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Criterion A of the AMPD in HiTOP

Thomas A. Widiger,¹ Bo Bach ,² Michael Chmielewski,³ Lee Anna Clark,⁴ Colin DeYoung,⁵ Christopher J. Hopwood,⁶ Roman Kotov,⁷ Robert F. Krueger,⁵ Joshua D. Miller,⁸ Leslie C. Morey,⁹ Stephanie N. Mullins-Sweatt,¹⁰ Christopher J. Patrick,¹¹ Aaron L. Pincus,¹² Douglas B. Samuel,¹³ Martin Sellbom,¹⁴ Susan C. South,¹³ Jennifer L. Tackett,¹⁵ David Watson,⁴ Mark H. Waugh,¹⁶ Aidan G. C. Wright,¹⁷ Johannes Zimmermann,¹⁸ R. Michael Bagby,¹⁹ David C. Cicero,²⁰ Christopher C. Conway,²¹ Barbara De Clercq,²² Anna R. Docherty,²³ Nicholas R. Eaton,²⁴ Kelsie T. Forbush,²⁵ J. D. Haltigan,²⁶ Masha Y. Ivanova,²⁷ Robert D. Latzman ,²⁸ Donald R. Lynam,¹³ Kristian E. Markon,²⁹ Ulrich Reininghaus,³⁰ and Katherine M. Thomas¹³

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ABSTRACT

The categorical model of personality disorder classification in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. [DSM-5]; American Psychiatric Association, 2013) is highly and fundamentally problematic. Proposed for DSM-5 and provided within Section III (for Emerging Measures and Models) was the Alternative Model of Personality Disorder (AMPD) classification, consisting of Criterion A (self-interpersonal deficits) and Criterion B (maladaptive personality traits). A proposed alternative to the DSM-5 more generally is an empirically based dimensional organization of psychopathology identified as the Hierarchical Taxonomy of Psychopathology (HiTOP; Kotov et al., 2017). HiTOP currently includes, at the highest level, a general factor of psychopathology. Further down are the five domains of detachment, antagonistic externalizing, disinhibited externalizing, thought disorder, and internalizing (along with a provisional sixth somatoform dimension) that align with Criterion B. The purpose of this article is to discuss the potential inclusion and placement of the self-interpersonal deficits of the DSM-5 Section III Criterion A within HiTOP.

ARTICLE HISTORY

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The Alternative Model of Personality Disorder (AMPD) was included in Section III of the fifth edition of the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The many problems with the DSM-IV personality disorder (PD) diagnostic categories, such as excessive diagnostic cooccurrence, heterogeneity among persons sharing the same diagnosis, and lack of treatment specificity, have been well documented (Clark, 2007; Krueger & Eaton, 2010; Livesley, 2001; Verheul, 2005; Widiger & Trull, 2007). The development of the AMPD was in recognition of these apparent failings (Krueger & Markon, 2014; Skodol, 2012). The AMPD consists of two primary components: Criterion A and Criterion B. Criterion A concerns deficits (or impairments) in the sense of self (more specifically, problems with identity and self-direction) and interpersonal relatedness (empathy and

intimacy; Skodol, 2012). Criterion B consists of 25 maladaptive personality traits (e.g., callousness and impulsivity) organized within five broad domains of negative affectivity, detachment, antagonism, disinhibition, and psychoticism (Krueger, Derringer, Markon, Watson, & Skodol, 2012; Krueger et al., 2011).

The problems and limitations of the categorical model of classification are not, of course, confined to the PDs. A primary goal for the authors of the DSM-5 was to begin shifting the entire classification toward dimensions (Kupfer, First, & Regier, 2002). DSM-5 Research Planning Work Groups were formed to set an effective research agenda for this next edition of the diagnostic manual with a move toward dimensional systems in mind. The Nomenclature Work Group, charged with addressing fundamental assumptions of the diagnostic system, concluded that it would be "important that consideration be given

to advantages and disadvantages of basing part or all of DSM–V on dimensions rather than categories” (Rounsaville et al., 2002, p. 12)

An empirically based, dimensional organization of psychopathology has been developed concurrently with the DSM–5 AMPD (e.g., Achenbach & Rescorla, 2001; Clark & Watson, 2008; Forbush & Watson, 2013; Kotov et al., 2011; Krueger & Markon, 2006; Lahey et al., 2008). This quantitative nosology is emerging from multiple research groups working together to identify the natural organization of psychopathology (Kotov, 2016). Indeed, a consortium of 40 investigators coauthored an initial Hierarchical Taxonomy of Psychopathology (HiTOP) as an alternative to the traditional categorical classification (Kotov et al., 2017).

HiTOP currently includes, at the highest level, a general factor of psychopathology, beneath which are the broad domains of internalizing, externalizing, and thought disorder (Caspi et al., 2014; Forbes et al., 2017; Kotov et al., 2017; Lahey et al., 2012; Lahey, Van Hulle, Singh, Waldman, & Rathouz, 2011). This organizational structure received formal recognition within DSM–5, wherein the categorical diagnoses are clustered in a manner consistent with the HiTOP structural model: “Clustering of disorders according to what has been termed internalizing and externalizing factors represents an empirically supported framework” (American Psychiatric Association, 2013, p. 13). Further down within this initial version of the HiTOP structural model are the five domains of detachment, antagonistic externalizing, disinhibited externalizing, thought disorder, and internalizing (along with somatoform). These five domains are not equivalent or confined to PD (e.g., internalization includes mood and anxiety disorders), but they do clearly align with the domains of the DSM–5 Section III dimensional trait model (i.e., Criterion B), consisting of detachment, antagonism, disinhibition, psychoticism, and negative affectivity (Kotov et al., 2017).

