General Personality Disorder: A study into the core components of personality pathology
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General discussion
Background and aims of this thesis

The main objective of this thesis was to contribute to the understanding of the core features of personality disorders (i.e., General Personality Disorder) and its assessment procedures. The assumed underlying structure of a personality disorder (PD), as a functional or structural impairment, was investigated in part I of this thesis. In addition, the convergent and divergent validity of General PD models versus personality trait models was empirically evaluated in part II of this thesis.

Models of General PD and personality trait models are relevant in the context of an integrative approach to the assessment of personality and PDs (Hopwood et al., 2011; Huprich & Bornstein, 2007; Stepp et al., 2011), and with respect to the recently developed Alternative model for PDs in DSM-5 Section III (APA, 2013).

In order to appraise the findings of this thesis, we first summarize and discuss its main findings, present relevant methodological limitations, and consider its clinical implications. Finally, we suggest directions for further research.

Overview and discussion on the main findings

The structure of General PD

In part I of this thesis we examined the structure of various models of core features and severity levels of PDs. The findings indicated that it is possible to identify a global dimension of personality pathology, which also can serve as a dimension of personality pathology severity. The main components within this dimension consist of impairments related to the self and interpersonal functioning. Both components were an integral part of all models investigated in this thesis (Kernberg & Caligor, 2005; Livesley, 2003; Verheul et al., 2008), and also matched with various other models of General PD (e.g. Bornstein & Huprich, 2011; Cloninger, 2000; Lowyck et al., 2013; Luyten & Blatt, 2011; Parker et al., 2004) and with the Alternative DSM-5 Model for PDs in Section III (APA, 2013). We found that both components were associated with comprehensive models of personality and personality pathology, and were able to differentiate between patients with and without PD, and between patients and the general population. The psychometric properties of the questionnaires we used with respect to General PD (i.e. IPO and GAPD) were in line with findings in other studies (Hentschell & Livesley, 2013a,b; Lenzenweger et al., 2001; Smits, Vermote, Claes, & Vertommen, 2009).

The self-pathology factor emerged as the strongest and most univocal factor in our studies. This factor could be divided in the lower-order factors Identity and Self-direction. Identity is related to the structure of the self (Jørgensen, 2010; Kernberg, 1984; Kohut, 1971; Livesley, 2003; Wilkinson-Ryan & Westen, 2000); i.e., a separate (from others), differentiated and integrated (within oneself) sense of self. Self-direction is related to self-control (cognitive, behavioral, and emotional) and to goal-oriented behavior, to moral values that give meaning to life, and to the concept of primitive defenses (Cloninger, Svrakic, & Przybeck, 1993; Kernberg &
Caligor, 2005; Parker et al., 2004; Verheul et al., 2008). In the present study, Self-direction showed overlap with the factor of Interpersonal functioning, in that Self-control and Moral values also had a direct impact on pro-social behavior and social concordance. In our factor analyses these lower-order factors therefore loaded on both main dimensions, i.e. Self and Interpersonal functioning.

The factor of Interpersonal (dys)functioning refers to the (in-)capacity to form and maintain close, reciprocal, and intimate relationships (e.g., friends, partner, and kinship relationships), and the capacity for cooperative behavior (i.e. working together with others in personal or occupational relationships). Interpersonal (dys)function is recognized as a central domain in personality pathology across distinct theoretical models (Hopwood, Wright, Ansell, & Pincus, 2013).

Given these assumptions and findings, it stands to reason that the therapeutic relationship, and aspects of identity and self-control are primary treatment targets in patients with PDs (e.g. Benjamin, 2005; Clarkin, Yeomans, & Kernberg, 2006; Fonagy & Bateman, 2006; Livesley, 1993; Livesley, 2003, 2012).

A severity dimension of PD

In addition to the support for the underlying structure of General PD models, we also found that the components of these models could be used as an overall dimensional PD severity measure. The main components of General PD were significantly associated with the probability of being assigned to one or more DSM-IV PD diagnosis, and with the total number of criteria or DSM-IV PD diagnosis. As stated, these components also differentiated between patients with and without PD, and between patients and non-patients.

