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The LPFS Brief Form (LPFS-BF)

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BRIEF REPORT

Development and Preliminary Psychometric Evaluation of a Brief Self-Report Questionnaire for the Assessment of the *DSM–5* Level of Personality Functioning Scale: The LPFS Brief Form (LPFS-BF)

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The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association, 2013) alternative model for personality disorders (PDs) introduced a new paradigm for the assessment of PDs that includes levels of personality functioning indexing the severity of personality pathology irrespective of diagnosis. In this study, we describe the development and preliminary psychometric evaluation of a newly developed brief self-report questionnaire to assess levels of personality functioning, the Level of Personality Functioning Scale–Brief Form (LPFS-BF; Bender, Morey, & Skodol, 2011). Patients ($N = 240$) referred to a specialized setting for the assessment and treatment of PDs completed the LPFS-BF, the Brief Symptom Inventory (BSI; Derogatis, 1975), the Severity Indices of Personality Problems (SIPP-118; Verheul et al., 2008), and were administered the Structured Clinical Interview for *DSM–IV* Axis I Personality Disorders (SCID-I; APA, 1994; First, Spitzer, Gibbon, & Williams, 1997) and the SCID Axis II Personality Disorders (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin, 1996). When constrained to a 2-factor oblique solution, the LPFS-BF yielded a structure that corresponded well to an interpretation of Self- and Interpersonal Functioning scales. The instrument demonstrated fair to satisfactory internal consistency and promising construct validity. The LPFS-BF constitutes a short, user-friendly instrument that provides a quick impression of the severity of personality pathology, specifically oriented to the *DSM–5* model. Clearly, more research is needed to test its validity and clinical utility.

Keywords: personality, assessment, *DSM–5*, screening, level of personality functioning

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The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association, 2013) alternative model for PDs (Section III) introduced a new paradigm for the assessment of PDs. This paradigm emanates from a hybrid model comprising the assessment of (a) difficulties in personality functioning and (b) pathological personality traits. The clinician is advised to assess the level of personality functioning on a dimension ranging from *little or no* to *some*, *moderate*, and *severe to extreme* problems, based on the individual's impairment in self- and interpersonal functioning. Self-functioning is based on ratings of the level of identity integration and self-direction, and interpersonal functioning is based on ratings of the capacities for intimacy and empathy; both are captured by the Level of Personality Functioning Scale (LPFS; Bender, Morey, & Skodol, 2011). These impairments in self- and interpersonal functioning are considered essential core features of personality pathology—irrespective of the type of PD—and should help to delineate PDs from other types of psychopathology.

Accumulating evidence suggests that the assessment of severity of personality functioning has incremental clinical utility for treatment selection and planning as compared with the actual *DSM–5* classification of PDs (APA, 2013). For example, severity of personality pathology has been identified as an important predictor of concurrent and future functioning (Hopwood et al., 2011), social dysfunction (Yang, Coid, & Tyrer, 2010), differential outcome for specialized versus general treatment for borderline PD (Bateman & Fonagy, 2013), and of rates of remission for Axis-I disorders (Oleski et al., 2012). Moreover, as severity is deemed highly informative for treatment planning, there is general agreement that its assessment should be included in any new classification system for PDs (Tyrer, 2005).

Several alternative methods have been proffered to assess severity of personality functioning, including the mere presence or absence of a categorical diagnosis of PD (Oleski, Cox, Robinson, & Grant, 2012), the number of scored criteria of all 10 PDs (Hopwood et al.,

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2011), and the number of (comorbid) PDs (Bateman & Fonagy, 2013). The LPFS (Bender et al., 2011) offers a new operational definition of severity of personality pathology, specifically relating severity to the (mal)development of adaptive capacities in several areas of personality functioning. Several advantages stem from this approach. First, the LPFS is derived from a model of healthy personality functioning, that is, it articulates which psychological capacities are essential to adapting to (stressful) life events, and thus promotes paying systematic attention to strengths and resilience in addition to pathology. Moreover, the LPFS allows the clinical assessment of areas of strengths and vulnerabilities in all patients seeking help for mental problems, regardless of their diagnostic status. Third, as severity of personality pathology has been defined in terms of core components of personality functioning, the LPFS enables clinicians to assess severity of personality pathology (relatively) independent of current symptoms or actual burden. Indeed, acute symptoms are often highly volatile in PD patients, accounting for a typical picture of "waxing and waning" of PDs in longitudinal studies (Zanarini et al., 2012). Fourth, assessing adaptive and maladaptive areas of personality functioning may directly inform treatment planning and focus clinicians on relevant targets for treatment. For example, if patients demonstrate a lack of goal-setting abilities (an aspect of self-direction in the LPFS), treatment may actively address commitment issues.

