The two main reasons, we suspect, why most health professionals shy away from assessing personality status is that it is considered both too complicated and too risky. The risky aspect is discussed in Chapter 9 in dealing with stigma. In this chapter, the process of assessment is taken in stages in a form that everybody can appreciate without prior knowledge of the subject. Throughout the book we will be putting the main focus on the new ICD-11 classification of personality disorder, but the general principles of assessment apply to all ways of looking at personality disorder.

We are also assuming in this chapter that the reader has a fair knowledge of psychiatric assessment, but the first stages apply to all health professionals, including general practitioners, who are involved in patient care. The main message here is to emphasise that personality assessment is not just a task for the specialist.

2.1 Preliminary Stage

Six elements are essential when assessing personality (Table 2.1).

These six areas are covered in any good clinical assessment, and once the ancillary questions are answered the assessor should be able to at least make a rough impression of personality status. Please note that this assessment can be completed in a 20–30-minute clinical interview.

From this interview, it is relatively easy to place the person’s current personality status on the scale above. Some will baulk at the idea that after a short interview it is possible to make an assessment of personality status, still less to disclose this to the patient. To use a comment on the MIND website: ‘being given a diagnosis or label of personality disorder can feel as if you’re being told there’s something wrong with who you are’ (MIND, 2020). The important two words here are ‘can feel’. If the information is conveyed in the right way, it can be construed as valuable and positive.

The first task is to use the personality spectrum in Figure 2.1 to place the person at an approximate point. It will be extremely rare for anyone with severe personality disorder to be seen without clear evidence of serious dysfunction already being known, so the clinician is likely to be looking at placing the person somewhere on one of the three lower levels of severity, or in the no personality dysfunction group. One difficulty here will be in separating the problems created by current mental state symptoms from the difficulties of personality function. This is best clarified by checking on timescales. If the problems posed by personality difficulties are long-lasting (which they usually will be) and the mental state ones have clear beginnings and ends, then it is possible to conclude that the personality problems are likely to be independent. But in some instances (e.g. in chronic anxiety disorders beginning
in childhood), it may be more difficult. In these instances, it is easy to forget about the personality and decide on an anxiety diagnosis. For many reasons, including the unsatisfactory nature of the diagnosis of generalised anxiety disorder (Tyrer and Baldwin, 2006; Tyrer, 2018) as well as its treatment implications (see Chapter 10), it might be preferable to think of the personality diagnosis first.

It would be arrogant and wrong to recommend here exactly what should be said to the patient after this initial personality assessment has been made. Many would feel it wise to say

Table 2.1 Essential first elements of personality assessment

<table>
<thead>
<tr>
<th>Questions to ask after clinical assessment</th>
<th>Strands of relevant evidence</th>
<th>Follow-up questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there any evidence of interpersonal social dysfunction?</td>
<td>Difficulties expressed in family/child/occupation during interview</td>
<td>Is this problem only with this person? Does it apply to others too?</td>
</tr>
<tr>
<td>Is the dysfunction persistent?</td>
<td>History of problem will indicate if same problem is repeated</td>
<td>How long (or how many times) has this problem lasted?</td>
</tr>
<tr>
<td>Does it only show itself in certain situations?</td>
<td>Determine places and times of difficulties</td>
<td>Would other people (in different situations) be aware of this?</td>
</tr>
<tr>
<td>Has the person the ability to perform appropriate societal roles?</td>
<td>Determine if present role is consistent with past training and education</td>
<td>Do you think you are working at the right level for you?</td>
</tr>
<tr>
<td>Is there any risk of harm to self or others?</td>
<td>History should include any episodes of violence or self-harm</td>
<td>What were the circumstances of these episodes? How often are/were they?</td>
</tr>
<tr>
<td>Are there other mental state problems?</td>
<td>If personality problems are conspicuous, there will almost certainly be evidence of other mental illness (and often this is how the person will present)</td>
<td>Do you think your difficulties with other people are linked to your other symptoms (of the relevant mental illness)?</td>
</tr>
</tbody>
</table>

Figure 2.1 The full spectrum of personality. Note that all are on this spectrum somewhere.
nothing and just make an entry in the notes, but we have found that the following approach can be very effective:

My assessment suggests you have (the current mental state problem) and this may be complicated by your personality (structure). I get the impression, but please correct me if I have it wrong, that you have long/always been a person with difficulties in relationships with (give examples), and this has not helped. Have I described this correctly?

