# A brief screener for impairment in personality functioning: Psychometric validation of the Five-Item Screening Scale for Personality Disorders in a Dutch-speaking clinical sample.

Eggermont, K.; Smits, D.; Bogaerts, A.; Pauwels, E.; Dierckx, E.; Luyckx, K.; Claes, L.

**DOI**
10.1037/per0000666

**Publication date**
2024

**Document Version**
Final published version

**Published in**
Personality Disorders: Theory, Research, and Treatment

Personality Disorders: Theory, Research, and Treatment


ISSN: 1949-2715

2024, Vol. 15, No. 4, 269–274
https://doi.org/10.1037/per0000666

BRIEF REPORT

# A Brief Screener for Impairment in Personality Functioning: Psychometric Validation of the Five-Item Screening Scale for Personality Disorders in a Dutch-Speaking Clinical Sample

Kristina Eggermont[1, 2, 3], Dirk Smits[4], Annabel Bogaerts[5], Els Pauwels[3], Eva Dierckx[6, 7], Koen Luyckx[1, 2, 8], and Laurence Claes[1, 2, 9]

[1] Faculty of Psychology and Educational Sciences, KU Leuven
[2] Child & Youth Institute, KU Leuven
[3] Psychologenpraktijk De Vest, Tienen, Belgium
[4] Research Department, Odisee University of Applied Sciences
[5] Department of Clinical Psychology, University of Amsterdam
[6] Psychiatric Hospital Alexianen Zorggroep Tienen, Tienen, Belgium
[7] Faculty of Psychology and Educational Sciences, Vrije Universiteit Brussel (VUB)
[8] UNIBS, University of the Free State
[9] Faculty of Medicine and Health Sciences (CAPRI), University of Antwerp

Personality disorders (PDs) are characterized by problems with identity and self-direction. Since the recent dimensional PD models of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*) and the *International Statistical Classification of Diseases and Related Health Problems*, 11th edition, the role of identity and self-direction in personality pathology has been made explicitly by including these problems in a general personality pathology criterion. This criterion reflects impairment in personality functioning (IPF), which is assessed on a continuum to determine the severity of personality pathology. The present study aimed to psychometrically evaluate the Five-Item Screening Scale for Personality Disorders (FISSPD; Skodol et al., 2011), a short screener for IPF, in a Dutch-speaking clinical sample of 820 adults. This screener mainly taps into self-related impairment, with four items measuring self-related impairment and one item measuring interpersonal impairment. The factor structure, scale reliability, measurement invariance (across sex, age, and patients with vs. without PD), and convergent validity were investigated. The Dutch FISSPD showed a unidimensional structure and good scale reliability. Scalar measurement invariance was established across sex, age (patients below vs. above age 40), and patients with versus without PD. The Dutch FISSPD was significantly related to identity and all *DSM-IV/5* Section-II PD symptoms. The present study indicates that the Dutch FISSPD has potential as a reliable and valid screener for personality pathology in adult patients.

*Keywords:* impairment in personality functioning, Alternative Model for Personality Disorders, personality pathology, psychometric validation, Five Item Screening Scale for Personality Disorder

*Supplemental materials:* https://doi.org/10.1037/per0000666.supp



Personality disorders (PDs) are characterized by problems with identity and self-direction (Kaufman & Meddaoui, 2021; Schmeck et al., 2013; Vizgaitis & Lenzenweger, 2022). Erikson (1968) and Kernberg (2006) described the concept of identity diffusion in their theories, referring to individuals who seem unable to achieve identity synthesis or integration. Identity-diffused individuals experience an absence or loss of the ability for self-definition and a disintegration of the self, which can ultimately result in personality

This article was published Online First May 23, 2024.
Josh Miller served as action editor.
Kristina Eggermont https://orcid.org/0000-0002-5133-2641
This work was supported by Fonds Wetenschappelijk Onderzoek, Belgium [Grant numbers G070620N and G0D3521N].

Kristina Eggermont served as lead for project administration and writing–original draft, contributed equally to conceptualization, and served in a supporting role for formal analysis. Dirk Smits served as lead for formal analysis and methodology and served in a supporting role for writing–review and editing. Annabel Bogaerts served as lead for data curation and investigation and served in a supporting role for writing–review and editing. Els Pauwels and Eva Dierckx served in a supporting role for writing–review and editing. Koen Luyckx and Laurence Claes contributed equally to supervision and writing–review and editing.