To our knowledge, there currently is no brief questionnaire specifically oriented to the *DSM–5* (APA, 2013) level of personality functioning. Extant related questionnaires, like the Severity Indices of Personality Problems (SIPP-118; Verheul et al., 2008) and the General Assessment of Personality Disorders (GAPD: Livesley, 2006) refer to similar constructs, but predate the *DSM–5* conceptualization. Furthermore, these instruments include many items (>100), rendering them less suitable for a quick impression regarding level of personality dysfunction. Even the specifically developed item sets derived from the SIPP-118 and GAPD, proposed by Morey and colleagues (2011), include a rather large number of items (65) rendering these less than convenient for quick screening. For clinicians, an efficient self-report questionnaire may facilitate paying systematic attention to potential personality pathology to identify patients that will benefit from further, more detailed assessment and/or subsequent treatment. For patients, a screening instrument may assist them in self-assessing the possible presence of personality dysfunction, enabling them to find specialized help.

In sum, this study describes the development and preliminary psychometric properties of a brief self-report questionnaire assessing the level of personality functioning. The aim of developing this instrument was twofold. First, its development was explicitly oriented to measure the level of personality functioning as defined in the *DSM–5* Section III alternative model for PDs (APA, 2013). Second, it was constructed to provide a preliminary, "first glance" impression of the presence of personality pathology enabling clinicians to assign patients for further investigation. We document preliminary findings regarding its factor structure, reliability, and construct validity.

Method

Participants

All participants ($N = 240$) were consecutively admitted, treatment-seeking adolescents and adults who were (self-)referred to "de Viersprong," a tertiary-care mental health-care center specialized in the assessment and treatment of adolescents and adults with personality pathology. All intakes were conducted between May and October, 2013. Of the total sample, 159 (66.3%) were women. Their age ranged from 17 to 64 years old, with a mean age of 33.97 ($SD = 10.42$). Clinical characteristics of the sample are presented in Table 1. As can be seen, the predominant PD diagnoses were avoidant PD and borderline PD; no patients with Cluster A diagnoses were included. The most prevalent Axis I comorbidity concerned affective and anxiety disorders.

Procedure

Test construction. The Level of Personality Functioning Scale–Brief Form (LPFS-BF) was originally developed to provide help-seeking patients with an easy-to-use tool to self-assess whether their problems were likely related to personality dysfunction. Such an estimate might assist them in deciding whether "de Viersprong" as a specialized center for the treatment of PD might offer helpful treatments for them. Given the emergence of the *DSM–5* alternative model (APA, 2013) and the presumed usefulness of the LPFS (Morey et al., 2011) to assess the severity of personality problems, we decided to develop a *DSM–5* Criterion-A-based instrument. An expert group, composed of four licensed clinical psychologists with extensive experience in academics and/or the assessment and treatment or research of PDs, articulated the basic psychological capacity implied by the description of the 12 facets of the LPFS and the description of the scoring criteria. For example, the scoring criteria of Facet 1 (experience of oneself as unique, with clear boundaries between self and others) all refer to the (lack of) basic psychological capacity of having an intact and clear awareness of oneself most of the time and being able to maintain this self-representation in contact with other people. The corresponding item was therefore identified (inversely) as "I often do not know who I really am." In a similar way, the other 11 facets were discussed by the expert group, which led to the delineation of

Table 1
Clinical Characteristics of the Sample ($N = 240$)[a]

DSM-IV diagnosis	*N* (%)
Personality disorder	
Avoidant PD	48 (20)
Dependent PD	4 (1.7)
Obsessive-compulsive PD	10 (4.2)
Narcissistic PD	6 (2.5)
Borderline PD	49 (20.4)
Antisocial PD	2 (.8)
PD NOS	91 (37.9)
Any PD	179 (74.6)
Clinical disorder	
Mood disorder	157 (66)
Anxiety disorder	95 (39.9)
Eating disorder	36 (15.1)
Somatoform disorder	7 (2.9)
Substance use disorder	36 (15.1)
Psychotic disorder	5 (2.1)
Any Axis I disorder	198 (83.2)

Note. PD = personality disorder; NOS = not otherwise specified.
[a] *N* varies between 238 and 240 because of missing values. The sum of the number of patients across the different diagnostic groupings is higher than the total number of patients because of comorbidity.