Although the DSM–5 AMPD dimensional trait model closely aligns with the current HiTOP structural model (Kotov et al., 2017) there is currently no explicit reference within HiTOP to the AMPD Criterion A deficits (or impairments). Indeed, if Criterion A deficits (or impairments) are considered to be independent of the Criterion B maladaptive personality traits, their placement within HiTOP is perhaps unclear. The purpose of this article is to review relevant research with respect to the potential inclusion and placement of Criterion A within HiTOP.

Criterion A and Criterion B

Criterion A consists of deficits or impairments in self-functioning (identity and self-direction) and interpersonal relatedness (empathy and intimacy). These deficits appear in two locations of the AMPD. First, they define the Level of Personality Functioning (LPF; Bender, Morey, & Skodol, 2011). The LPF is used to assess the severity of PD dysfunction or impairment, which in turn identifies the presence of PD. “The [LPF] rating is necessary for the diagnosis of a personality disorder (moderate or greater impairment) and can be used to specify the severity of impairment present” (American Psychiatric Association, 2013, p. 772). Five levels of impairment (little to none, some,

moderate, severe, and extreme) are specified for each of the areas (i.e., identity, self-direction, empathy, and intimacy). For example, at the severe level of identity impairment the boundaries with others are said to be confused or lacking, significant distortion and confusion in self-appraisal are present, and hatred and aggression are dominant affects (American Psychiatric Association, 2013). The severe level of impairment in empathy is defined by a pronounced inability to consider and understand others’ motivations, an absence of attention to others’ perspectives, as well as confusing and disorienting social interactions.

In addition, the self–other deficits constitute half of the diagnostic criteria for six PDs (identified therein as Criterion A), with two or more required for the disorder to be considered present. For example, for narcissistic PD, there are specified deficits in identity (e.g., exaggerated self-appraisal either as inflated or deflated), self-direction (e.g., goal setting based on gaining approval from others), empathy (e.g., inability to recognize or identify with the feelings or needs of others), and intimacy (e.g., relationships are largely superficial and exist to serve one’s own self-esteem).

The A and B diagnostic criteria are derived from distinguishable scholarly traditions (Bender et al., 2011; Krueger & Markon, 2014; Waugh et al., 2017) and are intended to represent distinct components of personality (American Psychiatric Association, 2013). However, in some cases, it is difficult to distinguish the deficits of Criterion A from the maladaptive traits of Criterion B. For example, the Criterion A deficit in empathy for antisocial PD is a “lack of concern for feelings, needs, or suffering of others; lack of remorse after hurting or mistreating another” (American Psychiatric Association, 2013, p. 764). Criterion B includes the maladaptive trait of callousness, which is similarly defined as a “lack of concern for feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one’s actions on others” (American Psychiatric Association, 2013, p. 764). For obsessive–compulsive PD (OCPD), the Criterion A self-direction deficit involves “rigid and unreasonably high and inflexible internal standards of behavior; overly conscientious” (American Psychiatric Association, 2013, p. 768). Criterion B maladaptive traits for OCPD include rigid perfectionism as “an aspect of extreme conscientiousness” that includes a “rigid insistence on everything being flawless, perfect, and without errors or faults” (American Psychiatric Association, 2013, p. 768).

In most other cases, there is not as much explicit redundancy, albeit some overlap is still apparent. For example, narcissistic PD Criterion B includes attention-seeking, which involves “excessive attempts to attract and be the focus of the attention of others; admiration seeking” (American Psychiatric Association, 2013, p. 768), whereas for Criterion A the identity deficit involves an “excessive reference to others for self-definition and self-esteem regulation” (American Psychiatric Association, 2013, p. 767). There is also an “exaggerated self-appraisal inflated” (American Psychiatric Association, 2013, p. 767) as part of Criterion A, which would appear to mirror closely the grandiosity of Criterion B.

In other cases, there is no explicit overlap. For example, for borderline PD, none of the Criterion B maladaptive traits refer explicitly to an instability or uncertainty of self-image, whereas

instability and uncertainty in self-image are predominant features of the Criterion A deficits and the LPF. The fact that this instability in self-image appears nowhere within the Criterion B trait model would suggest an important and fundamental distinction. On the other hand, this could also reflect simply a difference in coverage rather than a fundamental distinction between functional deficits (or impairments) and maladaptive traits. Instability or uncertainty in self-image is not included anywhere within the *DSM-5* dimensional trait model, but it is not the case that the *DSM-5* AMPD trait model is necessarily providing or covering all possible maladaptive traits. For example, the Computerized Adaptive Test of Personality Disorder (CAT-PD; Simms et al., 2011), includes a number of traits not included within the *DSM-5* trait model, such as health anxiety, domineering, hostile aggression, norm violation, rigidity, rudeness, and workaholism. Indeed, other measures of maladaptive personality traits do include scales specifically assessing instability or uncertainty in self-image. For example, included within the Five Factor Borderline Inventory (FFBI; Mullins-Sweatt et al., 2012), a measure of maladaptive personality traits (aligned with domains of the Five-Factor Model [FFM]), is a Self-Disturbance scale (including such items as, “I sometimes wonder who I really am” and “I can be so different with different people that I wonder who I am”). Similarly, the Dimensional Assessment of Personality Pathology–Basic Questionnaire (DAPP–BQ; Livesley & Jackson, 2009), a commonly used measure of a long-standing dimensional trait model of PD (Livesley, 2001), includes a scale of Identity Problems, which again assesses for unstable sense of self or identity.

In sum, a consideration of the content of Criterion A and Criterion B would appear to suggest considerable overlap, but the degree of overlap and distinctiveness is an empirical question. If these were distinguishable empirically from one another, it would suggest that Criterion A would need to be added to the HiTOP model. If there were considerable overlap then it would suggest that Criterion A is already within HiTOP by virtue of the Criterion B traits. To address this question, we consider research concerning the relations between Criterion A and the general factor of PD as well as the traits of Criterion B.

