# Classification of Personality Disorders

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# Classification of Personality Disorder

- Attempts to dismiss personality disorder as a non-diagnosis.
- As a specialist subject that non-experts should not be expected to identify and treat.
- Pejorative, untreatable therefore best ignored.

- DSM-IV personality disorders have evolved from historical precedent, clinical experience and committee consensus.
- There is general agreement that the current ten operationally defined disorders are unsatisfactory.
- A recent survey reported that three quarters of personality disorder experts thought that the current system should be replaced (Berstein et al. 2007).

| Schnieder | DSM 5 | ICD 10 |
|---|---|---|
| Emotionally unstable | Borderline | Emotionally unstable – borderline and unstable |
| Explosive | Antisocial | Dissocial |
| Self-seeking | Narcissistic | Narcissistic |
| | Histrionic | Histrionic |
| Depressive | | |
| Asthenic | Avoidant | Anxious |
| Weak-willed | Dependent | Dependent |
| Affectless | Schizoid | Schizoid |
| Fanatical | | |
| Hyperthymic | | |
| | Obsessive-compulsive | Anankastic |
| | Paranoid | |
| | Schizotypal | |

# DSM 5 classification

- Originally proposed hybrid model which included assessment of severity, a reduction from ten to six categories and an assessment of 25 trait facets grouped into five broad trait domains.
- APA Board of Trustees felt the model was not yet ready for general use. Relegated to Section 111
- DSM 5 is essentially DSM IV R

# Limitations of DSM and ICD classifications

- Assumes discrete categories with boundaries between normality and illness
- Great heterogeneity within categories (Lykien 2006, Stone 2010)
- Extensive diagnostic overlap; over half the individuals who fulfil criteria for one PD also fulfil criteria for at least one other category (Mulder & Joyce 1997, Widiger & Clark 2000)
- Most PD categories are ignored – 97% consist of BPD, ASPD or PD NOS in Australia (MOH 2012)

# Changes in ICD 11

- Conceptually compatible in many ways with the DSM 5 Section 111 alternative model.
- Major differences are its emphasis on the severity of personality disturbance and not attempting to preserve traditional personality categories.

- ICD 11 classification abolishes all type specific categories of personality disorder apart from the general one of personality disorder itself.
- Different levels of severity reflect the following:
  - Personality dysfunction is best represented on a continuum or dimension.
  - The severity of the personality dysfunction is the best predictor of outcome regardless of type.
  - There is abundant evidence that the severity and form of personality disorders fluctuate over time depending on many psychosocial factors.

# Personality disorder

- A pervasive disturbance in how and individual experiences and thinks about the self, others, and the world, manifested in maladaptive patterns of cognition, emotional experience, emotional expression, and behaviour.
- The maladaptive patterns are relatively inflexible and are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships.

- The disturbance is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or situations).
- The disturbance is relatively stable over time and is of long duration. Most commonly, personality has its first manifestations in childhood and is clearly evident in adolescence.

# Level 2 of ICD-11 – mild personality disorder

**Mild personality disorder**

There are notable problems in many interpersonal relationships and the performance of expected occupational and social roles, but some relationships are maintained and/or some roles carried out.

- Examples: Able to maintain, and has some interest in maintaining a few friends. Intermittent or frequent, minor conflicts with peers, co-workers and/or supervisors or, alternatively, exhibits withdrawn, isolative behaviour but, in either case, is capable of sustaining and willing to sustain employment, given appropriate employment opportunities. Has meaningful relationships with some family members but typically avoids or has conflict with others.

Mild personality disorder is typically not associated with substantial harm to self or others.

# Level 3 of ICD-11 – moderate personality disorder

**Moderate personality disorder**

There are marked problems in most interpersonal relationships and in the performance of expected occupational and social roles across a wide range of situations that are sufficiently extensive that most are compromised to some degree.

- Examples: Able to maintain very few friends or has little interest in maintaining friendships. Regular conflicts with peers, co-workers and/or supervisors or marked withdrawal and isolative behaviour that interferes with the ability to function constructively at work or with others. May exhibit little interest in and/or efforts toward sustained employment when appropriate employment opportunities are available. May have a history of frequently changing employment as a result. Has conflicted, or a marked absence of, relationships with many family members.

Moderate personality disorder often is associated with a past history and future expectation of harm to self or others, but not to a degree that causes long-term damage or has endangered life.

- Examples: Recurrent suicidal ideation or suicide attempts without clear expectation of death, recurrent episodes of self-harm without clear lethality, recurrent hostile and confrontational behaviour, or occasional violent episodes that involve only minor destruction of property (eg. Breaking things) or interpersonal aggression such as pushing, shoving, or slapping that is not sufficient to cause lasting injury to others.

# Level 4 of ICD-11 – severe personality disorder

**Severe personality disorder**

There are several problems in interpersonal functioning affecting all areas of life. The individual's general social dysfunction is profound and the ability and/or willingness to perform expected occupational and social roles is absent or severely compromised.