12 items that were included in the first version of the LPFS questionnaire, each facet being represented by one matching item. Participants were asked to indicate for each item whether they think it applies to them (yes or no). A simple binary response format was chosen to for optimal convenience for both patients and clinicians. In a piloting phase, patients of different age groups and widely varying levels of education attainment were asked to judge the items for clarity and ease; some fine-tuning was needed before the questionnaire was finalized for the present study.

Present validation study. In addition to the standard admission procedure, which included semistructured interviews to assess Axis I and Axis II disorders as well as several self-report questionnaires including the SIPP-118 (Verheul et al., 2008) and the Brief Symptom Inventory (BSI; Derogatis, 1975; translated by de Beurs & Zitman, 2006; see below), all referred patients were asked to complete the LPFS-BF. All patients agreed upon completing the questionnaire and signed informed consent. Extensively trained graduate-level psychologists, all participating in regular booster sessions to avoid interview drift, administered the semistructured diagnostic interviews.

Measures

Level of Personality Functioning Scale–Brief Form.[1] The LPFS-BF is a questionnaire that aims to measure the LPFS as described in Section III of the *DSM–5* (APA, 2013). The LPFS consists of 12 facets, which are clustered into four subscales (Identity, Self-Direction, Empathy, and Intimacy). These subscales are clustered into two higher domains, Self-Functioning and Interpersonal Functioning. Internal consistency, as measured by Cronbach's α, was .69 for the LPFS-BF total scale, and .57 and .65 for the Self and Interpersonal subscales, respectively.

Structured Clinical Interview for *DSM–IV* Axis I Disorders. The SCID-I (APA, 1994; First et al., 1997; translated by Groenestijn, Akerhuis, Kupka, Schneider, & Nolen, 1999) is a semistructured interview to measure *DSM–IV* Axis I disorders. The SCID-I has demonstrated good interrater reliability in diverse samples, especially when interviewers had received a formal training; overall $\kappa = .85$ (Ventura, Liberman, Green, Shaner, & Mintz, 1998).

Structured Clinical Interview for *DSM–IV* Axis II Personality Disorders. The SCID II (APA, 1994; First et al., 1996, translated by Weertman, Arntz, & Kerkhofs, 1996) was used to diagnose Axis II PDs. Criteria were scored if they were pathological, pervasivem and persistent. PD not otherwise specified (PD-NOS) was classified when five criteria defining PD were present (Verheul, Bartak, & Widiger, 2007). The SCID-II has good interrater and test–retest reliability in PD samples (see, e.g., Maffei et al., 1997; Weertman, Arntz, Dreessen, Van Velzen, & Vertommen, 2003) with sum intraclass correlations (ICCs) reported as high as .90 for avoidant and .95 for borderline PDs in a Dutch sample (Lobbestael, Leurgans, & Arntz, 2011).

Brief Symptom Inventory. The BSI (Derogatis, 1975; translated by de Beurs & Zitman, 2006) was used to assess symptom severity. It consists of 53 items covering nine symptom dimensions, but for the present study, we only used the total score, which provides an index of the intensity of distress by psychological symptoms during the past week. Respondents rank each item on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). Cronbach's α in the present sample was high at .96.

Severity Indices of Personality Problems. The SIPP-118 (Verheul et al., 2008) is a dimensional self-report measure and aims to measure core components of (mal)adaptive personality functioning. The SIPP-118 asks the respondents to think about the last 3 months and answer the extent to which they agree with statements presented. The response categories range from 1–4 and are described as *fully disagree*, *partly disagree*, *partly agree*, and *fully agree*. The measure comprises 16 facets, clustered into five higher-order domains: Self-Control, Identity Integration, Relational Capacities, Social Concordance, and Responsibility. High scores indicate better adaptive functioning, whereas lower scores represent more maladaptive personality functioning. The comprising SIPP subscales have generally yielded adequate to strong internal consistencies in PD samples, with α scores ranging from .62 to .89 (Feenstra, Hutsebaut, Verheul, & Busschbach, 2011; Verheul et al., 2008). In the present sample, α scores ranged from .75 (responsible industry) to .86 (self respect).

Internal Structure

A principal-components analysis (PCA) with a fixed number (i.e., two, reflecting the presumed Self- and Other domains) of factors was conducted to investigate the structure of the questionnaire. A PROMAX rotation was chosen to allow the subscales to covary. The emergent two factors accounted for 35.2% of the variance, and the pattern of loadings were consistent with an interpretation of the Self Functioning and Interpersonal Functioning domains (see Table 2).

