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The assessment of personality disorder: methodological, developmental, and contextual considerations

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The reliable and valid assessment of personality disorders (PDs) faces several challenges in different domains. In particular, the variety of methods, settings, and informants relevant for PD assessment raises questions about best practices. Additionally, issues surrounding assessment across the lifespan, including youth and the elderly, further complicate PD assessment. We review these issues here and point toward future directions in PD assessment, with an emphasis on the utility of dimensional PD assessment.

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Personality disorders (PDs) result in severe impairment and wide-ranging consequences; these problems underscore the need for reliable and valid assessment. First, we will briefly highlight some of the challenges presented by using various assessment methods. Next, we will review the challenges presented by the assessment of PD across the lifespan and potential developmental concerns. Finally, we will discuss challenges in multi-source and multi-informant PD assessment. We end with a forward-looking perspective on PD assessment and a movement toward improving both classification and treatment.

Methodological considerations

Methods of assessment have a large impact on the way PDs are conceptualized across contexts. One central focus in the push to improve PD assessment has been the question of categorical versus dimensional conceptualizations of PD (and, accordingly, decisions around which measures to use). Mounting evidence suggests that a dimensional conceptualization of most disorders, including PDs, is most appropriate [1,2•,3,4]. Convincingly, research has suggested four broad dimensions of personality psychopathology (Disagreeableness, Emotional Instability, Introversion, and Compulsivity) which are stable across clinical and nonclinical samples, with some later evidence for a fifth dimension (Oddity/Peculiarity; [5]). These five dimensions bear striking resemblance to normal personality traits [6,7]. However, resistance to a dimensional approach remains. Nuanced arguments about the benefits and problems of both categorical and dimensional systems have been articulated at length elsewhere [1,8–11]. However, it is important to acknowledge the tension between these two conceptual approaches because they further impact assessment methods accordingly.

The demands of treatment/clinical contexts may influence a preference for categorical conceptualizations of PDs. In contrast, PD assessment methods used in primarily research contexts often take a dimensional approach to better explore the full range of a given trait's distribution in the population. When considering various methods of PD assessment, it is important to note that the method of assessment (e.g., interview versus rating scale) is not de facto linked to one conceptualization of pathology. If, however, the empirical evidence largely supports a dimensional approach, it follows that one method for improving the assessment of PD across contexts would be to have our instruments reflect this.

In treatment/clinical contexts, where the primary goal is typically diagnosis for treatment planning and progress tracking purposes, the most common method is an informal, 'expert judgment' method where the clinician makes a diagnosis using their working knowledge of the diagnostic criteria and based on information gathered during ordinary therapeutic interactions [12]. This method is often idiosyncratic and done in a hierarchical way (e.g., matching to a category based on initial information and failing to assess the remaining symptoms [13•]). In addition, unstructured interviews are more likely to be influenced by the clinician's own biases (e.g., there is evidence for sex bias in the diagnosis of Borderline and Narcissistic PDs; [14]). One empirical method, called the LEAD method (Longitudinal, Expert, All Data), has been suggested as the 'gold standard' for PD diagnosis [15]. It involves a consensus judgment between a team of expert clinicians who, during a case conference, use information from self-reports, informant reports, the client's clinical

chart and notes, and ratings provided by therapists or staff who have interacted with the client. However, this method is time-consuming and infrequently used in actual clinical practice. Similarly, there are five empirically validated semi-structured diagnostic instruments focused specifically on the diagnosis of PDs: the Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV; [16]), the International Personality Disorder Examination (IPDE; [17]), the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; [18]), the Personality Disorder Interview-IV (PDI-IV; [19]), and the Structured Interview for DSM-IV Personality (SIDP-IV; [20]). Although these instruments address some of the shortcomings of unstructured interviews, many of them take 1–2 hours, and consist of as many as 390 items [21••], often rendering them impractical in treatment/clinical contexts.

In research contexts, on the other hand, where time is less of a constraint, structured or semi-structured diagnostic interviews that comprehensively assess the criteria for each possible PD are often used [12,22]. A recent review of instruments identified 23 different questionnaires and interview schedules for use across PD diagnoses [21••]. Additionally, lengthy self-report rating scales for adults, and both self-reports and parent-reports for youth are used [23]. Research contexts, without such pressing time constraints, can afford to collect comprehensive information from each individual, and have shown that understanding the full range of severity on a fine-grained level adds considerably to our understanding of PDs.

Across all contexts, disagreement across informants and sources is the norm. Interrater reliability between clinicians' expert judgements is typically moderate whether the diagnosis is assigned categorically (.40) or dimensionally (.46; [24••]). Similarly, for PDs specifically, clinicians' diagnoses agree with rating scales (e.g., self-report) quite poorly (median agreement = .23; [24••]). This lack of agreement between clinicians, as well as across research versus treatment contexts, emphasizes that there is still a lot of work to be done with regard to the reliable, valid, and practical assessment of PDs.

In order to move toward a dimensional PD conceptualization that resembles the one supported by the evidence, there is a need to use measures, both interviews and rating forms, which are based on this (e.g., [25,26]). Additionally, for maximum utility in treatment settings, there need to be empirically based, non-arbitrary cutoff points within a dimensional system to guide clinical decision-making. Despite evidence that there is improved validity with structured interviews, one major barrier to their use in treatment settings is perceived burdensomeness. It is important to note that there are other potential barriers, including a lack of effective, differentiated treatments based on diagnosis. This may mean that practitioners perceive time spent on increasing diagnostic specificity as having little worthwhile payoff in terms of improved treatment outcomes.