General factors of personality disorder and psychopathology

As noted earlier, a general factor of psychopathology forms the highest level of HiTOP (Caspi et al., 2014; Kotov et al., 2017; Lahey et al., 2012; Lahey, Krueger, Rathouz, Waldman, & Zald, 2017). There are compelling reasons to consider that this general factor of psychopathology, often referred to as the p-factor (Caspi et al., 2014), will align closely with the AMPD Criterion A deficits.

The Criterion A deficits are not only conjoined with the Criterion B traits to provide the diagnostic criteria for six PDs within the *DSM-5* AMPD (American Psychiatric Association, 2013, pp. 764–769); they are also used to define the overall level of personality functioning to be considered when identifying the presence of a PD. “Disturbances in self and interpersonal functioning constitute the core of personality psychopathology” (American Psychiatric Association, 2013, p. 762).

Consistent with this understanding, studies have suggested that the general factor of PD, often referred to as g-PD, is defined largely by these deficits. Sharp and colleagues (2015) considered the covariation among interview-rated diagnostic criteria for the six *DSM-IV* PDs included within the *DSM-5* Section III AMPD (i.e., they did not consider the diagnostic criteria for the dependent, histrionic, paranoid, or schizoid PDs). An exploratory bifactor analysis yielded a g-PD factor, along with six specific factors. They noted that all the borderline PD (BPD) criteria loaded solely on the g-PD factor. Additional PD criteria loaded on this factor (e.g., obsessive–compulsive, avoidant, and antisocial), but with only a few exceptions, these criteria also loaded on one of the additional specific factors. Sharp and colleagues (2015) therefore suggested that the g-PD factor was a substantive representation of the *DSM-5* Section III AMPD Criterion A: “Although we do not yet know the exact nature of the general factor, to stimulate further research, we speculate on some intriguing interpretative possibilities. ... One answer may lie in Criterion A of the new *DSM-5-III* General Criteria of Personality Disorder” (p. 394). BPD is the only personality disorder that includes explicitly the more severe Criterion A deficits in identity within its *DSM-IV* criterion set. “BPD is unique in that impairment in the ability to maintain and use benign and coherent internal images of self and others are integrated into one disorder” (Sharp et al., 2015, p. 394). It is then perhaps consistent with the centrality of these deficits to BPD and to personality disorder that BPD loads heavily and specifically on the g-PD.

Wright, Hopwood, Skodol, and Morey (2016) used a bifactor modeling approach to characterize the covariation among interview-rated PD criteria (using the diagnostic criteria for all of the *DSM-IV* PDs) and found a g-PD factor along with five more specific factors. They, too, found that the BPD criteria loaded uniquely on the g-PD factor and not on any of the specific factors. The g-PD factor also correlated with all but one of the maladaptive personality trait scales of the Schedule for Nonadaptive and Adaptive Personality Inventory–2 (Clark, Simms, Wu, & Casillas, 2014); the exception was Exhibitionism. In comparison to the specific factors, g-PD had the highest concurrent and longitudinal associations with worsening in social, occupational, and leisurely functioning across several years, consistent with the findings obtained for the p-factor (Caspi et al., 2014; Lahey et al., 2012). In line with the Sharp et al. (2015) understanding of the g-PD factor, Wright et al. (2016) suggested that “one possible interpretation is that it reflects borderline personality organization (Kernberg, 1984), with core impairments involving maladaptive self and other representations and identity formation” (p. 1129). Kernberg (1984) had proposed a broad continuum of dysfunction that would cover all of psychopathology, consisting of a neurotic level, a borderline level (including most PDs), and a psychotic level (including the severe forms of psychopathology, such as schizophrenia). Indeed, Kernberg (2012) also suggested that *DSM-5* AMPD Criterion A is aligned well with his understanding of borderline personality organization.

It should be acknowledged, however, that not all g-PD studies have reported that the BPD criteria largely defined the general factor. Jahng et al. (2011) delineated a bifactor model of PD and substance abuse syndromes. They reported that the

PDs with the highest loadings were paranoid, schizoid, avoidant, and dependent (i.e., not borderline) and interpreted the g-PD as reflecting interpersonal dysfunction. “These disorders’ symptoms have in common interpersonal distance or interpersonal problems” (Jahng et al., 2011, p. 665).

Muñoz-Champel, Gutierrez, Peri, and Torrubia (in press) used Goldberg’s exploratory “bass-ackwards” method of factor analysis to delineate a hierarchical structure of personality pathology from self-reported PD symptom criteria. Their general factor of personality pathology correlated highly (e.g., $r > .50$) with nine *DSM-IV* PDs, as well as 13 of 22 scales of the DAPP-BQ (Livesley & Jackson, 2009). They did not provide a substantive interpretation of the g-PD, but they did explicitly suggest that their findings did “not portray borderline as a general factor” (Muñoz-Champel et al., in press, p. 11). They noted that in the multifactor exploratory analyses, most of the BPD criteria loaded on multiple factors. BPD did correlate highly with the general factor, but it was just one of nine PDs that obtained large effect size relationships with the general factor.

Nevertheless, perhaps it should not be surprising that g-PD would align with the p-factor, and that these would in turn be highly related to BPD. The p-factor has correlated strongly with FFM neuroticism, antagonism, and low conscientiousness (Caspi et al., 2014; Tackett et al., 2013) as has the g-PD (Wright et al., 2016). In fact, this might also help to explain why BPD would be highly related to g-PD, as both are defined primarily by the same domains (e.g., high neuroticism, low conscientiousness, and high antagonism). In addition, PDs have been included within some p-factor studies and “Axis I” syndromes have been included in some g-PD studies. For example, antisocial PD was included within the p-factor study of Lahey et al. (2012), and substance use disorders were included within the g-PD study of Jahng et al. (2011).