- Examples: Has no friends but may have some associates. Unwilling or unable to sustain regular work due to lack of interest or effort, interpersonal difficulties, or inappropriate behaviour (eg. Irresponsibility, fits of temper, insubordination), even when appropriate employment opportunities are available. Conflict with or withdrawal from peers and co-workers. Family relationships are absent (despite having living relatives) or marred by significant conflict.

- Severe personality disorder is associated with a past history and future expectation of severe harm to self or others that has caused long-term damage or has endangered life.
- Examples:
  - Suicide attempts with a clear expectation of death
  - Episodes of self-harm that permanently injure, disfigure or deform the individual
  - Episodes of serious property destruction such as burning down someone's house in anger
  - Episodes of violence sufficient to cause lasting injury to others

# Personality difficulty

- Not a disorder: To be placed in ‘Z’ chapter, ‘Factors Influencing Health Status and Encounters with Health Services’.
- ‘A long-standing, recurrent or intermittent disturbance in an individual’s way of viewing the self, others and the world, emotional experience and expression, and patterns of behaviour that impairs some aspects of social functioning and interpersonal relationships.
- However, impairment in functioning is not as severe as that found among people with personality disorder and are seen only in certain social and interpersonal contexts than may not be apparent elsewhere’.

# What determines level of disorder

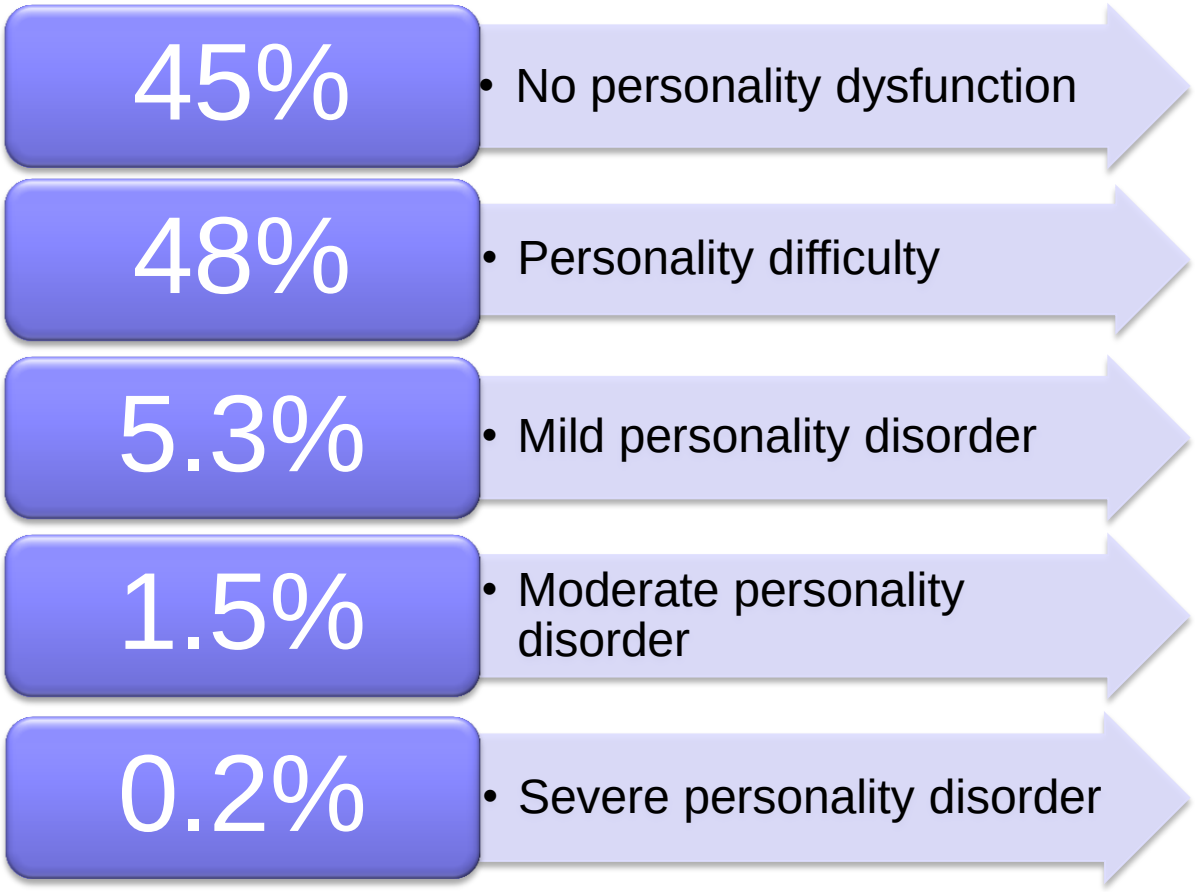
- Degree of interpersonal social dysfunction
- Degree of pervasiveness
- Situational aspects
- Ability to perform societal roles
- Risk of harm to self or others
- Mental state comorbidity