These findings are relevant as they may help to identify and operationalize a clinically useful, meaningful and measurable dimensional severity measure. It is stated that distinguishing PD severity (as quantification of dysfunction) and PD style (as the specific manner in which PD dysfunction is expressed) is important for the understanding of PDs (Hopwood et al., 2011; Livesley, 1998; Widiger & Trull, 2007; Parker & Hadzi-Pavlovic, 2001; Parker, 2002). Several dimensional severity measures have been proposed from different theoretical perspectives (e.g. Karterud et al., 1995; Lowyck et al., 2013; Tyrer & Johnson, 1996; Tyrer et al., 2011), or severity measures are suggested in terms of their relations with social costs (Krueger & Eaton, 2010), or defined in more statistical terms by using empirically based cut points on specific dimensional scorings (Kamphuis & Noordhof, 2009). However, none of these proposals have been extensively used, probably because each has an exclusive focus on just one specific aspect of severity. The lack of a widely accepted, or DSM-adapted, dimensional severity measure is considered a major deficit in the clinical and research literature, as severity of PD has not only appeared to be one of the best predictors of the course of PDs (e.g., Barnicot et al., 2012; Gunderson et al., 2006; Yang, Coid, & Tyrer, 2010; Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012), but is also considered one of the most promising diagnostic features in the context of treatment assignment (van Manen et al., 2011, 2012).
**General PD versus personality traits**

In **Part II** of this thesis we investigated the validity of models of General PD in relation to existing models of personality traits. In general, General PD models were distinguishable from (FFM) personality traits, and General PD showed incremental validity relative to trait models in predicting the severity and presence of PDs.

More specifically, we found that two main components of General PD, i.e. Self-pathology, and Interpersonal functioning, were clearly differentiated from (FFM) personality traits. This finding is in line with the above stated distinction between PD dysfunction and PD style. From this point of view, PD dysfunction refers to a general dimensional severity measure of impairment, and can be used to understand the adaptive or maladaptive expression of personality traits. Personality style, or a personality trait-profile, represents the most likely manifestation form of pathology. This distinction between PD dysfunction and PD style may for instance help to determine to what extent problems of living associated with elevated scores on a specific trait domain reach clinical significance (see: Widiger et al., 2002; Widiger & Mullins-Sweatt, 2009), and to understand how the severity of a specific profile of maladaptive trait expression may lead to specific treatment selection in terms of school of therapy and intensity of treatment (Hopwood et al., 2011; Mullins-Sweatt, & Lengel, 2012).

Furthermore, we found that General PD significantly added to both normal and pathological personality traits in the prediction of the presence and severity of PD. A clear differentiation between models of General PD and trait models was observed. We consider this result as notable with respect to the Alternative model of PDs in DSM-5 Section III (APA, 2013), since both personality dysfunction and personality traits are used independently in this model. We also think that incremental value of personality dysfunction over and beyond personality traits (and vice versa) provides evidence in support of the notion of a hybrid and integrative approach to the assessment of PDs (Hopwood et al., 2011; Huprich & Bornstein, 2007; Stepp et al., 2011).

**The alternative model of PD in DSM-5**

Over the course of this thesis, the DSM-5 was developed, and ultimately published in 2013. Interestingly, but not entirely accidentally, the P&PD workgroup worked on a proposal to identify and measure core components and severity levels of PD (APA, 2010, 2011). The subsequent versions of the proposals received major criticisms from clinical and empirical perspectives (e.g. Clarkin & Huprich, 2011; Livesley, 2010, 2012; Pilkonis, Hallquist, Morse, & Stepp, 2011; Ronningstam, 2011; Shedler et al., 2010; Tyrer, 2012; Verheul, 2012; Widiger, 2011; Zimmerman, 2011) and the field trials showed mixed reliability results in empirical tests of the proposals. Based on these criticisms and results of reliability studies, the DSM-5 task force decided to place the Alternative DSM-5 model for PD in Section III of the DSM-5 (APA, 2013). After many years of widespread criticism on the
categorical DSM-IV model, and the loud call for a dimensional, prototypic or hybrid model of PD diagnosis of many researchers (Clark, 2007; Huprich & Bornstein, 2007; Krueger & Markon, 2006; Krueger & Eaton, 2010; Livesley et al., 1998; Samuel & Widiger, 2004; Trull & Durrett, 2005; Westen, Shedler, & Bradley, 2006; Widiger et al., 2009; Widiger & Samuel, 2005), it is regrettable that the workgroup has not been able to find sufficient clinical consensus and empirical support for a worthy successor for the current model. This is particularly regrettable as the Alternative model consisted of various components that were the result of thorough fundamental and empirical research into personality pathology in the last decades. Nevertheless, the Alternative DSM-5 model for PD has been published in Section III, and we hope that it can serve as a blueprint for research into the final acceptance of an integrative model of personality disorders in future revisions of the DSM system.