Correspondence concerning this article should be addressed to Kristina Eggermont, Faculty of Psychology and Educational Sciences, KU Leuven, Tiensestraat 102, Box 3717, 3000 Leuven, Belgium. Email: kristina.eggermont@kuleuven.be

pathology. In Kernberg's (1967) theory of personality organization, identity diffusion represents one of the three central markers of personality pathology. In each of these theories, problems with identity and self-direction are situated on a spectrum, and the degree of dysfunction is an indicator of the severity of personality pathology. More recently, the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*; American Psychiatric Association, 2013) and the *International Statistical Classification of Diseases and Related Health Problems*, 11th edition (*ICD-11*; World Health Organization, 2019) have respectively proposed the Alternative Model for Personality Disorders (AMPD) and a reformed personality pathology classification. Both models operationalize PD as a dimensional construct, in which impairment in personality functioning (IPF) serves as an indicator of the severity of personality dysfunction. IPF manifests itself through impairment in self-functioning (including problems with identity and self-direction) and interpersonal functioning (including problems with empathy and intimacy). Since the publication of the *DSM-5* and *ICD-11*, several self-report questionnaires and interviews have been developed to assess IPF (for an overview of instruments assessing Criterion A of the AMPD, see Birkhölzer et al., 2021). However, the debate on (the current operationalization of) Criterion A of the AMPD is ongoing. Scholars, for instance, disagree on whether Criterion A is able to distinguish PDs from other psychopathology or whether it provides incremental validity over Criterion B of the AMPD, which assesses maladaptive personality traits (Sleep & Lynam, 2022; Sleep et al., 2019, 2020).

Skodol et al. (2011) have proposed a Five-Item Screening Scale for Personality Disorder (FISSPD; see Table 1), aiming to efficiently screen for PD by assessing self-dysfunction using four items and interpersonal dysfunction using one item. This brief screener was derived from the General Personality Pathology (GPP) scale (Morey et al., 2011), a 65-item self-report questionnaire assessing Criterion A of the AMPD. The brevity of the FISSPD makes it a very convenient tool to quickly screen for PD in clinical contexts. Previously, the FISSPD has been validated in a Dutch community sample of adolescents and adults, showing a unidimensional structure and good scale reliability (Eggermont et al., 2022). Skodol et al. (2011) have investigated the sensitivity and specificity of the FISSPD for a semistructured interview diagnosis of PD in a clinical inpatient sample. They found that a total score of three or more (out of five) had a sensitivity of 79% and specificity of 54%. However, the factor structure and reliability of the FISSPD have to the best of our knowledge not yet been examined in a clinical sample.

**Table 1**
*FISSPD (Skodol et al., 2011) and Factor Loadings in the Current Study*

| Items | Factor loadings |
|---|---|
| 1. I can hardly remember what kind of person I was only a few months ago. | 0.53 |
| 2. My feelings about people change a great deal from day to day. | 0.68 |
| 3. Most of the time I don't have the feeling of being in touch with my real self. | 0.83 |
| 4. I drift through life without a clear sense of direction. | 0.81 |
| 5. I have very contradictory feelings about myself. | 0.79 |

*Note.* FISSPD = Five-Item Screening Scale for Personality Disorder.

In the present study, we aimed to psychometrically evaluate the Dutch FISSPD in a clinical sample. As a first research aim, we investigated the Dutch FISSPD's factor structure, reliability, and measurement invariance across sex, age, and patients with or without PD. A second aim of the study was to investigate associations with identity and *DSM-IV/5* Section II PD symptoms.