These introductory remarks set off a dialogue that can correct or reinforce the initial impression. Very rarely, there is the angry question: ‘Are you saying I have a personality disorder?’ The best way of responding to this is to point out that all of us have personalities, and to varying degrees they can cause difficulties, so there is nothing particularly special about this line of questioning. At the end of the interview, assuming that you have concluded that there is some degree of personality disorder present, you can disclose this to the patient, not in terms of personality disorder but personality function. The only element of personality that can be assessed accurately at just one point in time is personality function, not disorder. This is a critical point, emphasised in more detail elsewhere (Tyrer et al., 2007), and it illustrates the great variation in personality status over time that is mentioned in Chapter 8. There is also good evidence that the more severe personality disorders (using ICD-11 notation) are more persistent than less severe ones over a 12-year period (Tyrer et al., 2016b), so a diagnosis lower in the spectrum should be regarded as more provisional than for severe disorders.

The way this should be communicated to the patient is along the lines of, ‘At present your personality function is poor, in that it is contributing to your distress. We must take this into account in deciding how to help you.’ You could also add, ‘This does not mean that you necessarily have a personality disorder as this could easily change.’

Some people might well ask whether it is worthwhile going to all this trouble on the basis of inadequate information. The critical point here is that you are flagging up personality status at the initial interview and may need to return to this later. More importantly, it may influence choice of treatment (see Chapter 8). In the ICD-11 and DSM-5 classifications there is no Axis II, which used to be a separate axis for personality, and so there is a real danger that personality problems might be neglected altogether (Newton-Howes et al., 2015b). What unfortunately happens, far too often in practice, is that initial personality status is ignored and it is only when the patient has failed to respond as expected to treatment that a retrospective diagnosis is made of personality disorder. This is a slur on the diagnosis and is one of the main contributors to stigma.

In this chapter, we will be concentrating on assessments linked to the new classifications for personality disorder, ICD-11 and the alternative model for DSM-5. The original DSM-5 model was rejected by the American Psychiatric Association and placed in the category for further study; it has been only modified slightly and has been reinforced by additional empirical data. The DSM Alternative Model for Personality Disorder (AMPD) and ICD-11 classifications appear at first sight to be very different but in fact share many similarities.

### 2.2 Previous Classifications

At the time of writing the ICD-10 classification of personality disorder is still extant but will be replaced by ICD-11 on 1st January 2022. The radical change between the ICD-10 and
ICD-11 is the abolition of categorical diagnosis of personality disorder and its replacement by a single spectrum of personality pathology. The need for change was driven by the absence of empirical support for the 9–10 different categories, a massive degree of overlap between the criteria for different categories (wrongly described as comorbidity), the failure to use these categories in practice apart from borderline and emotionally unstable, with lesser support for antisocial and dissocial, and the wide use of ‘mixed personality disorder’ and ‘personality disorder – not otherwise specified (personality disorder–NOS)’ by clinicians who were just bemused by the confusing advice on offer.

All the existing categories of personality disorder will cease to exist in ICD after January 2022 with the exception of a ‘borderline pattern specifier’. This, we stress again, is not a diagnosis but can be used by those who wish to maintain continuity with the old classification.

2.3 Diagnosis of Personality Disorder in ICD-11

2.3.1 Assessment of Severity

This is outlined above in principle but needs to be defined more clearly to determine the exact level of severity on the personality spectrum. Ideally every patient seen in clinical practice should be expected to have at least some assessment of personality status at an early stage. This would not just apply to psychiatrists but to all health professionals. In the present climate of stigma the implementation of this suggestion is a long way off, but it is still desirable. The reasons for making this suggestion are clarified in Chapters 7 and 8, as awareness of personality status should influence the treatment and management strategy being offered.

The severity spectrum is simple, and because it is so important it is presented here again (Figure 2.2).

The details of the classification are shown in Table 2.2. The most important difference distinguishing ICD-11 from ICD-10 is the complete absence of overlap with other personality groupings. Everybody, at any point in time, is in one place on Figure 2.2; it is impossible to be in more than one.

![Figure 2.2](https://doi.org/10.1017/9781108951685.003) The need for a dichotomous separation of personality disorder for epidemiological purposes.
Table 2.2 The ICD-11 definitions for each level of severity of personality disorder.

