Dimensional Assessment of Personality Disorders:

Diagnosing Tony Soprano, Norman Bates, Hercule Poirot, and Carol Beer through the DSM-5 AMPD

Tim Bastiaens[1], Laurence Claes[2,3] and Samuel Greiff[4]

[1] UPC KU Leuven Campus Kortenberg, Leuvensesteenweg 517, 3070 Kortenberg, Belgium

[2] KU Leuven, Faculty of Psychology and Educational Sciences, Leuven, Belgium

[3] University of Antwerp, Faculty of Medicine & Health Sciences (CAPRI), Antwerp, Belgium

[4] Institute of Cognitive Science and Assessment (COSA), University of Luxembourg, Luxembourg

[1] **Corresponding author**

Tim Bastiaens, Phd

Clinical Psychologist

UPC KU Leuven Campus Kortenberg, Leuvensesteenweg 517, 3070 Kortenberg, Belgium

(+32) (0)2758 0669, tim.bastiaens@upckuleuven.be

EJPA publishes assessment-related manuscripts from all areas of psychology and occasionally uses editorials to take up important questions from one of these fields. Along this line of thinking, the current editorial discusses contemporary approaches towards assessing personality disorders, both categorical and dimensional with a specific focus on the recent developments in the 5th version of the Diagnostic and Statistical Manual (DSM-5). The aim of this editorial is to shape awareness of how even within the DSM, different approaches are combined in a more or less ideal way and to encourage further (assessment-related) research on this scientifically and clinically highly relevant topic.

Dimensional assessment of personality disorders: Yes But No But…

The traditional take on personality in psychiatry has been the DSM, which has historically entailed a categorical approach towards personality disorders. However, this categorical approach suffers from several problems. It has shown (a) considerable within-disorder heterogeneity (or important personality differences between people who are all put in the same category), (b) between disorder overlap (or multiple personality disorder categories being applicable to one person), (c) lack of relation to impairment (or important differences in severity of dysfunction that remain unaccounted for), and (d) a failure to exhaustively capture the phenomenology of personality pathology (or the existence of many personality problems that remain unaccounted for by the existing categories).

Contrasting with this categorical approach, various dimensional conceptualizations have been developed in clinical psychology over time, that are psychometrically superior and better able to capture personality pathology (see e.g., Trull & Durrett, 2005, for an overview). So in the run-up to the fifth edition of the DSM (DSM-5; American Psychiatric Association [APA], 2013), the Personality and Personality Disorders Work Group envisioned a dimensional model that would meet the criticisms formulated above and replace the somewhat outdated categorical model. However, at the end of the day, the APA Board of Trustees chose to preserve the current categorical model – despite its above mentioned shortcomings – as the standard clinical practice located in Section II of DSM-5, placing the proposed new model, since then known as the Alternative Model on Personality Disorders (AMPD; APA, 2013) in the new DSM-5 Section III (models suited for further research) (see Zachar, Krueger, & Kendler, 2016, for an overview of events leading to this decision), thus opting for a much smaller change than

originally anticipated by many researchers in the field. As a result, for the first time in history, the DSM now contains two conceptualizations of personality disorders. This forms a potential source of confusion, but also provides a welcome window for further study and necessary refinement of the AMPD.

The merits of the AMPD: Two interesting novelties

Criterion A (level of self and interpersonal functioning) or Tony versus Norman

Identical to its categorical predecessor, the AMPD defines a personality disorder as an enduring maladaptive pattern of behaviors, cognitions, and inner experiences, manifested in different contexts, differing from what is accepted by one's culture, and not better explained by other mental disorders or substance use. However, as a first interesting novelty, the AMPD contains a separate appreciation of the differing degrees of severity that can exist in personality dysfunction. This is defined in the AMPD criterion A, the level of self and interpersonal functioning, in which four components (identity, self-direction, empathy, and intimacy) are rated on five levels of impairment. The AMPD Criterion A provides an adequate answer to the lack of relation to impairment of the current DSM-5 Section II model [see critique (c) above], and allows researchers and clinicians alike to meaningfully differentiate individuals who share the same descriptive features by way of a continuum ranging from normality to abnormality.

Consider as a playful example the fictional characters *Tony Soprano* (from the HBO-series by David Chase in 1997) and *Norman Bates* (from the classic movie *Psycho* by Alfred Hitchcock in 1960). While (regardless of arguable co-morbid afflictions) both *Tony* and *Norman* could conceivably be diagnosed with the same antisocial personality disorder in DSM-5 Section II terms, a DSM-5 AMPD criterion A view would additionally incorporate *Tony's* ability (1) to experience himself as fairly unique person with clear boundaries between himself and others (identity), (2) to pursue personal middle-term goals (however illegal and murderous) with awareness of and adherence to interpersonal (be it mob) rules (self-direction), (3) to self-reflect (be it not without outbursts of antagonism towards his psychotherapist) (empathy) and (4) to at least on some level meaningfully relate to his children and his wife Carmela (notwithstanding his serial adultery) (intimacy). This would meaningfully contrast with

(1) *Norman's* dead mother invading his sense of self to a psychotic level, (2) his erratic behavior rather than ability to create and pursue personal middle-term goals, and his inability (3) to reflect upon his own feelings and cognitions, or (4) socially relate to others[1].

