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Advances in the Conceptualization of Personality Disorders: Issues Affecting Social Work Practice and Research

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Abstract

This article provides a review of the research that has informed the proposed changes to the DSM-5 conceptualization of personality psychopathology with a focus on implications for social work practice and research. A paradigm shift to a dimensional model is likely to replace the current categorical model of personality disorders and will have profound implications for the profession. While establishing a diagnostic system that is grounded in empirical knowledge is the primary benefit, this tool will also be more consistent with social work's orienting theories and values. Social workers should gain knowledge about the proposed changes and actively participate in the review process.

Keywords

Personality disorders; DSM-5; Five-factor model; Clinical social work

Clinical social work is now the nation's largest provider of mental health services with over 250,000 social workers certified, licensed, or receiving clinical supervision to diagnose and treat mental disorders (Harkness 2010; Center for Workforce Studies 2006). According to the federal government's Center for Mental Health Services, there were over 70,000 social workers employed by mental health organizations in 2000 compared to about 20,000 psychiatrists and 20,000 psychologists (Mechanic 2008). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association [APA] 2000) is currently being revised for a 2013 release of its 5th edition. Given the primacy of this diagnostic instrument and the leading role that social workers play in mental health treatment, it is vital that the social work profession not only becomes aware of the proposed changes, but also critically examines these changes from a social work perspective.

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The portion of the *DSM-IV-TR* that will arguably experience the most significant change will be the personality disorders (PDs). The current *DSM-IV-TR* is based on a discrete categorical approach with an assumption that diagnoses have clear boundaries (Maser et al. 2009). Informed by a substantial body of research, the conceptualization of PDs has moved towards a continuous, dimensional scheme within a hierarchical structure (Markon 2009; Krueger and Eaton 2010). This paradigm shift is quite significant and will have dramatic implications for both clinical practice and research. An overview of the empirical literature supporting this shift and the clinical implications will be discussed with emphasis on the impact to the field of social work.

Historical and Current Conceptualization of Personality Disorders

The general diagnostic criteria for PDs consists of a pattern of inner experience and behavior that deviate from the expectations of an individual's culture manifested in cognition, affectivity, interpersonal functioning, or impulse control. The current *DSM-IV-TR* distinguishes ten subtypes of PDs organized within three clusters: paranoid, schizoid, schizotypal (Cluster A), antisocial, borderline, histrionic, narcissistic (Cluster B), and avoidant, dependent, and obsessive–compulsive (Cluster C). Consistent with the *DSM-IV-TR*, the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD-10) specifies PDs separate from other clinical disorders as Disorders of Adult Personality and Behavior (World Health Organization 1993). Estimates of the prevalence of any PD in the general population have ranged from 9.0 to 15.7% (Samuels et al. 2002; Crawford et al. 2005; Lenzenweger et al. 2007). The most common PDs found in the National Comorbidity Study Replication (NCS-R) were avoidant (5.2%), schizoid (4.9%), schizotypal (3.3%), and obsessive–compulsive (2.4%), with common co-occurrence of PDs and comorbidity with other disorders (Lenzenweger et al. 2007).

While there is disagreement on seemingly basic issues, such as where PDs should exist in the *DSM*, the work groups charged with updating the *DSM* must attempt to balance the myriad empirical studies with considerations of clinical utility (First 2010). Although these revisions may change, there has been a major reconceptualization of personality psychology that has led to a proposed reformulation of PDs in the *DSM*. These proposed revisions can be found online (www.dsm5.org) and registered users are asked to provide feedback and comments. The system on the website is in flux and will be continually revised. The four proposed changes (Table 1) are found in the general definition of PDs, five severity levels of personality functioning, five PD types, and six personality trait domains and their corresponding facets.

As *DSM-IV-TR* diagnostic criteria are “poorly defined and not specific to personality disorder” (Livesley 2010, para. 1), the work group first recommends retaining the diagnosis of PD, but suggests a new general definition. Under the proposed definition, PDs “represent the failure to develop a sense of self-identity and the capacity for interpersonal functioning that are adaptive in the context of the individual's cultural norms and expectations” (APA 2010). “Adaptive failure” is manifested in either (or both) an impaired sense of self-identity or a failure to develop interpersonal functioning. Additionally, there must be an extreme level of at least one personality trait, stability across time, and evidence that the adaptive

failure is not just the consequence of another mental disorder, substance use, or another medical condition (APA 2010).