## The five severity levels of personality disturbance proposed in ICD-11

| Level | Main Features |
|---|---|
| No PD | No personality disturbance |
| Personality Difficulty | Some personality problems in certain situations but not universally |
| Mild PD | Definite well-demarcated personality problems across a range of situations |
| Moderate PD | Definite personality problems usually covering several personality domains and across all situations |
| Severe PD | As for complex disorder with personality problems leading to significant risk to self or others |

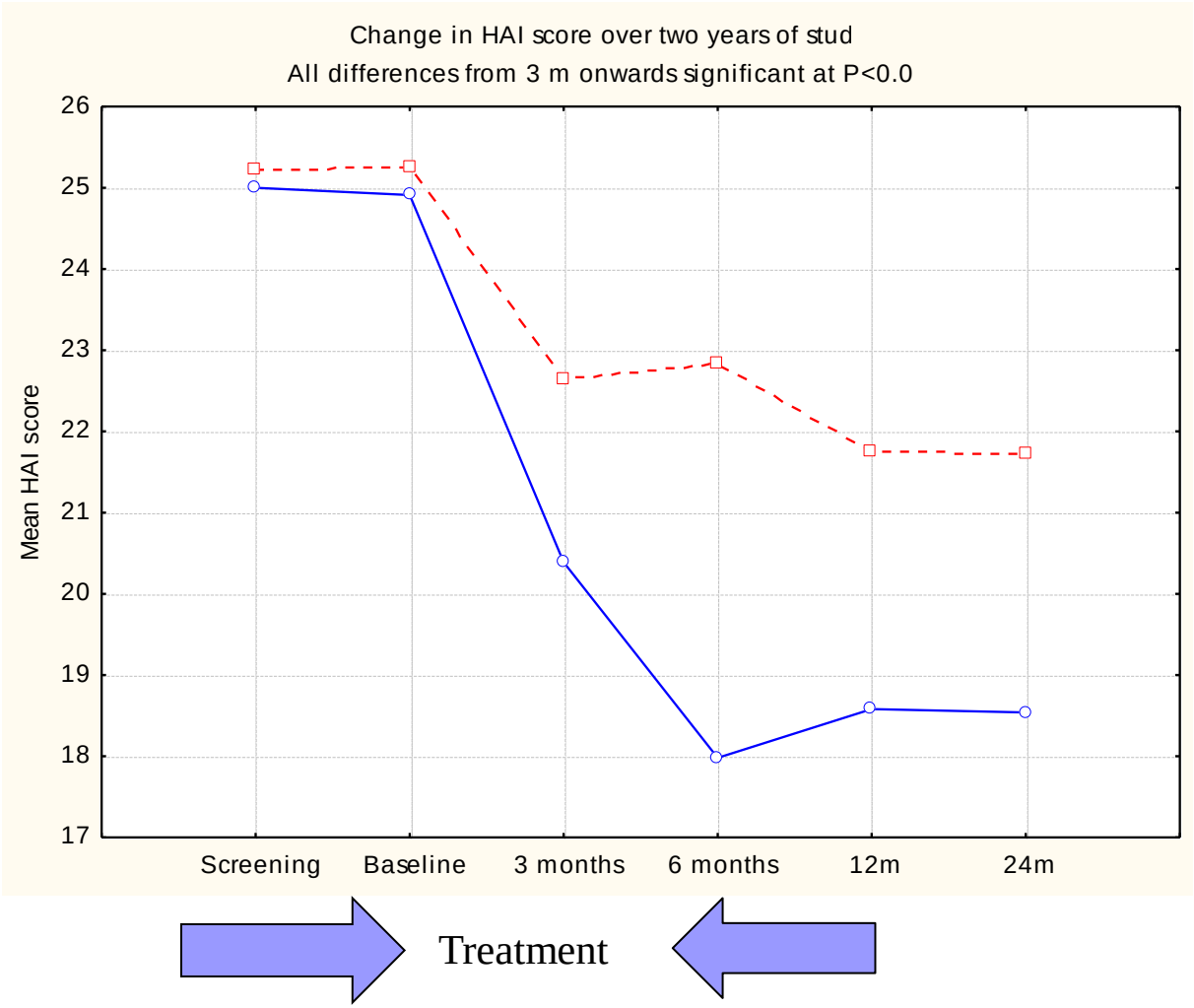
# New ICD-11 classification and likely population prevalence (Tyrer et al, 2014)

NB Onset of personality disorder can be at any age.



