Towards dimensional assessment of personality disorders (and psychopathology): providing further evidence for the DSM-5 alternative model for personality disorders (AMPD) or ICD-11 model for personality disorders (ICD-11 PD) in (older) adults.

As an empirically based model, the AMPD and the ICD-11 PD model are more clinically useful than the categorical criterion-based DSM approach (Morey et al., 2014), it allows a more personalised patient approach by its ease of communication as the personality description can be communicated to patients and their relatives, and it can inform treatment by understanding the person behind the illness by identifying the most salient personality problems that need to be addressed (Bach et al., 2015). Moreover, assessment of personality functioning (criterion A) and maladaptive traits (criterion B) is informative for all individuals since it applies to all patients in different degrees rather than being present versus absent in a categorical approach. To operationalize this AMPD approach in terms of assessment, APA (2013) proposed the Personality Inventory for DSM-5 (PID-5)-Adult (Krueger et al., 2012), a self-rated personality trait assessment of 220 items. In the meantime there is ample empirical support for the PID-5. The fact that APA did not propose a specific self-assessment measure for personality functioning probably hampered the criterion A research. Until recently, studies empirically evaluating personality dysfunction applied measures that were not designed for the DSM-5, and consequently did not perfectly correspond with criterion A. With the development of the Self-Report Form of the DSM-5 Level of Personality Functioning Scale (LPFS-SR; Morey, 2017), recently an 80-item questionnaire came available intended to precisely match the four components of personality functioning and the levels of the LPFS in terms of item weighting, yet the four-component structure lacks empirical support. Thus more research on criterion A, the distinction from criterion B, and its assessment are certainly needed. The ICD-11 PD that comes into effect in 2022 (WHO, 2019), overhauls the categorical approach by diagnosing the severity of a PD (as mild, moderate or severe) and allows to specify one or more trait domain qualifiers (i.e. negative affectivity, detachment, disinhibition, dissociality and anankastia) and a borderline pattern.

Until now validation studies are scarce. Interesting is the recent plea (Bach et al., 2020) to harmonize DSM-5 and ICD-11 by including the 4 shared (negative affectivity, detachment, antagonism, disinhibition) and two unique domains (DSM-5 psychoticism and ICD-11 anankastia-compulsivity), resulting in a six domain model. Further validation studies are sorely needed. Finally, applying an AMPD and/or ICD model recognizes the clinical reality of high co-morbidity of PDs and other symptoms. Evidence suggests that personality and psychopathology may have common underlying vulnerabilities (Kotov et al., 2017), more concretely, the AMPD model offers possibilities for comprehensive symptom coverage given its conceptual similarity with the HiTOP structural model. The HiTOP is an empirically based dimensional model that has been developed concurrently with the AMPD based on a review of structural evidence on spectra, subfactors, dimensional syndromes and maladaptive trait components (Kotov et al., 2017). Of the 4 identified clinical spectra three align with four PID-5 (i.e. AMPD criterion B) domains (not with Detachment), thus resulting in paired dimensions between clinical and personality domains: Internalizing with Negative Affectivity, Thought Disorder with Psychoticism and Externalizing with Disinhibition and Antagonism. Yet empirical evidence supporting this alignment is still needed. We are interested in research in adult and more specifically older adults. Notwithstanding the high prevalence and burden, PDs in older adults remain a flagging field of inquiry and insufficient attention has been given to the conceptualisation of PDs in later life (Penders et al., 2020).


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