## Method

### Participants and Procedure

The sample included data from adult patients following treatment in two different treatment centers in Flanders (Belgium). At the psychiatric hospital of Alexianen Zorggroep Tienen (AZT) ($n = 725$), patients from four different treatment units were included, that is, an intensive outpatient unit ($n = 184$), an inpatient general psychiatry unit ($n = 139$), an inpatient eating disorder unit ($n = 81$), and an inpatient substance use unit ($n = 321$). Each patient completed a standard set of questionnaires at the beginning of their treatment, including the questionnaires used in this study. After giving informed consent, patients completed these questionnaires through an online platform. Afterward, they received feedback about their results by a team member of the patient's unit. At the University Psychiatric Center (UPC) Duffel ($n = 95$), all patients were treated in an inpatient dialectical behavior therapy (DBT) treatment unit. Patients were referred to clinical assessment and were invited to participate in the current study by the clinical psychologist performing the assessment. After giving informed consent, patients completed the questionnaires through an online platform and/or on paper. The total sample consisted of 820 individuals, of whom 59% were female ($n = 484$) and 41% male ($n = 336$), with a mean age of 36.11 ($SD = 11.90$, range = 18–65 years). A total of 289 patients (35.20%) were labeled as patients with PD, and 524 patients (63.90%) were labeled as patients without PD.[1] Table 2 shows the prevalence rates of each *DSM-IV/5* Section II PDs and provides information on comorbidity. As questionnaires were part of routine care in the treatment centers (rather than specifically administered within a research context), we were unable to screen for response validity. All data collections were approved by the Ethical Committee of the Faculty of Psychology and Educational Sciences of the University of Leuven.

### Measures

#### *Five-Item Screening Scale for Personality Disorder*

Participants completed the Dutch translation of the FISSPD (Skodol et al., 2011). This screening scale consists of five items to be rated on a 5-point rating scale ranging from 0 (*completely disagree*) to 4 (*completely agree*). A single severity score was calculated based on the mean score of the five items. As mentioned earlier, The Dutch version of the FISSPD has been previously validated in Dutch-speaking community adolescents and adults (Eggermont et al., 2022).

#### *Identity*

Identity was measured using the Dutch version of the self-concept and identity measure (SCIM; Kaufman et al., 2015; Dutch

[1] Patients were labeled according to the categorical scoring system of the ADP-IV questionnaire, using the trait (T) > 5 and distress (D) > 1 algorithm (see Measures section).

**Table 2**
*Prevalence Rates of the DSM-IV/5 Section II Personality Disorders*

| DSM-IV/5 section II personality disorder | *n* (%) |
|---|---|
| Paranoid PD | 50 (6.2) |
| Schizoid PD | 36 (4.40) |
| Schizotypal PD | 39 (4.8) |
| Antisocial PD | 31 (3.8) |
| Borderline PD | 175 (21.30) |
| Histrionic PD | 11 (1.30) |
| Narcissistic PD | 5 (0.60) |
| Avoidant PD | 146 (17.80) |
| Dependent PD | 44 (5.40) |
| Obsessive-compulsive PD | 102 (12.40) |

*Note.* Of the 289 patients labeled with PD, 159 of these patients (55%) met the criteria for more than one PD. *DSM-IV/5* = *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition/fifth edition; PD = personality disorder.

translation: Bogaerts et al., 2018). The SCIM was completed only by a subsection of the sample (21.58%, $n = 177$) because this questionnaire was not available to every patient during data collection in the psychiatric hospital of AZT. In this treatment center, only patients from the eating disorder unit completed this questionnaire (and one patient from the substance use unit). In UPC Duffel, all patients filled in the SCIM questionnaire. This self-report questionnaire includes 27 items rated on a 7-point scale ranging from 1 (*completely disagree*) to 7 (*completely agree*). The SCIM consists of three subscales: consolidated identity, disturbed identity, and lack of identity. The Dutch version of the SCIM has provided reliable and valid test scores in a Dutch-speaking clinical sample if Items 3, 11, 14, and 23 were excluded (Bogaerts et al., 2023). Consequently, we used this 23-item version in the present study. In the present study, Cronbach's α coefficients for consolidated identity, disturbed identity, and lack of identity were .73, .84, and 83, respectively.