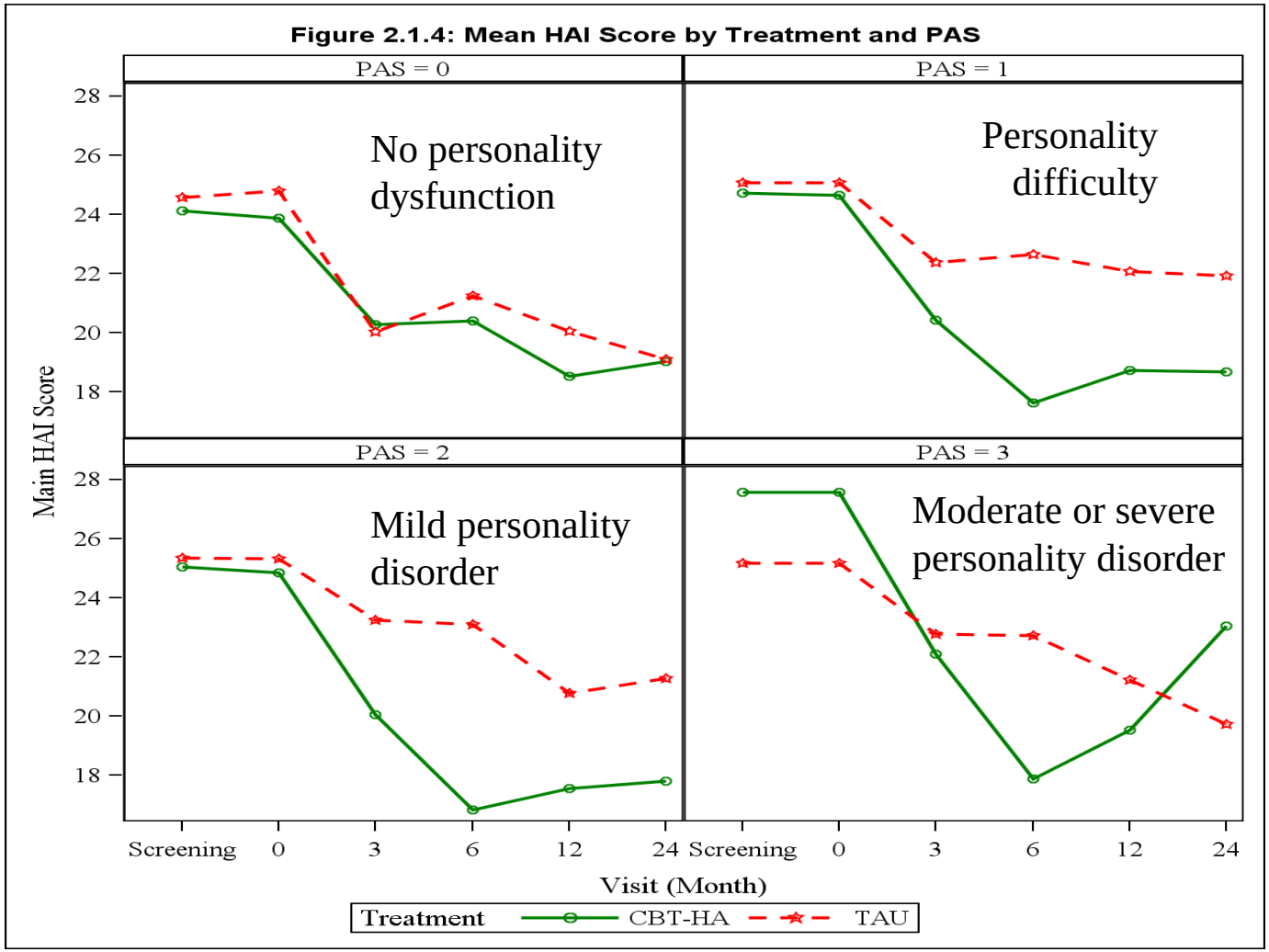
- Large numbers who have personality difficulties may help destigmatise the diagnosis.
- Allows dimensional nature of personality to be acknowledged and recorded.
- Helps clinical decision making e.g., high resource long-term interventions could be reserved for severe personality disorder.

# Significance: P<0.001 is <0.01 at all times of testing




But we also wanted to know if ICD-11 personality status affected the outcome

Note: Primary outcome is change in HAI scores at 1 year (P<0.001)




Sanatinia et al. British Journal of Psychiatry (2016; 209(3): 244-250)

**Development and psychometric properties of the Standardized Assessment of Severity of Personality Disorder (SASPD)**

Kike Olajide, Jasna Munjiza, Paul Moran, Lesley O'Connell, Giles Newton-Howes, Paul Bassett, Akintomide Gbolagade, Nicola Ng, Peter Tyrer, Roger Mulder, Mike J Crawford

Journal of Personality Disorders (In press)

- SASPD correctly identified the presence and severity of personality disorders (as determined by expert clinical raters) in almost 80% of patients
- Insufficient patient numbers to test severe PD accuracy
- Clinicians can reliably identify the presence of a PD and whether it is mild or moderate using a questionnaire
- The clinical utility of this needs to be tested

The level of severity may be qualified by a description of domain traits.

- These indicate which of the main facets of personality dysfunction are most prominent in the individual.
- They are not categories but represent a set of dimensions that correspond to the underlying structure of personality dysfunction.
- The proposed traits are distilled from studies in psychiatric patients and normal populations (Tyrer & Alexander 1979; Mulder et al. 2011; Livesley, 2011).