Construct Validity

Personality disorder versus no personality disorder and severity of personality disorder. PD patients scored significantly higher on the total LPFS-BF, $t = 5.20$, $p < .05$, as well as comprising Self ($t = 3.24$, $p < .05$) and Interpersonal ($t = 4.47$, $p < .05$) subscales than patients without PD. These comparisons all yielded large effect sizes (all Cohen's *d*s > 1.0).

Severity of personality pathology. A significant correlation was observed between the severity of personality pathology, as measured through the number of PD traits, and the total LPFS-BF score, $r = .37$, $p < 001$. In addition, the LPFS-BF total and Self- and Interpersonal Functioning scales were correlated with the BSI (Derogatis, 1975; translated by de Beurs & Zitman, 2006) total and the domain scores of the SIPP-118 (Verheul et al., 2008; see Table 3); all correlations were significant at $p < .01$. As might be expected, the Interpersonal domain correlated higher with SIPP Social Concordance ($z = 4.97$, $p < .001$) and with SIPP Relational Capacities ($z = 1{,}99$, $p < .05$) than did the LPFS-BF Self-Functioning domain. Also, compared with the LPFS-BF Interpersonal domain, a stronger association between the LPFS-BF Self-Functioning domain and SIPP Identity Integration domain was observed ($z = -3{,}41$, $p < .001$). No difference was found for SIPP Self Control ($z = -.14$, *ns*) or SIPP Responsibility ($z = .47$, *ns*).

[1] A copy of this instrument can be obtained from the first author.

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Table 2
Principal-Components Analysis With PROMAX Rotation of LPFS-BF Items[a] *(N = 238)*[b]

Component	F1: Interpersonal Functioning	F2: Self-Functioning
Eigenvalue	2.80	1.40
1. I often do not know who I really am.	.06	.69
2. I often think negatively about myself.	−.13	.64
3. My emotions change without me having a grip on them.	.12	.54
4. I have clear aims in my life and succeed in achieving those (reversed).	−.13	.52
5. I often do not understand my own thoughts and feelings.	.12	.67
6. I am often very strict with myself.	−.08	.24
7. I often have difficulty understanding the thoughts and feelings of others.	.69	−.05
8. I often find it hard to tolerate it when others have a different opinion.	.60	−.15
9. I often do not fully understand why my behavior has a certain effect on others.	.73	−.10
10. My relationships and friendships are often short-lived.	.63	.07
11. There is almost no one who is really close to me.	.39	.10
12. I often do not succeed in working cooperatively with others in an equal way.	.54	.06

Note. LPFS-BF = Level of Personality Functioning Scale–Brief Form.
[a] Unofficial translation; original items were in Dutch. [b] *N* varies between 238 and 240 because of missing values.

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Associations Between Specific Personality Disorders and the LPFS-BF Scales

Point-biserial correlations between specific PDs and the LPFS-BF total and subscale scores are displayed in Table 4. Moderate correlations were evident between the LPFS total and its subscales and the borderline PD diagnosis, and trends ($p < .10$) were noted for the associations with the avoidant PD diagnosis. No other associations were significant at the level of the (lower prevalent) individual PD diagnoses.

Discussion

In this study, we have presented preliminary data on the factor structure, reliability, and construct validity of a brief self-report questionnaire assessing the level of personality functioning in a sample of treatment seeking adults with personality pathology. Our findings demonstrated that the total scale was composed of two meaningful subscales, referring to Self-and Interpersonal Functioning. This factor structure supports the content validity of the LPFS-BF. Internal consistency of this brief screener can be considered satisfactory, and marginal to fair for its subscales. The screener clearly differentiated subjects with and without a *DSM–IV* (APA, 1994) diagnosis of PD, with higher scores on the questionnaire also being associated with more traits of *DSM–IV* PDs. Finally, the Self and Interpersonal subscales showed meaningful associations with similar constructs as measured by the SIPP (Verheul et al., 2008), with main components of Self-Functioning correlating to SIPP Identity Integration and Interpersonal Functioning with SIPP Relational Capacities and Social Concordance. Together, our findings generally support the construct validity of the LPFS-BF.