### *Personality Disorder Symptomatology*

Participants completed the Assessment of *DSM-IV* Personality Disorders (ADP-IV) questionnaire (Schotte et al., 1998, 2004). The ADP-IV is a self-report questionnaire containing 94 items, which assesses the criteria of the 12 PD categories of *DSM-IV/5* Section II. Each item is scored on a trait scale and a distress scale. The trait scale ranges from 1 (*totally disagree*) to 7 (*totally agree*), measuring to which degree a certain trait is applicable to the respondent. When the respondent rates the item a score higher than 4 on the trait scale, respondents are asked to fill in the distress scale. The distress scale ranges from 1 (*totally not*) to 3 (*most certainly*) and measures the level of distress experienced by the respondent/significant other(s) because of the trait. There are two scoring systems for the ADP-IV. The first scoring system is dimensional and scale scores are calculated by adding up the trait scores for each PD. The dimensional scoring system was used in this study to calculate dimensional PD scales in order to answer Research Question 2 (convergent validity). In the present study, Cronbach's α coefficients for the dimensional PD scales were .83 (paranoid PD), .67 (schizoid PD), .81 (schizotypal PD), .76 (antisocial PD), .85 (borderline PD), .79 (histrionic PD), .76 (narcissistic PD), .88 (avoidant PD), .79 (dependent PD), and .77 (obsessive-compulsive PD). The second scoring system is categorical and is calculated following the *DSM-IV/5* Section II definition of PDs by combining both T and D scores in a scoring algorithm. We used the T > 5 and D > 1 scoring algorithm, in which each item is transformed into a categorical variable (pathological/not pathological). An item is pathological when the trait score of the item is higher than 5 and the Distress score of the same item is higher than 1. Finally, categorical PD diagnoses are obtained by using the *DSM-IV* thresholds, for example, three or more pathological items are required in order to diagnose the avoidant PD. The T > 5 and D > 1 scoring algorithm shows good concordance with a semistructured interview for diagnosing PDs (Schotte et al., 2004). The categorical scoring system was only used to calculate prevalence rates and was not used to answer our research questions.

## Transparency and Openness

Hypotheses and the plan of data analysis were registered prior to conducting analyses at the Open Science Framework platform and can be accessed through this link https://osf.io/u4v87/?view_only=fe21e066feff4ecb8a4885e237f384e6.[2] The raw data used for this article are not publicly available since the ethical committee did not approve of this. The code behind the analyses has been made publicly available at the APA's repository and can be accessed through this link https://osf.io/njkyz/?view_only=e4c4948db8b24260abf959c06292873d.

## Results

Confirmatory factor analysis estimated in Mplus using weighted least square mean and variance adjusted estimation algorithm showed that a one-factor model fitted our data well; $\chi^2 = 73.023$, $df = 5$, $p < .001$, comparative fit index (CFI) = .981, standardized root-mean-square residual (SRMR) = .028[3] (no other model was tested). All item loadings were high and positive ranging from .53 to .83 (see Table 1). Scale reliability of the Dutch FISSPD in the clinical sample was good, with Cronbach's α being .81. Table 3 displays goodness-of-fit indices for the configural, metric, and scalar measurement invariance tests (examined by means of multigroup confirmatory factor analysis [CFA] using weighted least square mean and variance). Across sex, scalar invariance was obtained, indicating that each item contributed to a similar degree to the total factor in both male and female patients, and mean scores between males and females could be compared. Female patients, $M = 2.10$, $SD = 0.89$, scored significantly higher on the FISSPD compared to male patients, $M = 1.66$, $SD = 0.94$; $F(1, 818) = 44.65$, $p < .001$, $\eta^2 = .05$. Regarding age, we examined measurement invariance across patients in early (below 40 years old) and middle (above 40 years old) adulthood (Berk, 2022), as personality pathology may present itself differently

[2] During the review process, significant changes were made to the manuscript. As a result, this article differs from how it was initially described in the pre-registration. Two analyses were pre-registered, but have been omitted from the manuscript during the review process: (a) associations between the FISSPD and psychological symptoms and (b) receiver operating characteristic analyses in order to calculate cutoff scores for the FISSPD. Results from these analyses can be obtained by contacting Kristina Eggermont.

[3] Root-mean-square error of approximation (RMSEA) was .129, which is an indication of poor model fit. However, as clarified in the preregistration, we chose to rely on SRMR rather than RMSEA to determine model fit, as the SRMR provides more acceptable type I error rates for ordinal data (Shi et al., 2020). To allow comparison with future research on the FISSPD, we did report the RMSEA.