General factors of personality (GFP) studies, albeit at times controversial with respect to the validity of a GFP (Hopwood, Wright, & Donnellan, 2011; Pettersson, Turkheimer, Horn, & Menatti, 2012), have also included measures of PD and even psychopathology more generally. Irwing, Booth, Nyborg, and Rushton (2012) extracted a GFP from the clinical scales of the Minnesota Multiphasic Personality Inventory–2 (e.g., scales assessing for schizophrenia, mania, depression, and hypochondriasis, along with psychopathic deviate and social introversion), (Hathaway, McKinley, & MMPI Restandardization Committee, 1989). Rushton and Irwing (2009) extracted a GFP from the scales of the Millon Clinical Multiaxial Inventory–III (Millon, Millon, Davis, & Grossman, 2009; scales assessing for both Axis I and Axis II syndromes), the Personality Assessment Inventory (Morey, 2007; scales assessing for Axis I syndromes, treatment consideration, and maladaptive interpersonal relatedness), and the DAPP-BQ (Livesley & Jackson, 2009; scales assessing for maladaptive personality traits). Rushton and Irwing understood these to be GFP studies, but they could also be understood to be g-PD or p-factor studies. Oltmanns, Smith, Oltmanns, and Widiger (in press) obtained g-PD, p-factor, and GFP general factors with commonly used measures for each, and reported substantial correlations of all three with one another (ranging from .70–.92). In sum, to the extent that the Criterion A deficits are in fact central or common to all of the PDs, one would expect that they would be predominant within the general factor of PD (Sharp et al., 2015; Wright et al., 2016) and thereby

as well within the general factor of psychopathology more generally.

Criterion A and B studies

There is now a substantial body of research concerning the *DSM-5* AMPD Criterion B traits, with a number of studies documenting the ability of the Criterion B traits to account for variance in the *DSM-IV* PD symptomatology (Bagby, 2013; Krueger & Markon, 2014; Rojas & Widiger, 2017). There are fewer studies concerning Criterion A, due perhaps in part to the initial absence of an explicit or direct self-report measure for their assessment, albeit the number of such studies is clearly growing.

Studies comparing Criterion A versus B

One of the first explicit Criterion A studies was provided by Berghuis, Kamphuis, and Verheul (2012) in a study sampling 261 psychiatric patients. They reported evidence that the self-deficits of Criterion A lie outside of general personality structure, and suggested that this is consistent with the *DSM-5* AMPD providing an explicit distinction between Criterion A and B. “Our findings support the distinction between personality traits and personality dysfunction laid down in the recent proposal by the Personality and Personality Disorders Work Group of the *DSM-5* Task Force” (Berghuis et al., 2012, p. 704). Criterion B traits were assessed by the Revised NEO Personality Inventory (NEO PI-R; Costa & McCrae, 1992), for which the domain of neuroticism is closely aligned with *DSM-5* Section III Criterion B negative affectivity (Krueger, Derringer, Markon, Watson, & Skodol, 2012). For the assessment of Criterion A, they used (a) the 19 scales of the General Assessment of Personality Disorders (GAPD), which includes 15 scales of self-identity dysfunction and 4 scales of interpersonal dysfunction (Livesley, 2006), and (b) the 16 scales from the Severity Indices for Personality Problems (SIPP-118; Verheul et al., 2008). The scales from the GAPD and SIPP-118 clearly assess constructs closely comparable to the Criterion A deficits, including (for instance) lack of self-clarity, self-state disjunctions, fragmentary self–other representations, defective sense of self, and poorly differentiated images of others. It is also perhaps noteworthy that these measures were developed by members of the *DSM-5* Personality and Personality Disorders Work Group.

Berghuis et al. (2012) submitted the correlations among the NEO PI-R, GAPD, and SIPP-118 scales to a principal components analysis. The NEO PI-R scales did load substantially on and helped to define six of the seven factors. However, the first (self-identity) factor was not at all defined by any NEO PI-R scales. It was confined simply to 19 scales of self-pathology (15 from the GAPD and 4 from the SIPP-118). Berghuis et al. therefore concluded that the core components of personality disorder (i.e., self-pathology) and the FFM involved “clearly distinct components of personality” (Berghuis et al., 2012, p. 704).

Oltmanns and Widiger (2016), however, subsequently suggested that the results of Berghuis et al. (2012) might simply have reflected the phenomenon of a bloated specific factor

(Cattell & Tsujioka, 1964; Wright, 2017). Berghuis et al. (2012) had included a large number of scales assessing alternative forms of self-pathology (i.e., 15 from the GAPD and 4 from the SIPP-118). Even if these scales are validly understood as components of neuroticism, they would likely correlate much more highly with one another than with other facets of neuroticism, such as angry hostility, vulnerability, self-consciousness, and impulsivity. If one facet of neuroticism is much more heavily represented than the other facets of neuroticism, it will likely yield a factor independent of the other facets of neuroticism (DeYoung, 2011). Indeed, Oltmanns and Widiger (2016) demonstrated that self-pathology scales from the GAPD loaded within neuroticism when the representation of this potential facet of neuroticism was not represented excessively relative to other facets of neuroticism.

Berghuis, Kamphuis, and Verheul (2014) used the same data set of Berguis et al. (2012) to provide a more direct test of the distinction between Criterion A and Criterion B. Their original data set had included not only the GAPD and SIPP-118, but also a reasonable proxy measure of the Criterion B traits, provided by the DAPP-BQ (Livesley & Jackson, 2009). The DAPP-BQ assesses for such maladaptive traits as affective lability, callousness, and anxiousness, which are closely congruent with DSM-5 Criterion B. Berghuis et al. (2014) also administered the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First & Gibbon, 2004) as an assessment of the DSM-IV PDs.