The second change, a dimensional measurement of personality functioning, would be used to describe the severity of the disorder on a zero to four scale ranging from “no impairment” to “extreme impairment” for both self and interpersonal functioning. Current *DSM-IV-TR* severity indicators and the Axis V GAF lack adequate specificity for determining the severity of personality psychopathology (Bender 2010). Additionally, recent research has found that in assessment of PDs, determination of severity is the most important predictor of current dysfunction and prognosis (Hopwood et al. in press). The constructs used to determine severity level are categorized under self (identity integration, integrity of self-concept, self-directedness) and interpersonal functioning (empathy, intimacy and cooperativeness, complexity and integration of representations of others). One argument supporting the scale approach to impairment is that severity becomes “obvious with dimensions” and allows for continuity between normal and maladaptive behaviors or cognitions (Maser et al. 2009).

Third, there will be a reduction in the number of PD types from 10 to 5. The retained types will be borderline, antisocial/psychopathic, schizotypal, avoidant, and obsessive–compulsive. Dropped from the *DSM* list of types would be paranoid, schizoid, histrionic, narcissistic, dependent, depressive, and negativistic (the last two being PDs described in the appendix of *DSM-IV*; Skodol 2010). The proposed diagnostic rubric will include a description of each PD type in a narrative format that includes a brief overview of functional deficits and typical trait configuration. There will be a dimensional rating of the match for each type and for the personality traits associated with each type. These changes are justified by “the excessive comorbidity among *DSM-IV* personality disorders, the limited validity for some existing types, arbitrary diagnostic thresholds included in *DSM-IV*, and instability of current *DSM-IV* PD criteria sets” (Skodol 2010, para. 1). The dropped types from the *DSM-IV-TR* and the residual PDNOS diagnosis will be subsumed under a general PD diagnosis with the descriptive trait profiles providing the salient information regarding the disorder.

Lastly, there has been growing consensus that “normal and abnormal personality variation can be treated within a single, unified framework” (Markon et al. 2005, p. 139). Therefore, it is recommended that individuals be rated on a dimensional scale of six higher-order personality trait domains. Within each domain, there are more specific lower-order facets that comprise each domain. In addition to being empirically validated, there are a number of reasons why the use of traits as the essential diagnostic criteria for PDs is beneficial. According to the work group (Clark and Krueger 2010; Krueger and Eaton 2010), trait profiles eliminate both comorbidity and PD-NOS, clarify within-diagnosis heterogeneity, increase diagnostic stability, and acknowledge the continuous nature of personality. Practitioners will be more confident that their diagnosis is correct and that it will be clearly distinguishable from other diagnoses. The empirical work that undergirds the rationale for a mixed categorical-dimensional system for diagnosis will be described further (Maser et al. 2009).

Five-Factor Model and Diagnosis

Researchers have found overwhelming support for a “Big Trait” model of personality structure that has been replicated across cultures, languages, and ages using advanced psychometric and analytic techniques (Marsh et al. in press; Ashton et al. 2004; Ashton and Lee 2009; De Raad et al. 2010). This development is viewed as “one of the most important accomplishments of personality and research” (Markon 2009, p. 1). There has been notable consensus around a “Big Five” or Five Factor Model (FFM) (McCrae and Costa 1985; Goldberg 1990; Saucier 2009). These factors are Neuroticism, Extraversion, Agreeableness, Conscientiousness, and Openness.

There is considerable evidence that the structure of PDs strongly relate to four of the five trait domains of the FFM. However, the Openness factor has been found to be unrelated to PDs in meta-analyses (Clark and Krueger 2010; O'Connor 2005; Saulsman and Page 2004). These same studies found that the FFM did not provide adequate coverage of specific traits found in Obsessive–Compulsive PD and Schizotypal PD (Saulsman and Page 2004). As the *DSM* is a tool to diagnose maladaptive functioning, appropriate emphasis on abnormal personality structure is a requirement. Thus, domains of Compulsivity and Schizotypy were added to provide full coverage of both normal and abnormal personality with a six domain model, pending further empirical examination on how these domains relate to the other four domains. As shown in Table 1, these six domains (Neuroticism, Extraversion, Agreeableness, Conscientiousness, Compulsivity, and Schizotypy) correspond to the six proposed trait domains for the *DSM-5* (Negative Emotionality, Introversion, Antagonism, Disinhibition, Compulsivity, and Schizotypy) although there is still debate over how the domains should be named (Costa and McCrae 2010).