**Table 3**
*Goodness-of-Fit Indices for Testing MI Across Sex, Age (Early Adulthood Versus Middle Adulthood), and Across Patients With and Without PD*

| Measurement invariance | $\chi^2$ (*df*) | CFI | ΔCFI | SRMR | ΔSRMR |
|---|---|---|---|---|---|
| MI across sex | | | | | |
| Configural | 76.148 (10) | .982 | | .029 | |
| Metric | 68.688 (14) | .985 | −.003 | .030 | −.001 |
| Scalar | 74.694 (28) | .987 | −.002 | .032 | −.002 |
| MI across age groups | | | | | |
| Configural | 76.782 (10) | .980 | | .029 | |
| Metric | 79.194 (14) | .980 | 0 | .031 | −.002 |
| Scalar | 69.231 (28) | .988 | −.008 | .031 | 0 |
| MI across patients with and without PD | | | | | |
| Configural | 77.532 (10) | .980 | | .031 | |
| Metric | 64.170 (14) | .985 | −.005 | .032 | −.001 |
| Scalar | 94.357 (28) | .980 | .005 | .036 | −.004 |

*Note.* MI = measurement invariance; PD = personality disorder; CFI = comparative fit index; SRMR = standardized root-mean-square residual.

throughout adulthood (Videler et al., 2019). Scalar measurement invariance across age was obtained. Patients in early adulthood, $M = 2.10$, $SD = 0.88$, obtained a significantly higher mean FISSPD score compared to patients in middle adulthood, $M = 1.60$, $SD = 0.94$; $F(1, 818) = 59.07$, $p < .001$, $\eta^2 = .07$. Comparing patients with and without PD, scalar invariance was again reached. Patients without PD, $M = 1.59$, $SD = 0.85$, scored significantly lower on the FISSPD compared to patients with (at least one) PD, $M = 2.52$, $SD = 0.77$; $F(1, 811) = 238.49$, $p < .001$, $\eta^2 = .23$.

In terms of convergent validity, Table 4 displays Pearson correlations between the Dutch FISSPD and identity and PD symptomatology. Regarding identity, the FISSPD was negatively correlated with consolidated identity and positively correlated with disturbed identity and lack of identity. To examine significant differences between correlations, Fisher's $r$ to $z$ transformations were performed online (Weiss, 2011) and the $z$ test and Cohen's $q$ were examined.[4] The correlation with consolidated identity was significantly weaker than the correlations with disturbed identity, $z = 12.06$, $p < .001$, $q = -1.29$, and lack of identity, $z = 13.53$, $p < .001$, $q = -1.45$. There was no significant difference between correlations of the Dutch FISSPD with disturbed identity and lack of identity. As for *DSM-IV/5* Section II PD symptomatology, the Dutch FISSPD was significantly and positively correlated with all dimensional PD scales. Table 1 in the online supplemental materials displays $z$ values and Cohen's $q$'s for the Fisher's $r$ to $z$ transformations. The strongest correlation was found with borderline PD symptoms, followed by correlations with dependent, histrionic, schizotypal, avoidant, and paranoid PD symptoms.

**Table 4**
*Correlations of the FISSPD With Identity and PD Symptomatology*

| Identity functioning/*DSM-IV/5 PD* symptomatology | Correlations with FISSPD |
|---|---|
| Consolidated identity | −.51 |
| Disturbed identity | .62 |
| Lack of identity | .71 |
| Paranoid PD | .53 |
| Schizoid PD | .37 |
| Schizotypal PD | .53 |
| Antisocial PD | .36 |
| Borderline PD | .66 |
| Histrionic PD | .58 |
| Narcissistic PD | .35 |
| Avoidant PD | .53 |
| Dependent PD | .59 |
| Obsessive-compulsive PD | .44 |

*Note.* All correlations were significant at $p < .001$. FISSPD = Five-Item Screening Scale for Personality Disorder; PD = personality disorder; *DSM-IV/5 = Diagnostic and Statistical Manual of Mental Disorders*, fourth edition/fifth edition.