Berghuis et al. (2014) reported substantial correlations of the GAPD and SIPP-118 with the DAPP-BQ. For example, GAPD Self-Pathology and SIPP-118 Identity Integration correlated .88 and -.82, respectively, with DAPP-BQ Emotional Dysregulation. The GAPD and SIPP-118 accounted for 34% and 32%, respectively, of the variance within total PD. The DAPP-BQ accounted for 42%. With respect to incremental validity, the GAPD had no incremental validity over the DAPP-BQ, and the SIPP-118 had only 1%. The DAPP-BQ had 7% over the GAPD and 4% over the SIPP-118. With respect to the individual PDs, the GAPD had incremental validity over the DAPP-BQ ranging from 1% to 2%, whereas the DAPP-BQ incremental validity ranged from 4% (paranoid) to 15% (avoidant). The SIPP-118 evidenced incremental validity over the DAPP-BQ ranging from 3% (avoidant) to 7% (borderline), whereas incremental validity of the DAPP-BQ over the SIPP-118 ranged from 4% (paranoid) to 12% (avoidant).

Berghuis et al. (2014) emphasized the positive results for the SIPP-118 relative to the DAPP-BQ: “The SIPP-118 significantly added to the prediction provided by the DAPP-BQ for every specific PD dimension analyzed” (p. 415). More generally, they concluded that the results supported the AMPD distinction between Criterion A and Criterion B because both accounted for unique variance within PDs. “The combination of general personality dysfunction models and personality traits models provided incremental information about the presence and severity of personality disorders, suggesting that an integrative approach of multiple perspectives might serve comprehensive assessment of personality disorders” (Berghuis et al., 2014, p. 410).

Bastiaansen, De Fruyt, Rossi, Schotte, and Hofmans (2013) administered the NEO PI-R (Costa & McCrae, 1992) and the

SIPP-118 (Verheul et al., 2008), along with the Assessment of DSM-IV Personality Disorders (Schotte et al., 2004), to 159 psychiatric patients. They reported substantial convergence of the NEO PI-R and SIPP-118 scales (e.g., Neuroticism correlated $-.79$ with SIPP-118 Identity Integration and Agreeableness correlated $.61$ with Responsibility), but each also demonstrated incremental validity. SIPP-118 explained from 3% (avoidant) to 10% (schizoid and narcissistic) additional variance, and the NEO PI-R explained from 6% (dependent) to 18% (avoidant) additional variance. Bastiaansen et al. (2013) suggested that their findings “can be interpreted as initial support for the two-component PD description ... in the alternative DSM-5 proposal” (p. 301), although they acknowledged that the NEO PI-R might not be understood as a direct measure of the DSM-5 maladaptive traits.

Few et al. (2013) administered the SCID-II (First & Gibbon, 2004) to 109 persons currently within psychological-psychiatric treatment. To assess Criterion A, the interviewers, after conducting the DSM-IV PD interviews, completed the DSM-5 AMPD LPF Scale (American Psychiatric Association, 2013), which assesses the four components of Criterion A. To assess Criterion B, the interviewers also completed the DSM-5 Clinicians’ Personality Trait Rating Form (PTRF; American Psychiatric Association, 2011), which assesses each of the 25 AMPD Criterion B traits. Few et al. (2013) also administered the Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012), which provides a self-report assessment of the DSM-5 AMPD Criterion B maladaptive traits. The LPF Criterion A Identity score correlated $.69$ with PID-5 Negative Affectivity; Self-Directedness, though, correlated only $.33$ with Disinhibition (albeit $.51$ with Negative Affectivity); Empathy correlated $.43$ with Antagonism; and Intimacy correlated $.54$ with Detachment. The four Criterion A scores each related strongly with the sum of the DSM-IV PDs (ranging from $.53$ – $.59$). However, the PTRF Criterion B assessments accounted for 14% (avoidant) to 50% (antisocial) additional variance over and above the LPF Criterion A assessments. The LPF Criterion A assessments did not account for any significant additional variance for any DSM-IV PD (ranging from 0%–5%), over and above the PTRF Criterion B assessments. Few et al. (2013) concluded, “the impairment ratings may have limited clinical utility in that they did not provide incremental information beyond pathological personality traits in the explanation of PD constructs” (p. 1068).

Hentschel and Pukrop (2014) administered the GAPD and DAPP-BQ, along with the SCID-II (First & Gibbon, 2004), to 149 psychiatric patients (inpatient and outpatient). The DAPP-BQ and GAPD again correlated substantially. DAPP-BQ Emotional Dysregulation correlated $.86$ with GAPD Self-Pathology; DAPP-BQ Inhibitedness and Dissocial correlated $.64$ and $.42$, respectively, with GAPD Interpersonal Pathology (DAPP-BQ Emotional Dysregulation correlated $.54$). With respect to incremental validity, the GAPD accounted for 51% of the total PD variance, with the DAPP-BQ accounting for 7.5% of additional variance. The DAPP-BQ accounted for 57% of the variance in total PD, with the GAPD explaining only 1.5% additional variance, a nonsignificant finding. Hentschel and Pukrop (2014) concluded, “Criterion B shows incremental validity over criterion A but criterion A only in part over

criterion B” (p. 412). Perhaps most important for the purposes of this review, they emphasized that there is substantial overlap of Criteria A and B.

Clark and Ro (2014) administered a large number of measures of impaired functioning and maladaptive traits to a mixed sample of community adults and outpatients. The measures of personality impairment included scales from the SIPP–Short Form, a 60-item version of the SIPP–118 (Verheul et al., 2008), Livesley’s GAPD, and Parker and colleagues’ (2004) Measure of Disordered Personality Functioning (MDPF), which also has scales for self- and interpersonal impairment. They extracted five factors and found that measures of personality impairment and maladaptive traits were intermixed in each of the first two factors: The first factor was marked by measures of self-impairment and multiple scales tapping negative affectivity, whereas the second factor was marked by measures of interpersonal impairment and scales tapping the maladaptive traits of detachment and antagonism. Given this intertwining of personality impairment and maladaptive traits, they concluded “there remains the empirical challenge of showing that we can assess traits and functioning distinctly and reliably” (p. 67).