In the Alternative DSM-5 model for PD, the diagnosis of PD consists of several parts. First, levels of personality functioning are determined based on the assessment of elements and aspects of Self- and Interpersonal functioning. Impairments in self functioning are reflected in elements of Identity and Self-direction. Interpersonal impairments consist of impairments in the capacities for Empathy and Intimacy. These core components serve both for the new general criteria for the presence of a PD, and a severity dimension of personality dysfunction (the Levels of Personality Functioning Scale; APA, 2013). In addition, pathological personality traits are defined. These traits are mapped according to a model with five trait domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) divided in 25 lower order facets. Finally, specific personality disorders are defined by typical impairments in personality functioning and characteristic pathological personality traits. Six specific personality disorder types are defined: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal PD. The diagnosis of Personality Disorder Trait Specified (PDTS) can be made when a PD is considered present, but the criteria for a specific disorder are not met. PDTS is also defined by significant impairment in personality functioning, and one or more pathological personality trait domains or trait facets.

Our study found a solid foundation for the Self and Interpersonal factors as criteria for the overall functioning of personality. These components can also be used in a dimensional severity scale on personality functioning. In this sense we consider these main factors of personality function in the Alternative DSM-5 model for PD as promising. However, as has already been noted, the combination of General PD with pathological personality traits as a predictor of specific PDs was less clear in our study. This part of the Alternative DSM-5 PD model (i.e. the newly defined specific PDs), was also under strong criticism during the development of the Alternative model (Clarkin, & Huprich, 2011; Gunderson, 2010; Ronningenstam, 2011; Zimmerman, 2011). Therefore, further research should reveal whether this method of defining specific PD by combining personality dysfunction and personality traits is the most optimal.
In our view, the fundamental difference between the present categorical model and the Alternative DSM-5 model for PD emerges most strongly in this part of the proposed personality types. A strict dimensional approach would actually imply the absence of categories. Or, as stated by Hopwood and colleagues: "Given that dimensional models are more likely to stand up to formal tests of psychometric adequacy than categorical, and clinicians may be increasingly comfortable with dimensional models, practically speaking the DSM-5 as proposed would appear to be an intermediary step toward replacing PD constructs with trait dimensions. In other words, from a clinical perspective it might be simplest to diagnose every PD patient PDTS (Personality Disorder Trait Specific), and thus PDs in the DSM-5 appear to function primarily as a means for clinicians to become accustomed to a new and more efficient pathological trait system (Hopwood et al., 2012, p. 429). It should be noticed that the removal of existing specific PDs might lead to a complicated break with the existing scientific knowledge and existing forms of psychotherapy based on specific PD, in particular borderline PD, such as Dialectical Behavior Therapy (DBT), Mentalization Based Therapy (MBT), Schema Focused Therapy (SFT), and Transference Focused Therapy (TFT). However, at the same time there is a movement towards integration of common factors in all specific PD-psychotherapy models (Livesley, 2013a,b; Clarkin, 2013; Bateman & Krawitz, 2013), which can be interpreted as a clear movement away from PD-category forms of treatment and as a movement towards a dimensional conceptualization PD.

Methodological considerations

Overall, this series of investigations have several strengths and limitations. First, our study was conducted with relatively large samples of both general populations in two different countries (Canada and the Netherlands), and PD patients samples relatively representative for standard clinical practice, which should make our findings informative for clinicians working in similar settings. Also our study made use of both well validated and existing measurements (DAPP-BQ, NEO-PI-R, SCID-II) and newly most promising instruments (GAPD, IPO, SIPP-118). We consider the use of semi-structured interview (SCID-II) based ratings of diagnostic criteria of DSM-IV PDs also as a strength, as it bypasses method variance inflated correlations. SCID-II interviewers were unaware of the results of the self-report questionnaires. Finally, a non-methodological strength is the timely character of this investigation with respect to the simultaneous development of the DSM-5 proposals for PD diagnosis, and therefore an important contribution to a relatively new area of research.

Several limitations are worth mentioning as well. First, the current research relied exclusively on self-report measures for the assessment of personality dysfunction and personality traits. The limitations of self-report instruments are extensively discussed (Ganellen, 2007; Huprich et al., 2011; Paulhus & Vazire, 2007),
and it has been suggested that there are limitations in the capacity for psychological insight and awareness in patients with personality pathology (Shedler et al., 1993). Likewise, it is open to question whether self-report is suitable to cover complex concepts like identity and relational functioning, since it is also stated that clinical judgment remains crucial in PD assessment (Westen & Weinberger, 2005). Although we recognize these being important general issues, the use of self-reports made it possible to collect relatively large data samples to increase power, and self-report is a widely used method in both PD research and clinical practice. Moreover, an interview procedure to measure impairments in the level of personality dysfunction with sufficient feasibility, reliability and validity, was not yet available at the time of the present study.