## Discussion

Obtaining a quick indication of a patient's IPF in clinical contexts could guide clinicians in evaluating the need for a more extensive clinical assessment. The aim of the present study was to examine the psychometric properties of the Dutch FISSPD, a five-item screener mainly tapping into self-related IPF, in a Dutch-speaking sample of adult patients.

CFA revealed that a one-factor model or unidimensional structure fitted our data well, which is in line with the one-factor structure found earlier in community adults and adolescents (Eggermont et al., 2022). Furthermore, the Dutch FISSPD showed good scale reliability. Scalar measurement invariance was reached across sex, age (patients in early adulthood vs. middle adulthood), and patients with versus without PD(s). Female patients scored significantly higher on the FISSPD compared to males. Furthermore, patients in early adulthood (aged 18–40) reported higher FISSPD scores compared to patients in middle adulthood (aged 41–65). Finally, patients with at least one PD diagnosis according to a questionnaire measuring Section II PD criteria (the ADP-IV) scored significantly higher on the FISSPD compared to patients without such a diagnosis, which is an indication of convergent validity.

The FISSPD was significantly correlated with consolidated identity, disturbed identity, and lack of identity. The correlation with lack of identity was the strongest. This indicates that the FISSPD taps into more extreme self-related impairment, such as feeling broken

[4] For Cohen's $q$, values between .10 and .30 suggest small differences between correlations, values between .30 and .50 suggest moderate differences, and values above .50 suggest large differences (Cohen, 1988).

or empty inside or no longer knowing who one is, and thus seems to correspond closely to the concept of identity diffusion (Erikson, 1968; Kernberg, 2006). Furthermore, the Dutch FISSPD was significantly positively correlated with all *DSM-IV/5* Section II dimensionally assessed PDs, which is in line with the conceptualization of IPF as an indicator of general personality pathology. The FISSPD showed the strongest correlation with borderline PD symptoms. This finding could be situated within the idea that borderline PD symptoms do not reflect one specific PD, but rather indicate general personality pathology (Clark et al., 2018). As such, several studies have found that in bifactor models with a general factor and specific PD factors, borderline PD criteria do not load on one specific PD factor, but instead load on the general PD factor (Sharp et al., 2015; Williams et al., 2018; Wright et al., 2016).

Altogether, these findings indicate that the Dutch FISSPD has potential as a unidimensional, reliable screener for IPF in adult patients. Important to note is that the FISSPD has not been developed to fully capture the two subdomains of Criterion A of the AMPD (i.e., self- and interpersonal dysfunction) or the general PD conceptualization of the *ICD-11*. It should be used as a screener that mainly taps into self-related dysfunction, with the purpose to efficiently evaluate severity of personality pathology.

The results of this study were obtained in a large clinical sample that was reasonably balanced in terms of sex distribution. However, the findings of the present study must be interpreted in light of certain limitations. First, this is a cross-sectional study and, hence, we cannot draw conclusions on test–retest reliability or directionality of effects. Second, all the instruments used in the present study were self-report questionnaires. This could have led to higher correlations because of shared method variance (Podsakoff et al., 2003). Another limitation because of the use of self-report questionnaires is that convergent validity has only been tested by means of self-report of the patient and not by means of a clinical interview or a diagnosis obtained from a clinician working with the patient. Furthermore, only a part of our sample (177 participants) completed the SCIM, because this questionnaire was not available to every patient during data collection. Third, the cutoff in terms of age (early vs. middle adulthood) was made based on predetermined cutoffs from developmental psychology (Berk, 2022), which is somewhat arbitrary. Fourth, the present study did not assess (maladaptive) personality trait variables (i.e., Criterion B of the AMPD) and hence, no examination of the distinction between the FISSPD and (maladaptive) personality traits could be made, nor was it possible to test for incremental validity of the FISSPD over (maladaptive) personality traits. Fifth, it could be relevant to validate the FISSPD in patients of other age groups. For example, research has shown that PD screeners for adolescents should take into account developmental factors, as the main developmental tasks of adolescence coincide with the subdomains of IPF (Thomson et al., 2023). As the FISSPD is mainly focused on self-functioning, it has potential as a useful, developmentally sensitive screener for personality pathology in adolescence. The Dutch FISSPD has already been studied in community adolescents and showed to be a reliable and valid screener (Eggermont et al., 2022). Regarding older patients (above the age of 65), a brief screener for IPF could be relevant given the lack of validated instruments for personality pathology in older patients, but must be psychometrically evaluated and tested for age neutrality.