Fossati, Borroni, Somma, Markon, and Krueger (2017) similarly used the Parker et al. (2004) MDPF as a measure of the Criterion A impairments in a sample of 333 community participants, with the MDPF Noncoping scales aligning with Criterion A self-impairments and the MDPF Noncooperativeness scale aligning with Criterion B. They reported substantial correlations of the MDPF scales with PID–5 domain and facet scales, concluding that there is perhaps little distinction: “The majority of pathological traits imply dysfunctions in self and interpersonal functioning” (Fossati et al., 2017, p. 279).

Zimmermann et al. (2015) had 145 therapists rate a patient who had personality problems, and 515 lay persons describe someone they knew (one third of whom were considered to be “psychologically healthy” and two thirds had “mental health or interpersonal problems”), with respect to the DSM–5 Section III LPF, as well as with the informant version of the PID–5 (Markon, Quilty, Bagby, & Krueger, 2013). Participants also provided a single-item assessment of overall level of personality functioning. Zimmermann et al. reported that, in both samples, only the self-pathology rating obtained incremental validity with respect to global level of functioning (Criterion B traits obtained no incremental validity). They also reported substantial covariation and apparent overlap across Criteria A and B. Most important for this review, perhaps, is that they conducted a joint factor analysis of the four LPF scales with the 25 trait scales, yielding a seven-factor solution. Zimmermann et al. indicated that “the first two factors resembled the self- and interpersonal functioning factors [of the LPF] but were also saturated with specific content from the Criterion B trait facets” (p. 540). The first factor was identified as a self-pathology factor, which had a high primary loading for Criterion B Depression and moderate loadings for Separation Insecurity, Anhedonia, and Rigid Perfectionism (which loaded negatively on this dimension). The second factor was said to capture Criterion A Interpersonal Pathology, but also had strong primary loadings for Criterion B Grandiosity and Callousness, as well as moderate cross-loadings for Hostility. The additional five factors were defined by Criterion B traits. Zimmermann et al.

concluded that “our findings point to the fact that the distinction between Criteria A and B is not as clear cut as the model suggests” (p. 544).

Creswell, Bachrach, Wright, Pinto, and Ansell (2016) administered the PID–5 and GAPD to a sample of 877 persons recruited on Craigslist. They related the two measures of personality to alcohol use. They reported that “despite a significant zero-order association between [GAPD] general personality pathology and [alcohol use] scores, general personality pathology no longer predicted hazardous alcohol use once Antagonism and Disinhibition were added into the models” (p. 108).

Rossi, Debast, and Van Alphen (2017) administered the PID–5 and SIPP–Short Form (SIPP–SF; Verheul et al., 2008) to a sample of younger ($n = 210$) and older ($n = 171$) adults. They reported considerable convergence of the PID–5 scales with the SIPP–SF scales (e.g., PID–5 Disinhibition correlated .68 with SIPP–SF Self-Control and .70 with SIPP–SF Responsibility; PID–5 Negative Affectivity correlated .55 with Identity Integration; and PID–5 Antagonism correlated .53 with Social Concordance). Rossi et al., however, did not speak to their potential overlap or distinctiveness, as the focus of the study was concerned instead with the validity of the SIPP–SF within older adults. The results of Rossi et al. were subsequently replicated by Debast, Rossi, and van Alphen (2017) with an abbreviated measure of the PID–5, again administered to an older adult (over 65) community sample.

Roche (in press) conducted a 14-day electronic diary study, assessing both daily levels of Criteria A and B along with daily levels of personality dysfunction across several domains in a sample of 175 college students. The shared variance was substantial, but Criteria A and B both evidenced a degree of incremental validity in accounting for different aspects of dysfunction. They concluded that “Both Criterion A and B are uniquely predictive of several outcomes, suggesting both Criterion A and B are useful to retain in the AMPD model moving forward” (p. 21). Comparable results were provided in an earlier study by Roche, Jacobson, and Pincus (2016).

Studies concerning specific personality disorders

Two recent studies have examined OCPD specifically (Liggett & Sellbom, in press; Liggett, Sellbom, & Carmichael, 2017). Liggett, Sellbom, et al. (2017) administered the PID–5, the SCID–II Personality Questionnaire, and Personality Diagnostic Questionnaire (PDQ–4; Bagby & Farvolden, 2004) OCPD scales, and several impairment measures, one that was specifically designed to assess Criterion A OCPD-specific impairment (Liggett, Carmichael, Smith, & Sellbom, 2017) to 313 community and university student adults. Liggett, Carmichael, et al. (2017) found that the OCPD-specific Criterion A measure correlated moderately with a latent factor representation of OCPD, and added a statistically significant increment above and beyond Criterion B personality traits in a hierarchical regression model. Liggett and Sellbom (in press) replicated these general findings using a sample of 212 community-dwelling individuals who reported being in mental health treatment currently or within the past 12 months. They also had informants who knew them well rate them on informant versions of the PID–5, SCID–II–PQ OCPD scale, and the OCPD-specific

Criterion A measure mentioned earlier. In both the self-report and the informant analysis, Criterion A impairment was observed to statistically increment Criterion B personality traits in the prediction of SCID-II-PQ OCPD symptom scores. Liggett and Sellbom (*in press*) concluded that “the alternative model’s reliance on disorder-specific impairment was strongly supported by the study’s results” (p. 23).

Wygant et al. (2016) administered the SCID-II (First & Gibbon, 2004) and the Psychopathy Checklist-Revised (PCL-R; Hare, 2003) to 200 male inmates, along with the PID-5 (Krueger et al., 2012) and the DSM-5 PTRF (American Psychiatric Association, 2011) to assess Criterion B traits; and 14 interview-based items developed to assess for the Criterion A impairments specified for antisocial personality disorder (ASPD). In a hierarchical regression, the seven PTRF ASPD traits were entered first, followed by the four impairment-deficit scales to account for variance in DSM-IV ASPD and PCL-R psychopathy. The authors noted that, “In the regression analyses, the four impairment scores significantly augmented the seven PTRF ASPD traits in all analyses” (Wygant et al., 2016, p. 236), with increments in variance ranging from 3% to 6% (although a reverse comparison, evaluating whether the traits had incremental validity over the impairment deficits, was not conducted). They concluded that, “Our analyses yielded consistent evidence that impairment scores indeed augmented prediction for the trait profile in all instances, with specific impairment facets mapping onto conceptually relevant psychopathy domains” (Wygant et al., 2016, p. 237). They suggested that their findings were more encouraging than the results reported by Few et al. (2013) because their assessment included items (questions) written explicitly with respect to the deficits specified for ASPD Criterion A.