There is already some indication that the FFM will provide an improvement in diagnostic and clinical utility. One study found that clinicians preferred the FFM to the *DSM* for describing case vignettes (Samuel and Widiger 2006). Perhaps most important, the interrater reliability using the FFM exceeded categorical diagnosis for prototypic and non-prototypic cases. Thus the FFM not only performs more reliably, it also provides the opportunity for deeper assessment and diagnostic utility exceeding the diagnosis-by-prototype approach of the *DSM* (Clark 2007). There are currently several standardized instruments that can be employed to assess PD dimensions, including the Revised NEO Personality Inventory (Costa and McCrae 1992), the Structured Interview for the Five Factor Model (Trull et al. 2001), and the Schedule for Nonadaptive and Adaptive Personality (Clark 1993).

Hierarchical and Dimensional Conceptualizations

The FFM represents one of the many models of personality structure that attempt to describe both normal and abnormal personality within a single framework (Eysenck 1947; Cloninger 1987) and more recently, under a single integrative hierarchy of superordinate and subordinate traits (Markon et al. 2005). The main question is whether PDs are “discrete clinical conditions or arbitrary distinctions along dimensions of general personality functioning” (Widiger et al. 2009, p. 243). Currently, two people may receive the same diagnosis, but present with different personality traits and meet different criteria of the

disorder (Trull and Durrett 2005; Widiger et al. 2009). The categorical versus dimensional debate has been all but resolved in recent years in favor of the dimensional approach.

The question then becomes how to accomplish a shift to a dimensional model and which system to use. Concerns about clinical utility and communication have been expressed (Clark 2007). Although a dimensional system would be more complex, it is specifically the invalid simplicity of the previous system that should be addressed in order to provide a more informed process of diagnosis and treatment (Verheul 2005). FFM measures exhibit excellent psychometric properties, making them reliable and valid instruments to assess PDs and distinguish traits (Clark 2007). Thus, a “hybrid model” combining types and traits assessed using dimensional ratings (mixed categorical-dimensional system) has received preliminary empirical support and is presented as the proposed model for the *DSM-5* (Skodol 2010; Maser et al. 2009; Morey et al. under review).

In evaluating the proposed changes to the *DSM-5*, it is evident that advances in the conceptualization of PDs were considered in developing the recommendations. Personality traits will be measured using a standardized dimensional measure to determine the underlying personality structure of the client. With a dimensional view of the level of functional impairment and types that exhibit divergent and convergent validity, these changes represent a revolutionary shift in the way in which PDs are diagnosed and treated.

Implications for Clinical Social Work

There is evidence that clinicians already think dimensionally when considering patient characterization and that the *DSM* has sacrificed clinical utility to mimic medical categorization (Maser et al. 2009). In the field of social work some have taken this point beyond the dimensional versus categorical debate of diagnosis. There is a strong position that the use of the *DSM* is incongruent with the history and focus of the profession (Kirk and Kutchins 1992; Kirk 2005). Indeed two national surveys of clinical social workers use of the *DSM-III* (Kutchins and Kirk 1988) and the *DSM-IV* (Frazer et al. 2009) found that while it is being commonly used as clinical tool, its primary purpose is for management of insurance reimbursement. Only half of the respondents in the *DSM-IV* study indicated that they would use the reference if it was not required. Kirk and Kutchins (1992) have organized a reasonable opinion that the labeling and medicalization of psychosocial problems directly inhibits the understanding of the individual client, a key feature of clinical social work. Further, they suggest that social workers should pause before accepting the pairing of the *DSM* and the insurance billing system. Although these concerns are legitimate, the release of the *DSM-5* is inevitable and fast approaching. Given this fact, perhaps a more tenable position for social workers would be to purposefully join the *DSM-5* conversation by supporting and adding to those changes that encapsulate cardinal social work perspectives and values (Frazer et al. 2009).