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild Personality Disorder</strong></td>
<td>All general diagnostic requirements for Personality Disorder are met. Disturbances affect some areas of personality functioning but not others (e.g., problems with self-direction in the absence of problems with stability and coherence of identity or self-worth), and may not be apparent in some contexts. There are problems in many interpersonal relationships and/or in performance of expected occupational and social roles, but some relationships are maintained and/or some roles carried out. Specific manifestations of personality disturbances are generally of mild severity. Mild Personality Disorder is typically not associated with substantial harm to self or others, but may be associated with substantial distress or with impairment in personal, family, social, educational, occupational or other important areas of functioning that is either limited to circumscribed areas (e.g., romantic relationships; employment) or present in more areas but milder.</td>
</tr>
<tr>
<td><strong>Moderate Personality Disorder</strong></td>
<td>All general diagnostic requirements for Personality Disorder are met. Disturbances affect multiple areas of personality functioning (e.g., identity or sense of self, ability to form intimate relationships, ability to control impulses and modulate behaviour). However, some areas of personality functioning may be relatively less affected. There are marked problems in most interpersonal relationships and the performance of most expected social and occupational roles are compromised to some degree. Relationships are likely to be characterised by conflict, avoidance, withdrawal, or extreme dependency (e.g., few friendships maintained, persistent conflict in work relationships and consequent occupational problems, romantic relationships characterised by serious disruption or inappropriate submissiveness). Specific manifestations of personality disturbance are generally of moderate severity. Moderate Personality Disorder is sometimes associated with harm to self or others, and is associated with marked impairment in personal, family, social, educational, occupational or other important areas of functioning, although functioning in circumscribed areas may be maintained.</td>
</tr>
<tr>
<td><strong>Severe Personality Disorder</strong></td>
<td>All general diagnostic requirements for Personality Disorder are met. There are severe disturbances in functioning of the self (e.g., sense of self may be so unstable that individuals report not having a sense of who they are or so rigid that they refuse to participate in any but an extremely narrow range of situations; self-view may be characterised by self-contempt or be grandiose or highly eccentric). Problems in interpersonal functioning seriously affect virtually all relationships and the ability and willingness to perform expected social and occupational roles is absent or severely compromised. Specific manifestations of personality disturbance are severe and affect most, if not all, areas of personality functioning. Severe Personality Disorder is often associated with harm to self or others, and is associated with severe impairment in all or nearly all areas of life, including personal, family, social, educational, occupational, and other important areas of functioning.</td>
</tr>
</tbody>
</table>

(World Health Organization, 2018, 6D10 Personality disorder)

NB. The definition of personality difficulty is part of this classification and is described in Chapter 3. It is not included here as it is not a diagnosed psychiatric disorder.

https://doi.org/10.1017/9781108951685.003 Published online by Cambridge University Press
2.3.2 Generic Definition of Personality Disorder

Although the ICD-11 classification is a radical change from ICD-10, the general description of personality disorder is remarkably similar in both classifications:

Personality disorder is characterised by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others’ perspectives and to manage conflict in relationships) that have persisted over an extended period of time (e.g., 2 years or more). The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated) and is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles). The patterns of behaviour characterizing the disturbance are not developmentally appropriate and cannot be explained primarily by social or cultural factors, including socio-political conflict. The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

(World Health Organization, 2018, 6D10 Personality disorder)

The most noteworthy difference is the phrase ‘persisted over an extended period of time (e.g. 2 years or more)’. No timescale of onset is indicated, so in practice it is possible to diagnose personality disorder at any age from 10 to 100. The implications of this are discussed in Chapter 10.

All patients with mild, moderate and severe personality disorder have to satisfy the general description of the condition. The separation of the three further groups is shown in Table 2.2.

2.3.3 ICD-11 Trait Domain Qualifiers

The general view of those psychiatrists with a special interest in personality disorders, at least before 2010, was that the individual categories such as narcissistic, antisocial and borderline had clinical meaning and could not be linked to normal variation. This was expressed by the criticism of the ICD-11 proposal as promoting the ‘still unproved idea that normal personality offers a valid bridge to the structure of abnormal personality’ (Gunderson and Zanarini, 2011). At the same time, a large majority of general psychiatrists was expressing its views in a different way – by hardly ever diagnosing personality disorder.

The critical decision of the ICD-11 working group was to incorporate all personality disturbance into a single spectrum and to accept that the categories given credence by long standing had no intrinsic validity and should be abandoned. But in other ways some aspects of the categories were relevant and could be represented as domain traits. These could be then be used to qualify the level of severity of personality disorder.

This was difficult to accept for many. Although there was strong consensus that DSM-IV and ICD-10 personality disorder categories were unsatisfactory and should be replaced (Bernstein et al., 2007b), there was no consistency on what should be brought in to replace them (Mulder et al., 2011). Instead, there was a wide range of strongly held, often opposing, views. Some who commented, including a voluble group of patients, felt that all diagnoses of personality were stigmatising and should be discarded. There is partial justification for their views, as is explained in Chapters 9 and 10, but it is not a constructive option, except for some at low levels of personality disturbance who feel that their difficulties can be expressed
differently. Others, including patients, researchers and clinicians, supported the existence of specific personality disorders, particularly the borderline category, and they were very concerned that it should remain in some form in any new classification (Bateman, 2011). Even those who advocated for one of the most overused phrases in science, a ‘paradigm shift’, had very different views on exactly what form this shift should take. This chapter reviews these positions and attempts to show that the ICD-11 system is the most relevant and accurate in its descriptions of personality pathology.

