeness.

_____ **Manipulativeness.** Use of cunning, craft, or subterfuge to influence or control others; casual use of others to one's own advantage; use of seduction/charm/glibness/ingratiation to achieve one's own ends.

_____ **Narcissism.** Vanity/boastfulness/exaggeration of one's achievements and abilities; self-centeredness; feeling and acting entitled, firmly holding the belief that one is better than others and deserves only the best of everything in life.

_____ **Histrionism.** Behaving so as to attract and be the focus of others' attention; admiration seeking; flamboyance; audacity; inappropriate sexualization of interpersonal relationships.

_____ **Hostility.** Irritability, hot temperedness; being unfriendly/rude/surlly/nasty; responding angrily to minor slights and insults.

_____ **Aggression.** Being mean/cruel/cold-hearted; verbally/relationally/physically abusive; engaging willingly and willfully in behaviors that humiliate and demean others, and in acts of violence against persons and objects; active and open belligerence/vengefulness; use of dominance/intimidation to control others.

_____ **Oppositionality.** Displaying defiance by refusing to cooperate with requests, meet obligations, and complete tasks; resentment of and behavioral resistance to reasonable performance expectations; acting to undermine authority figures.

_____ **Deceitfulness.** Dishonesty, untruthfulness; embellishment or fabrication when relating events; misrepresentation of self; fraudulence.

_____ **Disinhibition.** Diverse manifestations of being present- (vs. future- or past) oriented, so that behavior is driven by current internal and external stimuli, rather than by past learning and consideration of future consequences.

_____ **Impulsivity.** 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 and following plans; failure to learn from experience.

_____ **Distractibility.** Difficulty concentrating and focusing on tasks (e.g., attention easily diverted by extraneous stimuli); difficulty maintaining goal-focused behavior, including a focus on conversations.

_____ **Recklessness.** Engaging in dangerous, risky activities/behaviors unnecessarily and without regard for consequences; boredom proneness and unplanned initiation of activities to counter boredom; lack of concern for one's limitations; denial of the reality of personal danger; high tolerance for uncertainty and unfamiliarity.

_____ **Irresponsibility.** Disregard for, or failure to honor, financial and other obligations or commitments; lack of respect and follow through on agreements and promises;

(Appendices continue)

unreliability; failure to keep appointments or to complete tasks or assignments; carelessness with own and/or others' possessions.

Compulsivity. The tendency to think and act according to a narrowly defined and unchanging ideal, and the expectation that this ideal should be adhered to by everyone.

Perfectionism. Insistence on everything being flawless, without errors or faults, including one's own and others' performance; conviction that reality should conform to one's own ideal vision; holding oneself and others to unrealistically high standards; sacrificing of timeliness to ensure correctness in every detail.

Perseveration. Persistence at tasks long after behavior has ceased to be functional or effective; belief that lack of success is due solely to lack of effort or skill; continuance of the same behavior despite repeated failures.

Rigidity. Being rule- and habit-governed; belief that there is only one right way to do things; insistence on an unchanging routine; difficulty adapting behaviors to changing circumstances; processing of information on the basis of fixed ideas and expectations; difficulty changing ideas and/or viewpoint, even with overwhelming contrary evidence.

Orderliness. Need for order and structure; insistence on everything having a correct place or order; intolerance of things being "out of place"; concern with details, lists, arrangements, schedules.

Risk aversion. Complete lack of risk-taking; unwillingness even to consider taking even minimal risks; avoidance of activities that have even a small potential to cause injury

or harm to oneself; strict adherence to behaviors to minimize health and other risks.

Schizotypy. Exhibits a range of odd or unusual behaviors and cognitions, including both process (e.g., perception) and content (e.g., beliefs).

Unusual perceptions. Having odd experiences in various sensory modalities; experiencing synesthesia (cross-modal perception); perceiving events and things in odd ways that others do not.

Unusual beliefs. Content of thoughts that is viewed by others of the same culture and society as bizarre; idiosyncratic but deeply held convictions that are not well justified by objective evidence; interest in the occult and in unusual views of reality.

Eccentricity. Unusual behavior (e.g., unusual mannerisms; wearing clothes obviously inappropriate to the occasion or season); saying unusual or inappropriate things; frequent use of neologisms; concrete and impoverished speech; seen by others of the same culture and society as bizarre, odd, and strange.

Cognitive dysregulation. Unusual thought processes; having thoughts and ideas that do not follow logically from each other; derailment of one's train of thought; making loose associations or nonsequiturs; disorganized and/or confused thought, especially when stressed.

Dissociation proneness. Tendency to experience disruptions in the flow of conscious experience; "losing time," (e.g., being unaware of how one got to one's location); experiencing one's surroundings as strange or unreal.