In the move away from categorical and toward dimensional measures, the recommendation from Widiger and Samuel to rely on more than one measure with uncorrelated errors is just as relevant [12]. A critical next step would be to find a combination of efficient self-report and semi-structured measures that clinicians can realistically apply given the time constraints inherent in many treatment settings to alleviate perceived burdensomeness. Overall, research suggests that practitioners, despite the current categorical diagnostic system, are prescribing medication according to symptoms rather than diagnoses [27•], and that the dimensional conceptualization of PDs in DSM-5 is more closely related to clinical judgements regarding treatment planning and prognosis [3,28]. This bodes well for the transition to a transdiagnostic, dimensional conceptualization of PDs.

Developmental considerations

Recent evidence supports both stability and change in PDs across the lifespan [29,30]. This presents challenges for the methods typically used to study PDs, as reliable and valid assessment can be a moving target depending on developmental stage. Since research on PDs has historically focused on early and middle adulthood populations, researchers attempting to study PDs in other populations have typically adapted adult measures, such as diagnostic interviews or self-report and informant-report questionnaires, to use on children and the elderly. This method has allowed for much faster progress in research on these age groups, but is also potentially problematic because developmental changes may limit the utility and validity of adult measures in other groups [31].

Developmental considerations about what constitutes adaptive behavior may compromise the validity of PD measures designed for early and middle adulthood. In fact, it has been argued that nearly half of the diagnostic criteria for PDs may be biased when used with children and the elderly [32]. For example, in adults, an item used to assess schizoid PD may ask about a lack of interest in sexual activities. While this item is useful for adults, it is not as applicable to children and the elderly who may be uninterested in sexual activities for many other reasons besides having a PD. Similar items that probe into things like occupational behavior could be less relevant for younger and older populations. On the other hand, there are also personality-pathology relevant behaviors observable in youth that are not represented in measures created for adults [33–35].

Thus, rather than adapting adult measures, a more ideal approach is to create new measures that are empirically

validated in the appropriate population. However, this presents problems for studying PDs with both longitudinal and cross-sectional designs because the methodology must change as the age group changes. Alternatively, researchers could broaden the scope of scale items in order for application to multiple age groups. For instance, the item 'avoids occupational activities', which applies only to working-aged populations, could be rewritten as 'is avoidant' to extend the utility of this item across the lifespan [36].

Children who display early PD traits are at risk for a whole host of problematic outcomes [36], including highest risk for PD in early adulthood [37,38]. This impairment emphasizes the critical importance of appropriately identifying these individuals early on. In addition, measures to understand the developmental course of PDs into old age will aid in our conceptualization of disorder stability and change, informing interventions [31]. Thus, although population differences can introduce additional difficulties to the study of PDs across the lifespan, they can also open new avenues for research that will ultimately contribute to the understanding of these disorders in epochs other than early and middle adulthood.

Contextual and informant considerations

Because many individuals with PD do not have good self-awareness of their impairment and are not themselves necessarily reliable reporters [39,40], information is often gathered from multiple sources. While more information may offer a richer picture of the state of someone's mental health, it also raises difficult questions about how to integrate information across sources and contexts when that information is not consistent.

When different informants use the exact same rating scale to assess psychopathology broadly, the agreement between self-ratings and other-ratings is around .45; it drops to .30 when two different measures are used [41]. Similarly, agreement among acquainted peers rating a target's PD traits is modest [42]. There is even more disagreement late in life, such that self-reports suggest an increase in PD traits, and informant-reports show a decrease [43]. Giving credence to the idea that different sources of information provide complementary data, informant reports (rather than self-reports) provide better information about future impairment [42]. Interestingly, informants do not need to be well-acquainted with the target in order to provide valid information about PD traits; as little as 30 s allows an observer to make an accurate judgment [44]. The ongoing debate about cross-informant issues means that this is a fruitful area for further investigation in the quest to refine the definition of PDs across the lifespan.

An analogous challenge in youth regarding the assessment of PDs is that of discrepancies between reports from parents, teachers, the youth, and/or clinicians. Because self-reports are less of a 'gold standard' in youth populations, it is common to gather information from additional reporters. As with adults, self-informant correlations for adolescent PDs are modest at best (e.g., [45]). Although this can lead to confusion, these discrepancies can also be useful as an area of study for PDs in youth by examining how specific discrepancies among reporters on a given item or scale relate to other psychological outcomes [46–49]. Overall, the issues raised by multiple informants are complex ones, both in youth and in adults. Continuing to refine our knowledge of the information provided by different sources, and provided by the disagreements between sources, will improve our understanding of the psychological content of PD.

Conclusions

Although faced with imperfect assessment measures of PDs across the lifespan, there is much we do know. Identifying the barriers to reliable and valid assessment including differing methods of assessment, developmental considerations, and the challenges of integrating information across multiple sources, will move the field forward. Continuing to push for the improved assessment of PD will increase our understanding of the psychological nature of these disorders, and go a long way toward improving treatment.

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