# Proposals for alternative descriptions of personality pathology

- Gunderson (1988) – “trait disorders”; “self-disorders”; “spectrum disorders”
- Kernberg (1984) – “neurotic”; “borderline”; “psychotic”
- Mulder & Joyce (1997) – 4 As – antisocial, anankastic, asocial, asthenic
- Livesley et al (1987) – emotional dysregulation, dissocial behaviour, inhibitedness, compulsivity
- Clarke (1993) – SNAP 12 dimensions of maladaptive personality

- Siever & Davis (1991) – cognitive/perceptual organisation, impulsivity/aggression, affective instability, anxiety/inhibition
- Cloninger (1993) – TCI 7 factor model
- Five factor Model – neuroticism, extraversion, openness, agreeableness, conscientiousness

"There is a general consensus for the relevance of at least four higher-order domains of personality functioning that are clearly related to personality pathology: neuroticism/negative affectivity/emotional dysregulation, extraversion/positive emotionality, dissocial/antagonistic behaviour, and constraint/compulsivity. These relevant personality trait domains have been recognised for decades…"

(Trull and Durrett, 2005)

- One general factor explains most of the variance in personality pathology (Rutter 2013, Caspi et al. 2013).
- Two factors – similar to externalising and internalising are sufficient (Kendler et al. 2003, Krueger & Markon, 2011).
- Three or four factors most commonly reported using statistical manipulations (Mulder et al. 2011; Livesley, 2011).
- My favourite PD is valid and must be present – usually borderline, narcissistic and paranoid.

Journal of Personality Disorders, 25(3), 364–377, 2011


# THE CENTRAL DOMAINS OF PERSONALITY PATHOLOGY IN PSYCHIATRIC PATIENTS

Roger T. Mulder, MB ChB, PhD, FRANZCP,
Giles Newton-Howes, MB ChB, MRCPsych,
Michael J. Crawford, MD, MRCPsych,
and Peter J. Tyrer, MD, MRCPsych

- Commonest number of factors was 3
  - Internalising
  - Externalising
  - Schizoid / aloof factors
- Next most common – obsessive-compulsive factors which splits off the internalising factor

# Domains are qualifiers, not diagnoses

**Negative affective features (negative affectivity)**

- The negative affective trait domain is characterised primarily by the tendency to manifest a broad range of distressing emotions including anxiety, anger, self-loathing, irritability, vulnerability, depression, and other negative emotional states, often in response to even relatively minor actual or perceived stressors. Dependence may also be present.

# Dissocial features (dissociality)

The core of the dissocial trait domain is disregard for social obligations and conventions and the rights and feelings of others. Traits in this domain include callousness, lack of empathy, hostility and aggression, ruthlessness, and inability or unwillingness to maintain prosocial behaviour, often manifested in an overly positive view of the self, entitlement, and a tendency to be manipulative and exploitative of others.

# Anankastic features (anankastia)

- The core of the anankastic trait domain is a narrow focus on the control and regulation of one's own and others' behaviour to ensure that things conform to the individual's own high standards. Traits in this domain include perfectionism, perseveration, emotional and behavioural constraint, stubbornness, deliberativeness, orderliness, and concern with following rules and meeting obligations.

# Detached features (detachment)

- The core of the detachment trait domain is emotional and interpersonal distance, manifested in marked social withdrawal and/or indifference to people, isolation with very few or no attachment figures, including avoidance of not only intimate relationships but also close friendships. Traits in the detachment domain include aloofness or coldness in relation to other people, excessive reserve, passivity and lack of assertiveness, and reduced experience and expression of emotion, especially positive emotions, to the point of a diminished capacity to experience pleasure.

# Disinhibition features (disinhibition)

- The disinhibitive trait domain is characterised by a persistent tendency to act impulsively in response to immediate internal or environmental stimuli without consideration of longer term consequences. Traits in this domain include irresponsibility, impulsivity without regard for risks or consequences, distractibility, and recklessness.

Despite independent derivation the ‘domains’ are similar to the ‘Alternative DSM 5 Model for Personality Disorders’

| ICD11 (proposed) | DSM 5 (alternative) |
|---|---|
| Negative affect | Negative affectivity |
| Detached | Detachment |
| Dissocial | Antagonism |
| Disinhibition | Disinhibition |
| (Anankastic) | (Psychoticism) |

# Validating the proposed ICD11 Domains

- The SCID II data was obtained from outpatients who were enrolled in one of five randomised controlled trials (RCT) for the treatment of depression. Three studies were drug trials while the other two were psychotherapy studies. Details of each study are reported elsewhere (Carter et al., 2013; Joyce, Mulder, & Cloninger, 1994; Joyce et al., 2002; Luty et al., 2007)

Mulder, Horwood, Tyrer, Carter, Joyce
Personality and Mental Health (2016) 10:84-95

# ICD-11 Personality Domains

- Two authors (RM and PT) independently assigned each DSM personality disorder symptom into one of the five proposed ICD-11 domains. Symptoms judged to not fit into any domains were categorised as not addressed. When the raters disagreed this was resolved by review and discussion. A total of 57 symptom criteria were selected for inclusion in the study, with a further 22 classified as not addressed.