As social workers conscientiously anticipate the changes that will occur with the release of the *DSM-5*, it is imperative to evaluate how these changes relate to the profession's orienting theories. For example, Ecological Systems Theory, derived from the person-in-environment perspective, grounds social work practitioners and researchers in an understanding that

people and environmental systems mutually influence one another (Hepworth et al. 2010). Social workers are trained to look not only at individual psychopathology, but also to evaluate disorder as embedded in a deep social, cultural, and political fabric that may obscure, complicate, or augment pieces of the individual psyche. A dimensional approach to mental health diagnoses encourages social workers to use this broader lens in reaching the root of the problem rather than dealing only with the surface level manifestations. For example, in assessing the client's trait profile, not only will issues of functional impairment be incorporated, but social workers will be able to expand their understanding of personality structure while using their unique skills grounded in clinical social work theory to integrate other factors that may contribute to a complex personality structure. Social workers are trained to look for factors beyond the individual diagnosis that will aid in helping the client, and this orienting theory is critical to articulate as we conceptualize the changes being made in the *DSM-5*.

Additionally, the core values of the profession center on a strengths-based perspective, which will be better supported by the dimensional approach to diagnosing PDs. Hepworth's (Hepworth et al. 2010) seminal textbook on clinical social work practice distinguishes several cardinal values of the social work profession consistent with the Code of Ethics of the National Association of Social Workers (NASW 1999). Three of these that are directly applicable in framing this discussion can be paraphrased as: (1) respect for the inherent dignity and worth of the individual, (2) respect for self-determination and independent decision making, and (3) respect for unique characteristics of diverse populations. In the current model, a PD diagnosis implies that the client is inherently flawed and deviant. A dimensional approach to understanding PDs could potentially minimize the stigma associated with such a diagnosis. With an integrated, dimensional model, “a personality disorder no longer would be conceptualized as something that is qualitatively distinct from normal personality functioning. Personality disorders simply represent the presence of maladaptive variants of personality traits that are evident within all persons.” (Widiger et al. 2009, p. 246).

Although the dimensional approach will maintain the term “personality disorder,” the definition of disorder would center on adaptive failure manifested in either (or both) an impaired sense of self-identity or interpersonal functioning (APA 2010), as opposed to disorder indicating deviance. While still correctly termed “disorder,” this modification of the definition from deviant to maladaptive is of vital importance in how we understand the concept.

The evaluation of a disorder is placed on a continuum of normality rather than seen as a fundamental and pathological abnormality. This is a profound shift in conceptualizing mental illness that will be critical in aiding clinicians' work in empowering clients toward attaining greater levels of health and self-sufficiency.

Approaches to Assessment, Diagnosis, and Treatment

In reflection of the inherent values and characteristics of social work, the process of mental health treatment will inevitably be impacted by these changes. One of the primary roles of

the clinical social worker is to assess and diagnose mental disorders. The clinical social worker is trained to provide a differential diagnosis to determine the presenting condition, determine a reasonable prognosis, formulate a treatment plan, and make appropriate referrals. Clinical social workers are trained to use the *DSM-IV-TR* in conjunction with a thorough biopsychosocial assessment to determine the course of action within a framework of evidence-based practice.

One advantage of the proposed changes to the *DSM* will be a more accurate and specified diagnosis. As indicated on the APA's website, ratings from three assessments will be used jointly to diagnose a personality disorder, streamlining the diagnostic process for mental health professionals. These three assessments include, "(1) A rating of mild impairment or greater on the Levels of Personality Functioning (criterion A), (2) A rating of (a) a "good match" or "very good match" to a Personality Disorder Type *or* (b) "quite a bit" or "extremely" descriptive on one or more of six Personality Trait Domains (criterion B), and (3) Diagnosis also requires relative stability of (1) and (2) across time and situations, and excludes culturally normative personality features and those due to the direct physiological effects of a substance or a general medical condition" (APA 2010) (see Table 1). There is evidence that a dimensional model that does not rely on arbitrary boundaries will provide improved clinical utility in classifying disorder mainly by providing greater uniformity within diagnostic categories, less comorbidity with other disorders, and by eliminating the need for the NOS category (Widiger et al. 2009; Clark 2007). The practitioner's subjective judgment would still be a valuable tool in diagnosis. However, it would be accurate more often and based on empirically validated tools that fit with contemporary theoretical development.