First, it is important to realise that early on, a conscious decision was made to separate the two issues of 'disorder' and 'behavioural manifestations'. The first part of this chapter discusses using severity as the marker of disorder. This part describes the behavioural manifestations. These replace the rigid categories in previous systems, none of which had any nosological status; all were clinical groupings decided by expert committees operating by opinion, not knowledge.

Second, the description of behavioural disturbance was constrained by the need for the descriptions to be reasonably concise, for practical reasons, as well as being clinically useful. The descriptors needed to be useful in all medical settings in all WHO countries and not just appeal to the small number of specialist personality disorder services. The importance of this cannot be overstated. Most descriptions of personality pathology were designed and used by personality disorder specialists who have the time and motivation to undertake comprehensive assessments, usually in high-income countries. In contrast, most working clinicians across the world do not have the luxury of time. We believe that an evidence-based simple classification is more likely to be used by a range of clinicians. Because, as we hope this book will show you, personality disorders are such important factors in treatment and outcome in mental and physical disorders, widespread use of basic personality descriptions is preferable to detailed assessments confined to specialists’ clinics. In any case, specialist personality disorder clinics can always go beyond the ICD-11 categories if they wish.

Third, it was felt that linking personality disorder descriptors with models describing personality in community samples would be useful if evidence supported this. There is little doubt that personality pathology occurs on a continuum, however it is described. The logical consequence of this is that a dimensional descriptor of personality pathology would relate, in some way, to normally distributed personality dimensions.

Since the descriptors needed to be evidence-based, we systematically reviewed all studies which had explored the factor structure of patients with personality pathology. Our first observation was that the studies were very heterogeneous. They used different types of samples, including inpatients, outpatients and 'normal' subjects. They employed different models of personality pathology, varying methods to assess personality (including self-report and interviews) and subjected the findings to different statistical manipulations. Our second observation was that despite all their variability, the results were surprisingly consistent (Mulder et al., 2011).

All studies supported a general ‘personality distress’ dimension sharing common features such as generalised distress, low agreeableness, reduced flexibility and interpersonal difficulties. All studies also reported, in one form or another, two further dimensions. The first, usually largest with regard to explaining variance, is an externalising factor which incorporates symptoms then conceptualised as histrionic, narcissistic, borderline, anti-social and often paranoid personality disorder, in the ICD-10 and DSM-5 diagnostic systems.
The second factor, often called an internalising factor, is best represented as a mixture of avoidant and dependent personality disorder traits. Characteristics include shyness, anxious behaviour, pessimism and passivity.

Although not found in all studies, the third higher-order factor is what was generally conceptualised as schizoid behaviours: social indifference, aloofness and restricted expression of affect. In some studies, these behaviours overlapped with odd behaviours represented by schizotypal symptoms, in others, less so. Many people with this feature, as you might imagine, do not get included often in clinical studies.

A fourth factor also found in most, but not all, studies, was represented by obsessive-compulsive or anankastic symptoms and traits. In most studies which reported it, this factor was separated from the internalising factor. However, the factor seemed robust and relatively independent of all other symptoms of personality disorder.

Although these four factors were reported reasonably consistently across the reviewed studies and had good face validity, two problems were soon apparent. The first was that the externalising factor was broad and included important clinical symptoms conceptualised within the diagnoses of antisocial personality disorder and psychopathy. Traits such as callousness, lack of remorse and antisocial behaviour were part of externalising behaviours, but, some of the studies reported, loaded as a separate dimension (Dowson and Berrios, 1991; O’Boyle, 1995). After considerable debate within the ICD-11 group, a fifth factor, disinhibition, essentially trying to capture non-psychopathic externalising behaviours, was introduced for further study. This left the elephant in the room, borderline personality disorder, which despite being the most studied and venerated personality disorder, did not fit comfortably within any of these factors.

The ICD-11 proposal therefore consisted of five broad descriptions of personality pathology called trait domain qualifiers. These are not categorical syndromes but descriptive domains used ‘to describe the characteristics of the individual that are most prominent and that contribute to personality disturbance’ (World Health Organization, 2018, 6D11 Prominent personality traits or patterns). These domains, with some minor modifications, were accepted in ICD-11. They are described in Table 2.3 (https://icd.who.int/en).