Second, we did not collect data for establishing the interrater reliability of the SCID-II. Resolving concerns about the absence of interrater reliability data, we calculated internal consistencies for the SCID-II dimensional scores, which appeared to be adequate. In addition, other studies (Lobbestael et al., 2010; Maffei et al., 1997) have reported that the SCID-II is a reliable instrument.

Another possible limitation is the use of exploratory factor analytic (EFA) techniques to gain insight in the relation between the models of general personality dysfunction and a model of normal personality traits. In further research we should also make use of Confirmative Factor Analysis (CFA) to further analyze the structure of models of core features of PD, in particular the GAPD model. The CFA procedure is generally more appreciated to test different and competing existing models. In line with this, we regard the use of IRT-analyses in our study described in chapter 3 of interest, since it adds to the EFA techniques and generate differentiating items for a global dimension of personality pathology.

With regard to our analyses of personality trait models in relation to models of general personality dysfunction, we made almost solely use of domain scores. It is stated that facet-scores may be more powerful predictors of personality pathology (Reynolds & Clark, 2001; Samuel & Widiger, 2008). Further research should replicate our findings also at the facet level of measurement of personality traits.

Finally, although we consider the composition of our clinical sub-samples as representative for general mental health care as a strong point, we are aware that some PDs (e.g. antisocial, and histrionic PD) were relatively underrepresented. This means that some of our findings needs to be replicated in other groups of patients.

Clinical implications

Three relevant clinical implications can be distinguished based on our study: this study contributes to a more clinically applicable and a more 'theory-driven' model of General PD, it provides an overall dimensional severity measure of PD suitable for screening of PD, and the model of general personality dysfunction can be used in a two-step assessment or PD.
First, the core features of PD or the model of general personality dysfunction described in the present study, generates a more 'theory-driven' model of General PD. The existing general criteria of the DSM-IV (and DSM-5, Section II) are criticized for their lack of specificity for PDs, and for their lack of clinical relevance. The core features of PD as they emerge in our study are more inspired by theoretically based personality pathology models and therefore related to existing treatment models.

Second, in our view, the main factors and the general severity dimension are best used in clinical practice for the purpose of the diagnosis of personality disorders. Using these main factors of General PD for a severity dimension of personality pathology is, as previously stated, relevant with respect to the prediction of the course of PDs. Patients who are assessed with more severe personality can be assigned to appropriate therapy programs. However, the exact relationship between severity of personality pathology and a specific therapy program needs further investigation (van Manen et al., 2011). The GAPD, as self-report questionnaire, is in this context suitable for screening purpose to investigate whether severe personality pathology is present or absent, and may lead in combination with a clinical interview to a specific diagnosis of PD as defined in the Alternative DSM-5 model for PD.

Finally, Livesley (2003) and Pincus (2005) described a two-step procedure for the assessment of PD. In this two-step diagnostic process, the general definition of PD (step 1) is distinguished from the description of individual differences in PD phenomenology (step 2). Creating a clear context of presence or absence of PD (step 1) is relevant in the practice of personality assessment. The interpretation of (extreme) test results is different in a context of low pathology (e.g. general mental healthcare) than of severe personality pathology (e.g. specialized mental healthcare). Also the differentiation between test results of patients with and without PD is necessary. As demonstrated in our paper on the bi-polarity of normal personality traits, an extreme score on a given trait does not necessarily mean that maladaptive personality traits are present. The models of general personality dysfunction described in our study and the corresponding measurement instruments can be used to define the context of the severity of personality pathology.

Future directions

Because the models of general personality dysfunction or core features of PD described in our study are still relatively new in the field of personality disorder research, further research should involve a further refinement of the operationalization of the concepts used. For example, the dimension Interpersonal (dys)function is, on the conceptual level, a clear concept, but our study showed that at the level of operationalization there was overlap with concepts and scales from trait models (e.g. Extraversion and Agreeableness).
Next, a challenge can be to relate the levels of personality dysfunction, as distinguished in the present study and operationalized in the Levels of Personality Functioning Scale for the DSM-5 (APA, 2013), to existing treatment programs (e.g., DBT, MBT, SFT, TFP) or treatment modules as part of existing programs.

Finally, the objective of our study is related to the Alternative DSM-5 Model for PD. Further research is needed to empirically validate this Alternative model, and to make this model clinically applicable. Since the categorical DSM-IV has been widely and systematically criticized in literature and no update of this model is available, we should support the further development of an alternative (dimensional) model. An important question is whether dimensions of this model can be assessed by clinicians with reasonable interrater reliability (Morey et al., 2011).

Developing an assessment instrument which the clinician can provide a weighted assessment of the level of personality functioning of the patient (Berghuis, Hutsebaut, Kaasenbrood, de Saeger, & Ingenhoven, 2013) is the next research step to be taken.