For the individual, developing a treatment plan begins with providing an accurate diagnosis. With a dimensional approach to assessment, it would follow that treatment options would be more adequately tailored to the individual. The dose, setting, or treatment approaches that would be available would likely represent the broader spectrum of function and personality dimensions. The lack of a valid organizational structure in the *DSM-IV-TR* has been one reason why there have been so few empirical studies or attempts to develop manualized treatments for PDs (Widiger et al. 2009). With a diagnostic tool that better describes the complex array of behaviors that are the focus of treatment, the clincian would have a more specific starting point for determining the appropriate treatment plan. Again, this is consistent with the person-centered treatment approach central to clinical social work. There is also often a concern that the long-term goal of recovery or "cure" from a mental illness is not only too abstract but unrealistic for clinicians and clients to address. The real focus is on small, but not insignificant functional improvements and progress along a continuum. Focusing on incremental changes on a spectrum could have a tremendous impact on treatment planning, prognosis, and client motivation.

These changes would also have practical implications for the training and licensure of clinical social workers. While there will be challenges in incorporating new material into existing coursework and in training practicing social workers, this also represents an opportunity to expose clinicians to an improved approach to diagnosis. By incorporating the

cutting-edge research in human personality and diagnosis of PDs into coursework and professional development, social workers will be better trained to treat clients with PDs.

Implications for Social Work Research

Mental health research is becoming increasingly transdisciplinary. If the social work perspective is going to be incorporated in lines of research exploring PDs, a firmer grasp of *DSM* changes and the empirical evidence that led to such changes is required. This is in line with the profession's value of utilizing evidence-based practices in treating clients. The primary model of evidence-based interventions demonstrates a clear relationship between using strong empirical evidence, incorporating clients' preferences, understanding the social context, and drawing on the clinician's expertise. As new interventions are developed to treat PDs, dimensional measures of change would provide better specificity in development and evaluation.

The current *DSM* system of diagnosis for PDs has been characterized as arbitrary, unreliable, incomplete, inaccurate, and wrong (Clark 2007; Widiger et al. 2009). With the bar of scientific rigor continuing to rise, constructs that fail to exhibit superior reliability and validity should not be included in research plans or in statistical models. To diagnose PDs within individuals, the *DSM* and *ICD* categorical systems are the only choice but are empirically unjustified and atheoretical (Andrews et al. 2009). By simply moving from a categorical to a dimensional system of classification, our knowledge of risk factors and disease progression will improve dramatically. Clinical experience shows that disorders across the lifetime do not switch from either being present or absent but often exhibit a florid presentation of symptoms and dysfunction.

Implementation Challenges

There is some apprehension to a new system of diagnosis. Like many other suggested changes to the *DSM*, the proposed PD revisions have generated spirited debate among experts in the scientific community. The elimination of narcissistic personality disorder within the broader discussion of dimensional versus prototype-based diagnosis was recently described as a “battle worth watching” in *The New York Times* (Zanor 2010). In fact, Dr. Allen Frances, chair of the *DSM-IV* Task Force has openly criticized the goal of creating a paradigm shift in diagnosis as being “absurdly premature” (Frances 2009, p. 2). There is also concern with the appropriateness of a dimensional model in clinical diagnosis. While both sides agree that a dimensional trait model is a useful research tool, some have suggested that it “reflects mainly the methods and concepts valued by academic researchers who do not interact with patients” (Shedler et al. 2011, p. 98).

One of the immediate concerns is the feasibility of incorporating these changes into existing practice. While researchers may be able to perform lengthy interviews assessing the entire personality trait structure, a practitioner in a clinical setting typically does not have the time to evaluate dozens of criteria to comprehensively cover Axis II. While this could be viewed as problematic given the complexity of administration and interpretation of the proposed system, it could be viewed instead as providing both deeper and wider diagnostic abilities to the practitioner. The judgment of the practitioner, along with the client's needs, will dictate

whether a general screening tool or a scale that delineates distinctions of the individual within a specific personality domain is warranted. As new instruments are developed and tested, the options available to the practitioner should be greatly increased, improving the possibilities for treatment.