2.4 Psychopathy and Personality Disorder

The word ‘psychopath’ has been used indiscriminately over the last 200 years in connection with personality disorder, but in recent years it has been focused on part of what is now the dissociative domain in ICD-11. The key authority in this area is Robert Hare, whose core publication, the Psychopathy Check List (revised version PCL-R, published in 2003), developed this in the 1970s after studying the pioneer work of Hervey Cleckley (1941). Cleckley identified 21 characteristics of psychopathy entirely from his clinical experience. Many of these became part of Hare’s Psychopathy Check List, particularly in its revision in 2003 (PCL-R):

Cleckley’s original 21 items comprising the essentials of psychopathy (Cleckley, 1941)

1. Superficial attractiveness (glibness/superficial charm⁠\(^a\))
2. Apparently free from any neurotic or psychotic symptom
3. Little or no sense of personal responsibility (irresponsibility⁠\(^a\))
4. Disregard for the truth (pathological lying⁠\(^a\))
5. Does not accept blame for their actions (failure to accept responsibility for own actions⁠\(^a\))
6. Has no sense of shame (lack of remorse or guilt⁠\(^a\))
Table 2.3  ICD-11 Prominent personality traits or patterns

**6D11.0 Negative affectivity in personality disorder or personality difficulty**
The core feature of the Negative Affectivity trait domain is the tendency to experience a broad range of negative emotions. Common manifestations of Negative Affectivity, not all of which may be present in a given individual at a given time, include: experiencing a broad range of negative emotions with a frequency and intensity out of proportion to the situation; emotional lability and poor emotion regulation; negativistic attitudes; low self-esteem and self-confidence; and mistrustfulness.

**6D11.1 Detachment in personality disorder or personality difficulty**
The core feature of the Detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment). Common manifestations of Detachment, not all of which may be present in a given individual at a given time, include: social detachment (avoidance of social interactions, lack of friendships, and avoidance of intimacy); and emotional detachment (reserve, aloofness, and limited emotional expression and experience).

**6D11.2 Dissociality in personality disorder or personality difficulty**
The core feature of the Dissociality trait domain is disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy. Common manifestations of Dissociality, not all of which may be present in a given individual at a given time, include: self-centeredness (e.g., sense of entitlement, expectation of others’ admiration, positive or negative attention-seeking behaviours, concern with one’s own needs, desires and comfort and not those of others); and lack of empathy (i.e., indifference to whether one’s actions inconvenience hurt others, which may include being deceptive, manipulative, and exploitative of others, being mean and physically aggressive, callousness in response to others’ suffering, and ruthlessness in obtaining one’s goals).

**6D11.3 Disinhibition in personality disorder or personality difficulty**
The core feature of the Disinhibition trait domain is the tendency to act rashly based on immediate external or internal stimuli (i.e., sensations, emotions, thoughts), without consideration of potential negative consequences. Common manifestations of Disinhibition, not all of which may be present in a given individual at a given time, include: impulsivity; distractibility; irresponsibility; recklessness; and lack of planning.

**6D11.4 Anankastia in personality disorder or personality difficulty**
The core feature of the Anankastia trait domain is a narrow focus on one’s rigid standard of perfection and of right and wrong, and on controlling one’s own and others’ behaviour and controlling situations to ensure conformity to these standards. Common manifestations of Anankastia, not all of which may be present in a given individual at a given time, include: perfectionism (e.g., concern with social rules, obligations, and norms of right and wrong, scrupulous attention to detail, rigid, systematic, day-to-day routines, hyper-scheduling and planfulness, emphasis on organisation, orderliness, and neatness); and emotional and behavioural constraint (e.g., rigid control over emotional expression, stubbornness and inflexibility, risk-avoidance, perseveration, and deliberativeness).

(World Health Organization, 2018)
7 ‘Undependable’ – cheats and lies without any compunction (pathological lying\(^a\))
8 ‘Execrable’ judgement
9 Inability to learn or profit from experience (lack of realistic long-term goals\(^a\))
10 Gross egocentricity (grandiose sense of self-worth\(^a\))
11 Poverty of affect with no depth of feeling (shallow affect\(^a\))
12 Lacking insight cannot see self as others see them (callous/lacking empathy\(^a\))
13 No appreciation for kindness or consideration shown by others (parasitic lifestyle\(^a\))
14 Alcohol indulgences
15 When drinking ‘places self in disgraceful or ignominious position seeking a state of stupefaction
16 Not suicidal
17 Sex life shows peculiarities with interest in casual sex (promiscuous sexual behaviour\(^a\))
18 No evidence of familial inferiority or heredity
19 No evidence of early maladjustment
20 Inability to follow any plan consistently
21 Has a life plan that ends in failure

\(^a\)Concepts that have been retained in Hare’s PCL-R (2003) instrument.