Criterion B (pathological personality dimensions) or Hercule versus Carol

A second interesting novelty of the AMPD is that it incorporates, in addition to criterion A, a criterion B that positions every individual on 25 lower-order maladaptive personality traits, grouped into five higher-order domains. These five higher-order domains are: Negative Affectivity, Detachment, Antagonism, Disinhibition and Psychoticism; they parallel the well-known non-clinical Five Factor Model components (Costa & McCrae, 1992), creating the opportunity to directly compare normal and abnormal personality data (Krueger & Markon, 2014). The name of the model and its eponymous operationalization is the Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012). The addition of criterion B in the AMPD provides an adequate answer to the considerable within-categorical-disorder heterogeneity as well as the substantial between-disorder-overlap of the current DSM-5 Section II model [see critiques (a) and (b) above]. Indeed, in contrast to a mere categorical diagnosis, it allows for a person-tailored trait constellation mapping shared as well as differing traits between individuals.

Consider as a playful example Agatha Christie's fictional character *Hercule Poirot* and Little Britain's parodic *Carol – "Computer Says No" - Beer* figure. Restricted to the DSM-5 Section II model, both could be diagnosed with the same obsessive-compulsive personality disorder. A DSM-5 AMPD criterion B view on the contrary, would be able to describe *Hercule's* and *Carol's* shared high levels of PID-5 Rigid Perfectionism and Perseveration traits, while simultaneously contrast *Hercule's* fair amount of Grandiosity (be it a rather benign one according to the fans) with *Carol's* additional hilarious/distasteful (take your pick) Hostility and Callousness towards other people in the series[1].

The pitfalls of the AMPD

The confusing remainder of six categorical personality disorders

[1] If you want to get a real hear and taste of these characters, we recommend watching the movie/series!

Notwithstanding the merits of the two new criteria A and B described above, diagnosing an AMPD personality disorder is quite complicated. Diagnosis first requires a level of at least moderate impairment regarding criterion A. Secondly, this impairment has to be combined with the presence of at least one criterion B elevated domain or facet. In an obfuscating final step, this combination still results in a categorical personality disorder, namely by mapping onto one of the six categorical entities retained from the previous model. In case the combination does not fit one of the six remaining categories, it gets named as a trait-specific personality disorder. Not only is this return to personality disorder *categories* after the dimensional move away from them confusing and user-unfriendly; a heated discussion on the selection of the six presently remaining categories retained from the old model (the antisocial, borderline, narcissistic, schizotypal, avoidant, and obsessive-compulsive personality disorder were retained as categories) versus the omission of the other four (the paranoid, schizoid, histrionic, and dependent personality disorder were removed as categories) continues to-date (Lilienfeld, Watts, & Smith, 2012).

Incomplete coverage not covered

A second problem of the AMPD is that it does not account for many of the existing personality problems just as its predecessor [see critique (d) above]. Particularly problematic on the operational level is the complete absence of a Compulsivity domain in the PID-5, as research indeed shows that PID-5 Disinhibition is not a negatively keyed Conscientiousness/Compulsivity factor, but much more related to (Dis)agreeableness/Antagonism (Bastiaens et al., 2016). In fact, even in the original DSM-5 proposal Disinhibition and Compulsivity were already considered separate components (Krueger et al., 2011).

High correlation between criterion A and criterion B

As a third problem, separating severity (criterion A) and descriptive constellation (criterion B) on an operational level continues to challenge researchers (Bastiaansen et al., 2013). This leads some authors to contemplate the removal of criterion A (or B, arguably), as it, at least through measures used, cannot substantially add to the variance already explained by the criterion B (or A) (Widiger, 2015).

Conclusion

We as researchers involved in (clinical) assessment welcome the DSM movement towards dimensional personality models long since known in clinical psychology, with the DSM-5 AMPD as an important first step in the right direction. The fate the AMPD has befallen is perhaps confusing, but also creates a momentum for further study as a work-in-progress. A future version of the AMPD might leave the widely contested remnants of the categorical perspective behind, include a Compulsivity domain, and somehow account for the measurement overlap between criterion A and criterion B. Indeed, if it makes sense to discriminate between severity (criterion A) and coloration (criterion B) on conceptual grounds, science should move beyond the current predicament on the measurement level. Verheul et al. (2013) astutely advocated the creation of truly bipolar criterion B measurements (i.e., with maladaptive variants at the low as well as at the high end) instead of the current unipolar ones. This would create U-shaped curves and conceivably strongly decrease the current correlation between criterion A and criterion B measures, as we would expect high as well as low criterion B trait scores to associate with more severe criterion A impairments. As the creation of bipolar scales is psychometrically challenging, perhaps real progress in the field might also come from further studying the dynamic interaction between personality traits and triggering context factors (e.g., Fleeson, 2001). Indeed, using event-sampling methodology additional to nomothetic trait measurement would enable us to learn how specific situational elements (for example, a hospital patient asking *Carol Beer* to see a doctor) interact with otherwise dormant feelings of disillusion in *Carol*, causing her to lash out her aggression while at the same time guarding herself from any possible reproach by means of her passive-aggressive catchphrase: *'computer says no'*. The frequency of occurrence, the (non-) specificity of the trigger, and the duration of Carols negativistic emotional state simultaneously create the hilarious effect for the fans, as do they represent an ideographic proxy of the AMPD criterion A severity of personality dysfunction.

In conclusion, the APA board of trustees ultimately placed the AMPD in Section III of the DSM-5, preserving the current categorical model and this will not change any time soon. However, if we stay restricted to this paradigm, we might deprive ourselves from future knowledge arising from the use of dimensional models – in this sense the AMPD contains an important addition and was a huge step

forward. We encourage researchers, irrespective of whether they are primarily interested in assessment or in personality and clinical psychology to closely consider the advantages and disadvantages of both the categorical and the dimensional approach and to not ignore one of them in favor of the other. Needless to say, EJPA as a journal prefers papers that combine different approaches over those that are mono-methodological.

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