# Statistical Modelling

- Confirmatory factor analysis (CFA).
- Exploratory framework – model specification guided by hypothesised ICD11 domain structure the initial specification was successively modified to improve model fit and test alternative model structures.

# Patient Characteristics

- A total of 606 patients were included in the analyses. Of these 228 (37.6%) were male and 378 (62.4%) were female. The average age was 34.2yrs (SD 11.1 yrs). Patients were moderately depressed on entry to the four studies (mean HAM-D-17 score was 17.9 (SD 5.6)). The sample was predominantly European (91.2%) with a minority of New Zealand Maori or Pasifika (3.6%), Asian (2.5%) or other (2.1%).

| NEGATIVE EMOTIONAL | |
|---|---|
| **DSM Criterion** | **DSM Diagnosis** |
| Excessive social anxiety… | Schizotypal |
| Avoids occupational activities… | Avoidant |
| Unwilling to get involved with people… | Avoidant |
| Shows restraint within intimate relationships… | Avoidant |
| Is preoccupied with being criticised… | Avoidant |
| Is inhibited… | Avoidant |
| Views self as socially inept… | Avoidant |
| Has difficulty making decisions… | Dependent |
| Has difficulty expressing disagreement… | Dependent |
| Goes to excessive lengths… | Dependent |
| Feels uncomfortable… | Dependent |
| Urgently seeks another relationship… | Dependent |
| Is unrealistically preoccupied… | Dependent |
| Frantic attempts to… | Borderline |
| Identity disturbance… | Borderline |
| Recurrent suicidal behaviour… | Borderline |
| Affective instability… | Borderline |
| Chronic feelings of emptiness… | Borderline |

**Table 4:** Model goodness of fit and comparative fit indices for a series of models of personality disorder symptoms

| Model | Model $\chi^2$(df)[1] | CFI[2] | RMSEA[3] | SRMR[4] | AIC[5] | BIC[5] |
|---|---|---|---|---|---|---|
| I: Five factor models | | | | | | |
| 1. Five factors, uncorrelated residuals | 1103 (209) | .69 | .08 | .09 | 20599 | 20952 |
| 2. Five factors, correlated residuals | 595 (208) | .86 | .06 | .08 | 19906 | 20307 |
| 3. Five factors, correlated residuals, additional cross-factor loadings | 553 (204) | .88 | .05 | .07 | 19858 | 20278 |
| II: Four factor models | | | | | | |
| 4. Four factors, uncorrelated residuals | 1114 (224) | .68 | .08 | .09 | 20610 | 20940 |
| 5. Four factors, correlated residuals | 552 (211) | .88 | .05 | .07 | 19843 | 20232 |
| 6. Four factors, correlated residuals, additional cross-factor loadings | 469 (208) | .91 | .05 | .06 | 19744 | 20145 |
| III: Revised five factor models | | | | | | |
| 7. Five factors, uncorrelated residuals | 954 (220) | .74 | .07 | .08 | 20393 | 20741 |
| 8. Five factors, correlated residuals | 555 (211) | .88 | .05 | .07 | 19858 | 20246 |
| 9. Five factors, correlated residuals, additional cross-factor loadings | 449 (207) | .91 | .04 | .05 | 19727 | 20132 |

[1] Model chi square goodness of fit and degrees of freedom. In well-fitting models, ratio of chi square to df should be close to one.
[2] Comparative Fit Index (CFI). A model CFI over .90 indicates adequate fit, over .95 excellent fit.
[3] Root Mean Square Error of Approximation (RMSEA). In well-fitting models, RMSEA should be less than .05
[4] Standardised Root Mean Square Residual (SRMR). In well-fitting models, SRMR should be close to zero
[5] Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC). When comparing a series of alternative models, the model with the smallest value of AIC or BIC is considered to be the best fitting model.

**Table 5:** Factor loadings (standardised) for revised five factor Model 9

| Symptom Parcel[a] | Borderline | Antisocial | Detached | Anankastic | Negative Affective |
|---|---|---|---|---|---|
| (1) His1 His4 | .44 | | - | - | - |
| (2) His2, His3, His7 | .53 | | - | - | - |
| (3) Nar1 Nar2 | .57 | | - | - | - |
| (4) Nar5 Nar6 Nar7 | .39 | | - | - | - |
| (5) Bor1 Bor3 Bor5 | .62 | | - | - | .08[b] |
| (6) Bor6 Bor7 | .42 | | - | - | .27 |
| (7) Bor4 Bor8 | .42 | | - | - | - |
| (8) As1 As2 | | .76 | - | - | - |
| (9) As4 As6 As7 | | .82 | - | - | - |
| (10) As3 As5 | | .73 | - | - | - |
| (11) Par6 | .42 | | - | - | - |
| (12) Szo1 Szo2 Szo3 Szo4 | - | | .46 | - | - |
| (13) Szo5 Szo6 Szo7 | - | | .79 | - | - |
| (14) Szt6 Szt7 Szt8 | - | | .86 | - | - |
| (15) Szt9 | - | | - | - | .50 |
| (16) Oc1 Oc2 | - | | - | .63 | - |
| (17) Oc3 Oc4 Oc5 | - | | - | .72 | - |
| (18) Oc6 Oc7 Oc8 | - | | - | .49 | - |
| (19) Av4 Av7 | - | | - | .14 | .42 |
| (20) Av1 Av2 | - | | - | - | .50 |
| (21) Av3 Av5 Av6 | - | | - | - | .59 |
| (22) Dep1 Dep5 Dep7 | - | | - | - | .54 |
| (23) Dep3 Dep6 Dep8 | - | | - | - | .52 |