Apart from the alcohol elements, not now considered to be unrelated to personality directly (but see Chapter 7), most of these items constitute the PCL-R.

The PCL-R has become the lodestone of psychopathy. A score on the scale of 30 is said to be diagnostic of psychopathy and one between 25 and 29 being strongly indicative of the disorder. How does this square with moderate and severe personality disorder in the ICD-11 classification?

The conclusion reached by our ICD-11 working group was that the case to have psychopathy introduced as a separate domain in the classification was very weak. The main features of classical Cleckleyan psychopathy were all encapsulated within the dissociality domain. This conclusion chimes with the conclusion of Essi Viding, who has performed ground-breaking work on the genetics of personality disturbance in childhood. There has been much interest in callous and unemotional traits in young people, and the Viding group have suggested that it is these traits that are genetically determined and might be the core of psychopathy (Viding et al., 2005). But despite this, Essi Viding (2019) has concluded that the domain of psychopathy, although having some elements particular to its own, lies within the area of antisociality. There are small differences – Venables et al. (2014) show the core psychopath has more ‘boldness’ – but much of this can be explained by native intelligence. A cunning and manipulative classical psychopath is much more likely to impress than a 20 year recidivist who is trying to con.

The finding of a genetic component to psychopathy is also important to notice, as ever since Lee Robins’ influential book (1966) on the long-term outcome of childhood deviance there has been a tendency to overplay early environment as the main instigator of adult antisocial behaviour and the consequent term ‘sociopathy’. As Viding puts it, ‘the genetic propensity is of course not a destiny, but again highlights the fact that there are children who are more vulnerable than others and we should not shy away from identifying and helping them. I think “personality disorder in development” could be a helpful development in this regard’ (E. Viding 2020, personal communication, 14 December 2020).
2.5 What about Borderline Personality Disorder?

As noted previously, borderline personality disorder symptoms have a complex relationship with the ICD-11 model, and with all personality trait models. As discussed in Chapter 4, borderline personality disorder did not emerge from personality trait models and most features of borderline personality disorder are clinical symptoms rather than personality traits (Tyrer, 2009b). No factor analytic studies have supported a categorical borderline personality disorder factor (Sharp, 2016). It seems better to regard borderline personality disorder as a general personality factor (Sharp et al., 2015), possibly related to severity. Within the ICD-11 domains, it is strongly related to disinhibition and negative affectivity and moderately related to dissociality.

Nevertheless, despite this overwhelming evidence, challenging the existence of borderline personality disorder led to alarm. In particular, clinicians specialising in the treatment of borderline personality disorder, especially those with substantial research grants, supported strongly the retention of the diagnosis in its present form. They pointed out that borderline personality disorder was the most researched personality disorder category with regard to treatment and aetiology (Herpertz et al., 2017), and it should be retained regardless of its validity. A political compromise was eventually reached with the ICD-11 Classification Committee and an optional ‘borderline pattern qualifier’ was added to the five domains. This is defined in Table 2.4.

2.6 Measurement of ICD-11 Domains: Reliability and Validity

Because ICD-11 has only just been approved by the World Health Organization, instruments to measure severity and domains have only been developed very recently. Initial reliability and validity studies used older diagnostic measures. A Korean study using DSM-IV personality disorder symptoms reported that the anankastic, detached and dissocial domains were coherent and discriminated well. However, the other two domains, emotionally unstable and anxious/dependent (as they were then called), were less robust and seemed to be more diffuse (Kim et al., 2015). In a large sample of 606 depressed outpatients, DSM-IV personality disorder symptoms were independently assigned by two raters to the five ICD-11 domains and a confirmatory factor analysis in an exploratory framework was used.

<table>
<thead>
<tr>
<th>Table 2.4 ICD-11 Definition of borderline personality disorder</th>
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<tbody>
<tr>
<td><strong>6D11.5 Borderline pattern</strong></td>
</tr>
<tr>
<td>The Borderline pattern descriptor may be applied to individuals whose pattern of personality disturbance is characterised by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by many of the following: Frantic efforts to avoid real or imagined abandonment; A pattern of unstable and intense interpersonal relationships; Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self; A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours; Recurrent episodes of self-harm; Emotional instability due to marked reactivity of mood; Chronic feelings of emptiness; Inappropriate intense anger or difficulty controlling anger; Transient dissociative symptoms or psychotic-like features in situations of high affective arousal.</td>
</tr>
<tr>
<td>(World Health Organization, 2018)</td>
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https://doi.org/10.1017/9781108951685.003 Published online by Cambridge University Press
The best fitting model produced five domains with anankastic, detached and dissocial domains closely matching the ICD-11 proposal. The negative affectivity and disinhibition domains were less distinctly represented (Mulder et al., 2016), but it should be mentioned that not many of the relevant terms for these items appear in the DSM classification.