Sleep, Wygant, and Miller (*in press*) compared the ability of Criterion A and Criterion B to account for the variance within ASPD, BPD, and narcissistic personality disorder (NPD) in a sample of 200 female inmates. They reported substantial convergence of Criterion A and B for ASPD ($r = .57$) and BPD (.68), but not for NPD (.19). To examine the unique variance that Criterion A and B were able to capture in each target PD, regression analyses were conducted in which each PD was regressed simultaneously on the impairment and trait composites. In all cases, the trait composites accounted for a substantial proportion of the variance, ranging from 18% (NPD) to 27% (BPD) of unique variance in the PDs. Conversely, the impairment ratings only accounted for significant (and modest) amount of variance in two of these PDs (NPD and BPD), with semipartial squared values ranging from 0% (ASPD) to 7% (NPD).

Criterion A studies not involving Criterion B

Additional studies concerning Criterion A have been conducted, but these studies have not directly compared or related Criterion A with Criterion B. For example, Hentschel and Livesley (2013) reported a strong relationship of GAPD Criterion A scales with the DSM-IV PDs (with the self-scales showing incremental validity over the interpersonal scales) but made no comparisons with Criterion B traits. Morey, Bender, and Skodol (2013) indicated that the AMPD LPF had incremental

validity over DSM-IV PD symptomatology in accounting for clinical judgments of psychosocial functioning, short-term risk, estimated prognosis, and optimal level of treatment intensity.

Recently developed LPF and Criterion A measures

More recently, a number of self-report measures have been developed that assess explicitly DSM-5 Section III AMPD Criterion A: the DSM-5 Levels of Personality Functioning Questionnaire (DLOPFQ; Huprich et al., *in press*), the Level of Personality Functioning Scale-Brief Form (LPFS-BF; Hutsebaut, Feenstra, & Kamphuis, 2016), and the Level of Personality Functioning Scale-Self Report (LPFS-SR; Morey, 2017). Each of these self-report measures assess for the LPF of Section III. Anderson and Sellbom (2018) also developed a self-report measure of the Criterion A deficits specific to each PD (two of the scales were used in a study by Liggett, Carmichael, et al., 2017), but no title was provided for this measure. In some studies, these measures have been compared with or related to the DSM-5 Section III Criterion B traits. This was not the case, though, in other studies. Hutsebaut et al. (2016) correlated the LPFS-BF with the DSM-IV PDs; Liggett, Carmichael, et al. (2017) correlated the Criterion A scales for the obsessive-compulsive and avoidant PDs with general measures of dysfunction and impairment; and Morey (2017) correlated his LPFS-SR with the DAPP-BQ and SIPP-118 scales.

In three of the studies using these measures, the Criterion A measures have been related to DSM-5 Section III Criterion B traits. The LPFS-SR (Morey, 2017) is an 80-item measure developed to assess the four components of the DSM-5 Section III LPF (i.e., identity, self-direction, intimacy, and empathy). Hopwood, Good, and Morey (*in press*) administered the LPFS-SR, the CAT-PD (Simms et al., 2011), the PID-5 (Krueger et al., 2012), the PDQ-4 (Bagby & Farvolden, 2004), and the Big Five Inventory-2 (Soto & John, 2017), along with additional measures, to multiple samples obtained from Amazon’s Mechanical Turk. They reported substantial correlations for all of the LPFS-SR scales with the FFM (e.g., .67 for Self with Neuroticism, -.60 for Self-Direction with Conscientiousness, -.56 for Intimacy with Agreeableness, and -.55 for Empathy with Agreeableness). Correlations, not surprisingly, were even higher with the CAT-PD and PID-5 scales. LPFS-SR Identity correlated .70 with CAT-PD Affective Lability, Self-Direction correlated .67 with Irresponsibility, Empathy correlated .60 with Hostile Aggression, and Intimacy correlated .65 with Relationship Insecurity. With respect to the PID-5, LPFS-SR Identity correlated .66 with Emotional Lability and .74 with Depressivity; Self-Direction correlated .70 with Irresponsibility; Empathy correlated .70 with Callousness; and Intimacy correlated .61 with Hostility (.50 with Separation Insecurity). The LPFS-SR scales also correlated substantially with the DSM-IV PDs, but no direct comparisons or incremental validity analyses with respect to the CAT-PD or PID-5 scales were provided (the study focused more on discriminant validity). Hopwood et al. (*in press*) concluded that “this paper supports the validity of a new self-report measure that corresponds directly to the DSM-5 alternative model Criterion A” (p. 20), and in the discussion section suggested alternative models for potentially distinguishing between Criterion A and B.