Associations between the LPFS-BF Self and Interpersonal and corresponding SIPP domains (Verheul et al., 2008) were generally as might be expected. It bears mentioning that, although these domains are statistically separable (with a moderate intercorrelation of $r = .31$), psychologically, these domains are dynamically intertwined. Consistent with various models of PD, relational capacities greatly affect the degree to which an individual feels in control of his or her personal functioning and sense of self. With regard to specific PDs, the LPFS-BF appears to be most strongly related to borderline pathology. Marginal associations were detected with other individual PDs, but these findings are clearly in need of further testing, as we did not have adequate power to detect associations for most PDs.

Several additional limitations of the present study warrant specific mention. One of the main limitations is the absence of

Table 3
Correlation of Level of Personality Functioning Scale Scores and BSI/SIPP-118 (N = 232)[a]

Construct	LPFS-BF Total	LPFS-BF Self	LPFS-BF Interpersonal	*p*
BSI total score	.53	.51	.38	<.10
SIPP-118 Self Control	.62	.50	.51	*ns*
SIPP-118 Identity Integration	.69	.68	.47	S > I**
SIPP-118 Relational Capacities	.68	.48	.61	S < I*
SIPP-118 Responsibility	.35	.27	.31	*ns*
SIPP-118 Social Concordance	.58	.27	.63	S < I*

Note. BSI = Brief Symptom Inventory; SIPP-118 = Severity Indices of Personality Problems; *ns* = non significant.
[a] *N* varies slightly due to missing values; all test were two-tailed.
* $p < .05$. ** $p < .01$.

Table 4
Associations Between Specific Personality Disorders (PDs) and the LPFS-BF and its Domains

DSM-IV diagnosis	LPFS-BF Total	LPFS-BF Self	LPFS-BF Interpersonal
Avoidant PD	.17*	.10	.12
Dependent PD	.03	.06	−.02
Obsessive-compulsive PD	−.05	−.07	−.03
Narcissistic PD	.07	.04	.08
Borderline PD	.30**	.23**	.29**
Antisocial PD	.04	.06	.02
PD NOS	.11	.05	.14*

Note. LPFS-BF = Level of Personality Functioning Scale–Brief Form.
* $p < .05$. ** $p < .01$.

a gold standard to assess the level of personality functioning according to the LPFS (Morey et al., 2011) as included in Section III of the *DSM–5* (APA, 2013). This clearly limits the opportunities to investigate the validity of the questionnaire, for example as a screening tool for identifying "moderate or greater impairment in personality functioning" as a necessary criterion (A) for making a categorical diagnosis of PD according to the alternative *DSM–5* model. Ideally, a brief self-report questionnaire, like the LPFS-BF, would provide a preliminary impression upon which an indication for further detailed assessment can be based. However, a number of instruments also aiming to assess the level of personality functioning may be included in further studies to corroborate the construct validity of the LPFS-BF. For example, Morey et al., (2011) have empirically derived a subset of items from the SIPP (Verheul et al., 2008) and GAPD (Livesley, 2006) that could serve this purpose. Another limitation is the restricted range of types of PD included in the sample. No patients with Cluster A PDs were present in our sample and only a few patients with antisocial PD. Accordingly, although the LPFS-BF appears to have captured the personality dysfunctions of avoidant and borderline PDs, no data can currently speak to its sensitivity to the problems of individuals with Cluster A diagnoses, or antisocial PD. Further study in samples of these patients is indicated. Finally, although we acknowledge that observed internal consistency of the instrument was high, we hold that, for screening purposes, this may not be critical, and we surmise that the concept measured (that is, "level of personality functioning") is indeed broad and complex.

To our knowledge, the LPFS (Morey et al., 2011) is the first questionnaire explicitly constructed to tap the *DSM–5* (APA, 2013) alternative model to measure Self- and Interpersonal Functioning. As such, it constitutes a short and user-friendly instrument that provides a quick impression of the severity of personality pathology, specifically oriented to the *DSM–5* model. The LPF-BF may have clinical utility in assisting first-line general mental health professionals to gain a first impression of (associated) personality dysfunction of their patients. As such, the LPFS-BF may have incremental value above assessing symptomatic distress for referring patients. High-end scores may be followed by a more comprehensive assessment, for example by means of semistructured interviews and validated questionnaires. Our preliminary data indicate that assessing the level of impairment in Self- and Interpersonal Functioning is feasible, and the LPFS-BF is strongly associated with PD severity as described in *DSM–IV* (APA, 1994). Clearly, more research is necessary to establish its psychometric properties and clinical utility in other samples.

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