Bo Bach and colleagues developed an ICD-11 trait domain algorithm for the Personality Inventory for DSM-5 (PID-5), a diagnostic instrument developed for the DSM-5 Alternative Model for Personality Disorders (AMPD) which has been widely used. They reported that the ICD-11 and AMPD domains were largely compatible. The ICD-11 traits were organised in a hierarchal structure with a single personality disorder pathology domain at the top and the five ICD-11 domains at the lower level (Figure 2.3) (Bach et al., 2017).

A further study in psychiatric outpatients showed relative continuity with traditional categorical personality disorders and captured most of their information (Bach et al., 2018). Further support for the initial structural validity of ICD-11 has come from an Iranian sample (Lotfi et al., 2018).

Figure 2.3 The hierarchical structure of personality disturbance. (Bach et al., 2017)
Bach and colleagues also used the PID-8 to allocate ICD-11 trait domains in a group of 226 patients who had been diagnosed using the 10 traditional personality disorder categories. The relationship between traditional DSM-5 personality disorders and ICD-11 domains is shown in Table 2.5 from their paper (Bach et al., 2018).

The relationships are largely as predicted. Of note is that borderline personality disorder and paranoid personality disorder are moderately to strongly correlated with all ICD-11 domains.

More recently, instruments which attempt to measure the ICD-11 personality disorder classification model have been developed. The Standardised Assessment of Severity of Personality Disorder (SASPD) (Olajide et al., 2018) was modelled after the Standardised Assessment of Personality – Abbreviated Scale (Moran et al., 2003). It has nine items which are linked to the five ICD-11 domains. Each item is measured on a four-point scale (see Chapter 10).

The Personality Inventory for ICD-11 (PiCD) is a 60-item self-report measuring the five trait domains. Each domain has 12 items rated from 1 (strongly disagree) to 5 (strongly agree). More recently, an Informant-Report Form of the PiCD (Bach et al., 2020a) and a modified PID5F which measures ICD-11 and DSM-5 trait domains (Bach et al., 2020b) have been developed.

Several studies have examined the psychometric properties of these scales. In general, they have reported that the domains exhibit adequate internal consistency (Gutiérrez et al., 2015; Carnovale et al., 2019). Factor analyses have supported the ICD-11 structure with the notable exception that some studies find four factors rather than five. The anankastia and disinhibition domains are organised along a bipolar dimension (Gutiérrez et al., 2015; Carnovale et al., 2019; Bach et al., 2020b). However, other studies support a five factor solution in which anankastia and disinhibition are two distinct domains (Mulder et al., 2016; Bach et al., 2017). The clinical reality may be that complex personality disorder patterns can be characterised by both disinhibition and anankastia (Chamberlain et al., 2018).

The other major point is that the PiCD domains moderately overlap. While some may see this as a disadvantage, it probably reflects the true nature of personality traits. The PiCD domains average correlations are similar to those of DSM-5 taxonomy and the Big Five personality traits (Saucier, 2002; Gutiérrez et al., 2019) and overlap between personality domains focus on integral part of a repeatedly replicated structure (Markon et al., 2005).

We initially proposed that the five ICD-11 domains might be aligned with the five-factor model (FFM) in the following manner: negative affectivity with neuroticism, detachment with low extraversion, dissocial with low agreeableness, disinhibited with low conscientiousness and anankastia with high conscientiousness (Mulder et al., 2016). In general, these relationships have been supported. Table 2.6 shows the correlations between the PiCD scales and FFM scales in a sample of over 1,000 Italian adults.