[a] Abbreviations for DSM PD symptom criteria: His – Histrionic; Nar – Narcissistic; Bor – Borderline; As – Antisocial; Par – Paranoid; Szo – Schizoid; Szt – Schizotypal; Oc – Obsessive compulsive; Av – Avoidant; Dep - Dependent

[b] parameter not statistically significant $p>.05$, all other parameters $p<.01$

- Proposed ICD11 domain structure partially validated
- Detached and Anankastic closely match hypothesised domains
- Negative affective more constrained – mainly DSM5. Avoidant and Dependent PD symptoms

- No evidence of distinct Disinhibited domain.
- Single Dissocial/Disinhibited domain.
- Separate Antisocial domain.

# Domains

- Detached
- Anankastic
- Negative Emotional
- Antisocial (Dissocial)
- “Borderline”

# Forensic data set (n=1620)

- Split half sample approach
  a) test the original 5 factor model
  b) test and refine the revised 5 factor model from the Christchurch data

# Results

- Both models improved goodness of fit (Comparative Fit Index (CFI) 0.93 for both)
- Probably related to higher base rates of symptoms in the forensic data

Table 4. Factor loadings (standardized) for five-factor model in test sample.

| Symptom parcel[1] | Borderline | Antisocial | Detached | Anankastic | Negative Affective |
|---|---|---|---|---|---|
| (1) His1 His4 | 0.50 | — | — | — | — |
| (2) His2, His3, His7 | 0.51 | — | — | — | — |
| (3) Nar1 Nar2 | 0.52 | — | — | — | — |
| (4) Nar5 Nar6 Nar7 | 0.18 | 0.55 | — | — | — |
| (5) Bor1 Bor3 Bor5 | 0.30 | — | — | — | 0.27 |
| (6) Bor6 Bor7 | 0.39 | — | — | — | 0.30 |
| (7) Bor4 Bor8 | — | 0.61 | — | — | — |
| (8) As1 As2 | — | 0.58 | — | — | — |
| (9) As4 As6 As7 | — | 0.79 | — | — | — |
| (10) As3 As5 | — | 0.66 | — | — | — |
| (11) Par6 | 0.38 | 0.22 | — | — | — |
| (12) Szo1 Szo2 Szo3 Szo4 | — | — | 0.61 | — | 0.15 |
| (13) Szo5 Szo6 Szo7 | — | — | 0.90 | — | — |
| (14) Szt6 Szt7 Szt8 | — | — | 0.72 | — | 0.22 |
| (15) Szt9 | — | — | 0.14 | — | 0.48 |
| (16) Oc1 Oc2 | — | — | — | 0.54 | — |
| (17) Oc3 Oc4 Oc5 | — | — | — | 0.64 | — |
| (18) Oc6 Oc7 Oc8 | — | 0.30 | — | 0.45 | — |
| (19) Av4 Av7 | — | — | — | — | 0.70 |
| (20) Av1 Av2 | — | — | — | — | 0.65 |
| (21) Av3 Av5 Av6 | — | — | — | — | 0.73 |
| (22) Dep1 Dep5 Dep7 | 0.24 | — | — | — | 0.27 |
| (23) Dep3 Dep6 Dep8 | — | — | — | — | 0.52 |

[1]Abbreviations for DSM PD symptom criteria: His, Histrionic; Nar, Narcissistic; Bor, Borderline; As, Antisocial; Par, Paranoid; Szo, Schizoid; Szt, Schizotypal; Oc, Obsessive compulsive; Av, Avoidant; Dep, Dependent.