## References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorder* (5th ed.).

Berk, L. E. (2022). *Development through the lifespan* (7th ed.). SAGE Publications.

Birkhölzer, M., Schmeck, K., & Goth, K. (2021). Assessment of Criterion A. *Current Opinion in Psychology*, *37*, 98–103. https://doi.org/10.1016/j.copsyc.2020.09.009

Bogaerts, A., Claes, L., Verschueren, M., Bastiaens, T., Kaufman, E. A., Smits, D., & Luyckx, K. (2018). The Dutch Self-Concept and Identity Measure (SCIM): Factor structure and associations with identity dimensions and psychopathology. *Personality and Individual Differences*, *123*, 56–64. https://doi.org/10.1016/j.paid.2017.11.007

Bogaerts, A., Luyckx, K., Bastiaens, T., Sleuwaegen, E., Berens, A., & Claes, L. (2023). The self-concept and identity measure in patients with personality disorders: A psychometric evaluation and associations with identity processes, core domains of self-functioning, and personality disorder symptoms. *Assessment*, *30*(7), 2184–2197. https://doi.org/10.1177/10731911221140313

Clark, L. A., Nuzum, H., & Ro, E. (2018). Manifestations of personality impairment severity: Comorbidity, course/prognosis, psychosocial dysfunction, and 'borderline' personality features. *Current Opinion in Psychology*, *21*, 117–121. https://doi.org/10.1016/j.copsyc.2017.12.004

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Lawrence Erlbaum Associates.

Eggermont, K., Luyckx, K., Smits, D., Bogaerts, A., Buelens, T., Bastiaens, T., & Claes, L. (2022). The validation of a five-item screening scale for personality disorders in Dutch-speaking community adolescents and adults. *Journal of Psychopathology and Behavioral Assessment*, *44*(2), 418–431. https://doi.org/10.1007/s10862-022-09951-1

Erikson, E. (1968). *Identity, youth and crisis*. W.W. Norton.

Kaufman, E. A., Cundiff, J. M., & Crowell, S. E. (2015). The development, factor structure, and validation of the self-concept and identity measure (SCIM): A self-report assessment of clinical identity disturbance. *Journal of Psychopathology and Behavioral Assessment*, *37*(1), 122–133. https://doi.org/10.1007/s10862-014-9441-2

Kaufman, E. A., & Meddaoui, B. (2021). Identity pathology and borderline personality disorder: An empirical overview. *Current Opinion in Psychology*, *37*, 82–88. https://doi.org/10.1016/j.copsyc.2020.08.015

Kernberg, O. F. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association*, *15*(3), 641–685. https://doi.org/10.1177/000306516701500309

Kernberg, O. F. (2006). Identity: Recent findings and clinical implications. *The Psychoanalytic Quarterly*, *75*(4), 969–1004. https://doi.org/10.1002/j.2167-4086.2006.tb00065.x

Morey, L. C., Berghuis, H., Bender, D. S., Verheul, R., Krueger, R. F., & Skodol, A. E. (2011). Toward a model for assessing level of personality functioning in DSM-5, Part II: Empirical articulation of a core dimension of personality pathology. *Journal of Personality Assessment*, *93*(4), 347–353. https://doi.org/10.1080/00223891.2011.577853

Podsakoff, N., MacKenzie, S. B., & Lee, J.-Y. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology*, *88*(5), 879–903. https://doi.org/10.1037/0021-9010.88.5.879

Schmeck, K., Schlüter-Müller, S., Foelsch, P. A., & Doering, S. (2013). The role of identity in the DSM-5 classification of personality disorders. *Child and Adolescent Psychiatry and Mental Health*, *7*(1), Article 27. https://doi.org/10.1186/1753-2000-7-27

Schotte, C. K., de Doncker, D., Vankerckhoven, C., Vertommen, H., & Cosyns, P. (1998). Self-report assessment of the DSM-IV personality disorders. Measurement of trait and distress characteristics: The ADP-IV. *Psychological Medicine*, *28*(5), 1179–1188. https://doi.org/10.1017/S0033291798007041