2.7 Summary

The ICD-11 classification of personality disorders is a radical change from ICD-10; it offers a wholly dimensional system and discards all existing categories. The exception is the late retention of the borderline specifier, which is not part of the evidence-based model but whose removal was seen as too large a loss by various groups of researchers in personality disorders as well as a proportion of clinicians. The utility of the borderline specifier within
<table>
<thead>
<tr>
<th></th>
<th>PAR</th>
<th>SCD</th>
<th>STY</th>
<th>ANT</th>
<th>BOR</th>
<th>HIS</th>
<th>NAR</th>
<th>AVO</th>
<th>DPT</th>
<th>OBS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative affectivity</strong></td>
<td>0.45</td>
<td>0.06</td>
<td>0.33</td>
<td>-0.09</td>
<td>0.51</td>
<td>0.29</td>
<td>0.05</td>
<td>0.54</td>
<td>0.46</td>
<td>0.23</td>
</tr>
<tr>
<td><strong>Detachment</strong></td>
<td>0.43</td>
<td>0.46</td>
<td>0.41</td>
<td>0.26</td>
<td>0.38</td>
<td>0.04</td>
<td>0.23</td>
<td>0.33</td>
<td>0.17</td>
<td>0.15</td>
</tr>
<tr>
<td><strong>Dissociality</strong></td>
<td>0.52</td>
<td>0.31</td>
<td>0.36</td>
<td>0.60</td>
<td>0.43</td>
<td>0.32</td>
<td>0.71</td>
<td>0.00</td>
<td>0.06</td>
<td>0.26</td>
</tr>
<tr>
<td><strong>Disinhibition</strong></td>
<td>0.47</td>
<td>0.28</td>
<td>0.44</td>
<td>0.49</td>
<td>0.60</td>
<td>0.43</td>
<td>0.45</td>
<td>0.18</td>
<td>0.34</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>Anankastia</strong></td>
<td>0.44</td>
<td>0.22</td>
<td>0.40</td>
<td>0.15</td>
<td>0.48</td>
<td>0.34</td>
<td>0.25</td>
<td>0.35</td>
<td>0.24</td>
<td>0.62</td>
</tr>
</tbody>
</table>

Boldfaced correlations indicate the hypothesised trait domains for each personality disorder type. 
(Bach et al., 2018)
Table 2.6 The Personality Inventory for ICD-11 Scales: Correlations (i.e. Pearson r values) with the Five Factor Personality Model Index Scores (N = 1,122).

<table>
<thead>
<tr>
<th>Five Factor Model Personality Index subscales</th>
<th>M</th>
<th>SD</th>
<th>Stratified α</th>
<th>Personality inventory for ICD-11 scale r values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>.00</td>
<td>.89</td>
<td>.85</td>
<td>.81</td>
</tr>
<tr>
<td>Extraversion</td>
<td>.00</td>
<td>.91</td>
<td>.89</td>
<td>−.34</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>.00</td>
<td>.94</td>
<td>.90</td>
<td>−.15</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>.00</td>
<td>.90</td>
<td>.83</td>
<td>−.28</td>
</tr>
<tr>
<td>Openness to experience</td>
<td>.00</td>
<td>.94</td>
<td>.89</td>
<td>−.01</td>
</tr>
</tbody>
</table>

Note. ICD-11 = International Classification of Diseases, 11th Revision; NA = Negative Affective; DT = Detachment; DL = Dissocial; DN = Disinhibition; AN = Anankastic. For each Five Factor Index subscale, the stratified α coefficient was computed using sums of standardised scores of the Big Five Inventory and five factor model Rating Form corresponding scale. The expected convergent validity (i.e. Pearson r) coefficients between the Personality Inventory for ICD-11 scales and the Five-Factor Model Personality Index scales are underlined. The nominal significance level (i.e. p < .05) of Pearson r coefficients was corrected according to the Bonferroni procedure for multiple comparisons and set at p < .002. Pearson r values > .09 are significant at p < .002. Bold highlights large effect size correlations (r > .50).

(Somma et al., 2019)
the domain structure remains unclear. Its early study does not appear promising (Mulder et al., 2020), but the subject is ripe for further investigation.

Despite criticism that the classification is too simple, the combination of a severity diagnosis and a mixture of any of the five domains offers many diagnostic options (over 200) and to date the general structure has been generally supported by researchers and clinicians. A number of questionnaires have been developed to measure the domains. They have generally supported the validity of the five-domain maladaptive trait model in ICD-11. The major question is that two of the domains (anankastia and disinhibition) may represent opposite poles of the same higher order domain. How to represent this within the model is the subject of some debate, not least as it is quite possible for all five domains to coexist in the same personality disordered patient.

The remaining chapters in this book will use the ICD-11 system wherever possible but will obviously have to refer to past research with the former classification structure. But whenever we can link past data and descriptions to ICD-11, we will do so. Despite some difference in terminology, it is not difficult for the practitioner to recognise the traditional categories of personality disorder in the following pages. Later chapters discuss the potential clinical utility of the model and describe clinicians’ attitudes to the new structure; they have been positive to date.

We also want to widen the classification to all practitioners, irrespective of their status in medicine. There is the option of making a general diagnosis of personality disorder without necessarily adding trait domains. This does not suggest that the diagnosis can be attributed casually. It is just that when a practitioner feels that there is pathology beyond symptoms and interpersonal disturbance is prominent, the flag of personality disorder should be raised.

Although, as members of the ICD-11 revision group for personality disorders, we are clearly going to support its use, once it is being used in practice we are confident its value will be appreciated. But as we are always remembering evidence, more work is required before we can truly evaluate its validity and utility in clinical work.