The DLOPFQ (Huprich et al., *in press*) includes four scales (Identity, Self-Directedness, Empathy, and Intimacy), with each including two subscales, one for the assessment of the deficits (or impairments) within personal relationships and the other assessing the deficits within work or school. In a sample of 140 patients (83 from outpatient psychiatry and 57 from internal medicine), they reported substantial correlations of some DLOPFQ scales with respective scales from the PID-5-Brief Form (PID-5-BF; Krueger et al., 2012), such as .68 for DLOPFQ Identity with PID-5 Negative Affectivity, and .66 for DLOPFQ Intimacy with PID-5 Detachment. However, DLOPFQ Self-Directedness correlated “only” .45 with PID-5 Disinhibition (DLOPFQ Self-Directedness did correlate .64 with PID-5 Negative Affectivity), and DLOPFQ Empathy correlated only .39 with PID-5 Antagonism (DLOPFQ Empathy correlated .56 with PID-5 Negative Affectivity). Huprich et al. (*in press*) also compared the DLOPFQ impairment and PID-5-BF domain scales with respect to their ability to account for unique variance in a variety of measures of relationship quality (i.e., attachment, dependency) and overall functioning (i.e., well-being, health status). They reported that both obtained incremental validity over one another, albeit the DLOPFQ typically accounted for more unique variance than the PID-5. In sum, they acknowledged that although the “DLOPFQ shares substantial amounts of variance with the PID-5-BF” (p. 16), the DLOPFQ did appear to account for up to 14% more variance within a respective criterion measure. They concluded that “we believe our findings contradict those of Few et al. (2013) who suggested that assessing LPF may not be necessary when simultaneously assessing traits” (p. 21).

Bach and Hutsebaut (*in press*) administered an updated version of the LPFS-BF to 120 psychiatric outpatient ($n = 121$) and prison treatment ($n = 107$) units, along with an abbreviated version of the PID-5 (Maples et al., 2015) and measures of social and clinical dysfunction. Similar, perhaps, to the results of Huprich et al. (*in press*), they suggested that the LPFS-BF is “specifically useful for capturing lack of psychological health and fulfillment over and above PID-5 traits” (p. 7). They also reported, though, that the PID-5 total score obtained comparable incremental validity over the LPFS-BF, and that the incremental validity that was obtained was relatively small in comparison to the shared variance.

Anderson and Sellbom (2018) constructed scales to assess the self-interpersonal deficits that are specified within Criterion A for each respective Section III PD. They correlated their Criterion A scales for each of the six *DSM-5* Section III PDs with a measure of the *DSM-5* Section II (*DSM-IV*) PDs, as well as with the PID-5 trait scales specified for each respective PD (e.g., the sum of the PID-5 scales of Grandiosity and Attention-Seeking for narcissistic PD) in a sample of 347 undergraduates. The correlations were often quite substantial (e.g., .78 for avoidant, .75 for borderline, .60 for obsessive-compulsive, and .67 for schizotypal, albeit “only” .48 for anti-social and .45 for narcissistic). They further compared the incremental validity of the Criterion A deficits and Criterion B traits with respect to accounting for variance within the respective *DSM-IV* PDs, considering only the PID-5 trait scales that were specified for each respective *DSM-5* Section III PD (e.g., again only the traits of grandiosity and attention-

seeking for narcissistic PD). The Section III Criterion B traits obtained incremental validity over the Criterion A traits for five of the six PDs (the exception occurred for avoidant). The Section III Criterion A deficits obtained incremental validity only for avoidant PD. Anderson and Sellbom (*in press*) concluded that “our results continue to call into question the utility of the measurement of impairment as a necessary component in assessing and diagnosing PDs” (p. 10).

Conclusions

Many of the Criterion A and B studies have been concerned with the question of whether Criterion A is really necessary; or more specifically, whether Criterion A deficits have incremental validity over Criterion B traits. However, incremental validity is not the specific or precise concern of this article. This article is instead concerned with the questions of whether Criterion A can be included within the HiTOP model and, if so, where. On the other hand, to the extent that Criteria A and B are independent of one another, this would have an impact on the location of Criterion A within HiTOP—or whether it needs to be included at all.

The results of this review would suggest that the self-interpersonal deficits (or impairments) of Criterion A can to an appreciable extent be included within the HiTOP framework. There is even reason to expect that perhaps they would provide a predominant component of the general factor (Sharp et al., 2015; Wright et al., 2016). However, it must be acknowledged that how the general factor is to be understood remains open to debate (Caspi et al., 2014; Jahng et al., 2011; Lahey et al., 2012; Oltmanns et al., *in press*; Sharp et al., 2015; Wright et al., 2016) and will need to be clarified through further systematic research.

An additional question is whether the Criterion A self-other deficits would fall within one or more of the five (of six) domains of internalizing, antagonistic externalizing, disinhibited externalizing, detachment, and thought disorder (along with somatoform) or instead form their own independent factor. Based on the considerable overlap (American Psychiatric Association, 2013) and covariation of the Criterion A deficits and Criterion B traits (e.g., Anderson & Sellbom, 2018; Bach & Hutsebaut, *in press*; Berghuis et al., 2014; Clark & Ro, 2014; Few et al., 2013; Fossati et al., 2017; Hentschel & Pukrop, 2014; Hopwood et al., *in press*; Huprich et al., *in press*; Sleep et al., *in press*), one might expect that they will comfortably load on the same factors (e.g., perhaps Identity on internalization [along with neuroticism], Self-Direction on disinhibited externalizing, Empathy on antagonistic externalizing, and Intimacy on detachment), consistent with the factor analytic results of Berghuis et al. (2012) and Zimmermann et al. (2015). However, if the factor analysis includes a large number of self- or interpersonal deficit (or impairment) scales relative to the maladaptive personality trait scales (and other Axis I components of these domains), they might instead bind together to form their own distinct factor (Oltmanns & Widiger, 2016; Wright, 2017). In any case, one clear recommendation of this article is for future studies to explore this question empirically. With the presence now of multiple measures of the Criterion A deficits (i.e., the DLOPFQ from Huprich et al., *in press*; the LPFS-BF

of Hutsebaut et al., 2016; and the LPFS–SR by Morey, 2017), such studies are quite feasible.

It is also conceivable that further refinement in the construct specification and assessment will lead to better differentiation. Current research has also been confined largely to self-reports, and it would clearly be useful to expand the method of assessment (e.g., including informants and behavioral outcomes). In any case, what is clearly evident is that the overlap and potential distinctions of Criteria A and B will likely remain a matter of continued empirical exploration and debate.

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