Schotte, C. K., Doncker, D. A. D., Dmitruk, D., Mulders, I. V., D'Haenen, H., & Cosyns, P. (2004). The ADP-IV questionnaire: Differential validity and concordance with the semi-structured interview. *Journal of Personality Disorders*, *18*(4), 405–419. https://doi.org/10.1521/pedi.2004.18.4.405

Sharp, C., Wright, A. G., Fowler, J. C., Frueh, B. C., Allen, J. G., Oldham, J., & Clark, L. A. (2015). The structure of personality pathology: Both general ('g') and specific ('s') factors? *Journal of Abnormal Psychology*, *124*(2), 387–398. https://doi.org/10.1037/abn0000033

Shi, D., Maydeu-Olivares, A., & Rosseel, Y. (2020). Assessing fit in ordinal factor analysis models: SRMR vs. RMSEA. *Structural Equation Modeling: A Multidisciplinary Journal*, *27*(1), 1–15. https://doi.org/10.1080/10705511.2019.1611434

Skodol, A. E., Bender, D. S., Oldham, J. M., Clark, L. A., Morey, L. C., Verheul, R., Krueger, R. F., & Siever, L. J. (2011). Proposed changes in personality and personality disorder assessment and diagnosis for DSM-5 Part II: Clinical application. *Personality Disorders: Theory, Research, and Treatment*, *2*(1), 4–22. https://doi.org/10.1037/a0021891

Sleep, C. E., & Lynam, D. R. (2022). The problems with Criterion A: A comment on Morey et al. (2022). *Personality Disorders: Theory, Research, and Treatment*, *13*(4), 325–327. https://doi.org/10.1037/per0000585

Sleep, C. E., Lynam, D. R., Widiger, T. A., Crowe, M. L., & Miller, J. D. (2019). Difficulties with the conceptualization and assessment of Criterion A in the DSM-5 alternative model of personality disorder: A reply to Morey (2019). *Psychological Assessment*, *31*(10), 1200–1205. https://doi.org/10.1037/pas0000758

Sleep, C. E., Weiss, B., Lynam, D. R., & Miller, J. D. (2020). The DSM-5 Section III personality disorder criterion a in relation to both pathological and general personality traits. *Personality Disorders: Theory, Research, and Treatment*, *11*(3), 202–212. https://doi.org/10.1037/per0000383

Thomson, M., Cavelti, M., Lerch, S., Reichl, C., Mürner-Lavanchy, I., Moran, P., Koenig, J., & Kaess, M. (2023). Is a brief screen for personality disorder clinically useful for the detection of impairment in personality functioning in adolescents? *Personality Disorders: Theory, Research, and Treatment*, *14*(3), 300–308. https://doi.org/10.1037/per0000583

Videler, A. C., Hutsebaut, J., Schulkens, J. E., Sobczak, S., & van Alphen, S. P. (2019). A life span perspective on borderline personality disorder. *Current Psychiatry Reports*, *21*(7), Article 51. https://doi.org/10.1007/s11920-019-1040-1

Vizgaitis, A. L., & Lenzenweger, M. F. (2022). Identity and personality pathology: A convergence across the DSM-5 personality disorder model and the Alternative Model for Personality Disorders. *Journal of Personality Disorders*, *36*(5), 537–558. https://doi.org/10.1521/pedi.2022.36.5.537

Weiss, B. A. (2011). *Fisher's r-to-Z transformation calculator to compare two independent samples* (Version 2010) [Computer software]. https://blogs.gwu.edu/weissba/teaching/calculators/fishers-z-transformation/

Williams, T., Scalco, M., & Simms, L. (2018). The construct validity of general and specific dimensions of personality pathology. *Psychological Medicine*, *48*(5), 834–848. https://doi.org/10.1017/S0033291717002227

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.).

Wright, A. G., Hopwood, C. J., Skodol, A. E., & Morey, L. C. (2016). Longitudinal validation of general and specific structural features of personality pathology. *Journal of Abnormal Psychology*, *125*(8), 1120–1134. https://doi.org/10.1037/abn0000165