Administrative concerns about training and education are not sufficient reasons to delay the move forward. A growing area of mental health research is in the field of implementation science. This field is concerned primarily with addressing the gap between what is known about effective care and what is provided to consumers of mental health services (Proctor et al. 2009). Viewing changes to the *DSM* as an innovation, experts in this area could provide a great deal of knowledge and guidance in best practices for incorporating new methods of assessment and treatment planning within the organizational context of mental health services. As a form of an evidence-based practice, the dissemination of the *DSM-5* and the dimensional scales for assessing personality traits could be planned and evaluated.

Conclusion

Knowledge about human personality has increased significantly in recent years warranting an overhaul of the primary tool for diagnosis of PDs, the *DSM*. The empirical literature suggests a movement towards a dimensional conceptualization of traits and functioning to accurately diagnose PDs. The proposed changes for the *DSM-5* reflect the suggestions implied by the mounting research literature. As a leading provider of mental health services that include assessment, diagnosis, and treatment planning, social workers should become informed about the basis for these changes and the specific proposals. Additionally, social workers should be vocal advocates for the profession and for clients in this discussion of change.

While there will be many challenges associated with reformulating the *DSM*, leaders in the clinical social work arena should begin to address these issues. Social workers are encouraged to visit the *DSM-5* website and read the rationales provided for the proposed changes. Schools of social work could be instrumental in organizing groups to discuss the changes and the impact on clients and the profession. As change is inevitable, this paper serves as a possible template for framing the ensuing discussion surrounding changes to the *DSM* and the impact on the social work discipline.

Biography

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Table 1

Proposed Changes to *DSM-5* Personality Disorders

(1) Definition	PDs represent the failure to develop a sense of self-identity and the capacity for interpersonal functioning that are adaptive in the context of the individual's cultural norms and expectations.	
(2) Levels of functioning 4 = Extreme impairment 3 = Serious impairment 2 = Moderate impairment 1 = Mild impairment 0 = No impairment	Self	Identity integration: Regulation of self-states; coherence of sense of time and personal history; ability to experience a unique self and to identify clear boundaries between self and others; capacity for self-reflection Integrity of self-concept: Regulation of self-esteem and self-respect; sense of autonomous agency; accuracy of self-appraisal; quality of self-representation (e.g., degrees of complexity, differentiation, and integration) Self-directedness: Establishment of internal standards for one's behavior; coherence and meaningfulness of both short-term and life goals
	Interpersonal	Empathy: Ability to create an accurate model of another's thoughts and emotions; capacity for appreciating others' experiences; attention to range of others' perspectives; understanding of social causality Intimacy and cooperativeness: Depth and duration of connection with others; tolerance and desire for closeness; reciprocity of regard and support and its reflection in interpersonal/social behavior Complexity and integration of representations of others: Cohesiveness, complexity and integration of mental representations of others; use of other-representations to regulate self
(3) Types 5 = Very good match 4 = Good match 3 = Moderate match 2 = Slight match 1 = No match	Antisocial/psychopathic	Antagonism and disinhibition
	Avoidant	Negative emotionality, introversion, and compulsivity
	Borderline	Negative emotionality, antagonism, disinhibition, and schizotypy
	Obsessive–compulsive	Compulsivity, negative emotionality, introversion, and antagonism
	Schizotypal	Schizotypy, introversion, and negative emotionality
(4) Trait domains and facets 3 = Extremely descriptive 2 = Moderately 1 = Mildly 0 = Very little or not at all descriptive	Negative emotionality	Emotional lability, anxiousness, submissiveness, separation insecurity, pessimism, low self-esteem, guilt/shame, self-harm, depressivity, suspiciousness
	Introversion	Social withdrawal, social detachment, restricted affectivity, anhedonia, intimacy avoidance
	Antagonism	Callousness, manipulativeness, narcissism, histrionism, hostility, aggression, oppositionality, deceitfulness
	Disinhibition	Impulsivity, distractibility, recklessness, irresponsibility
	Compulsivity	Perfectionism, perseveration, rigidity, orderliness, risk aversion
	Schizotypy	Unusual perceptions, unusual beliefs, eccentricity, cognitive dysregulation, dissociation proneness