# Results of repeating original analysis

- Same problems as in the Christchurch sample despite higher base rates of disinhibited, dissocial and detached symptoms.
- Very similar domains emerge
- Some differences
  - Borderline symptoms load on negative affective domain and antisocial domain in addition to the “borderline” domain
  - Some obsessive symptoms load weakly on antisocial domain

Table 2. Factor loadings (standardized) for five-factor model in analysis sample.

| Symptom parcel[1] | Borderline | Antisocial | Detached | Anankastic | Negative Affective |
|---|---|---|---|---|---|
| (1) His1 His4 | 0.43 | — | — | — | — |
| (2) His2, His3, His7 | 0.58 | — | — | — | — |
| (3) Nar1 Nar2 | 0.48 | — | — | — | — |
| (4) Nar5 Nar6 Nar7 | 0.21 | 0.53 | — | — | — |
| (5) Bor1 Bor3 Bor5 | 0.22 | — | — | — | 0.45 |
| (6) Bor6 Bor7 | 0.25 | — | — | — | 0.46 |
| (7) Bor4 Bor8 | — | 0.62 | — | — | — |
| (8) As1 As2 | — | 0.66 | — | — | — |
| (9) As4 As6 As7 | — | 0.77 | — | — | — |
| (10) As3 As5 | — | 0.67 | — | — | — |
| (11) Par6 | 0.13 | 0.40 | — | — | — |
| (12) Szo1 Szo2 Szo3 Szo4 | — | — | 0.49 | — | 0.26 |
| (13) Szo5 Szo6 Szo7 | — | — | 0.95 | — | — |
| (14) Szt6 Szt7 Szt8 | — | — | 0.63 | — | 0.19 |
| (15) Szt9 | — | — | 0.11 | — | 0.52 |
| (16) Oc1 Oc2 | — | — | — | 0.58 | — |
| (17) Oc3 Oc4 Oc5 | — | — | — | 0.60 | — |
| (18) Oc6 Oc7 Oc8 | — | 0.35 | — | 0.42 | — |
| (19) Av4 Av7 | — | — | — | — | 0.70 |
| (20) Av1 Av2 | — | — | — | — | 0.67 |
| (21) Av3 Av5 Av6 | — | — | — | — | 0.73 |
| (22) Dep1 Dep5 Dep7 | 0.22 | — | — | — | 0.31 |
| (23) Dep3 Dep6 Dep8 | — | — | — | — | 0.54 |

[1]Abbreviations for DSM PD symptom criteria: His, Histrionic; Nar, Narcissistic; Bor, Borderline; As, Antisocial; Par, Paranoid; Szo, Schizoid; Szt, Schizotypal; Oc, Obsessive compulsive; Av, Avoidant; Dep, Dependent.

# Results

- Revised 5 factor model replicated in a forensic sample
- Some additional cross-factor loadings for some item parcels
- Notably borderline symptoms loaded more strongly on the negative affective domain and the antisocial domain than on the “borderline” domain
- Some OCD items loaded on antisocial domain
- Some narcissistic items loaded on antisocial domains

# Results

Detached Domain

- DSM-5 schizoid but adds some schizotypal symptoms
- Closely replicated in Christchurch and Forensic sample
- Consistent with clinical and historical concepts of schizoid behaviour

# Results

Anankastic Domain

- DSM 5 obsessive-compulsive PD
- Closely replicated in Christchurch and forensic sample
- Consistent with clinical and historical concepts of obsessive personality

# Results

Antisocial (Dissocial) Domain

- In Christchurch sample closely replicates DSM-5 ASPD
- In Forensic sample an enriched description emerges – now includes:
  - narcissistic criteria – sense of entitlement, interpersonally explorative, lacks empathy
  - borderline criteria – impulsivity, inappropriate intense anger
  - Obsessive-compulsive criteria – miserly, rigidity, insistence on others submitting to their way of doing things
- Consistent with clinical and historical concepts of ASPD

# Results

Negative Affective Domain

- Strong association between dependent and avoidant criteria in both samples
- Includes some borderline PD criteria in forensic samples

# Results

"Borderline" Domain ( Disinhibited)

- DSM histrionic, narcissistic, and some borderline criteria
- In forensic sample borderline criteria also align with negative affective domain and antisocial domain

# Limitations

- Domains derived from existing DSM-5 PD symptoms limiting their ability to identify and define non-DSM varieties of personality pathology.
- DSM-5 symptoms unlikely to represent all forms of personality pathology that a clinician is likely to encounter.
- No statistical procedure should be regarded as a mechanical truth generator

Meehl (1992), J. of Personality; 60:175-215

# Conclusions

- Detached, anankastic and dissocial domains consistent across samples and with clinical and historical concepts
- Negative affective domain consistently encompasses avoidant and dependent criteria and in some samples borderline criteria
- ‘Borderline’ domain is the least consistent domain incorporated histrionic, narcissistic and borderline criteria but the strength of the association varies in different samples

# Conclusions

- 4 or 5 domains appear sufficient for clinical purposes
- The most difficult to describe is non-ASPD externalising behaviour including borderline, histrionic and narcissistic criteria-we have tentatively called this disinhibited (again).
- Negative affective appears similar to avoidant-dependent criteria (neuroticism) in some samples but incorporate borderline criteria in others

# Conclusions

5 Domains

- Detached
- Anankastic
- Dissocial
- Negative affective
- Disinhibited

# Future

- Development of clinical interview based on the most discriminate criteria in the analyses
  - Detached  - 4 questions
  - Anankastic – 4 questions
  - Dissocial – 4 questions
  - Negative Affective – 8 questions
  - Disinhibited-? number questions
- Testing of the consistency and clinical utility of domains