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Is the Alternative Model for Personality Disorders Able to Capture Avoidant Personality Disorder According to Section II of the *DSM–5*? A Systematic Review

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This review aims at examining the continuity between the categorical model for personality disorders (PDs) as defined by Section II of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, and the alternative model for personality disorders (AMPD) with respect to Section II avoidant personality disorder (AvPD). Because the Criterion A of the AMPD, that is, the Level of Personality Functioning Scale (LPFS), is a prerequisite for a PD diagnosis, only studies assessing the LPFS were included, whether or not the Criterion B, that is, pathological personality traits, were assessed as well. A total of 13 studies met the inclusion criteria, with 6 studies comprising community/undergraduate samples and 7 studies comprising clinical samples. Weighted correlation between global LPFS and AvPD was .39 (r_w = .55 for community/undergraduate studies; r_w =.17 for clinical studies). When AvPD-specific impairment was evaluated, that is, impairment of personality functioning characterizing AvPD in the AMPD, correlations were substantially larger. In studies using regression analyses, the Criterion B appeared to have incremental utility in predicting the presence of Section II AvPD. To capture Section II AvPD in a sufficient degree by the AMPD, it might be necessary to use an AvPD-specific impairment questionnaire.

Keywords: alternative model for personality disorders, avoidant personality disorder, Level of Personality Functioning Scale

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According to Section II of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM–5*, American Psychiatric Association, 2013), a diagnosis of avoidant personality disorders (AvPD) can be given if a patient meets at least four out of seven AvPD criteria. These criteria describe a person who shuns social situations because of feelings of inadequacy or inferiority, with hypersensitivity to and preoccupation with criticism. AvPD is one of the most common PDs in community and clinical samples (Winsper et al., 2020) and has been shown to have good clinical utility (Lampe & Malhi, 2018).

Categorical models for PDs have been criticized for a number of well-known reasons, such as high rates of comorbidity, arbitrary diagnostic thresholds, and the notion that the severity of personality pathology has greater clinical utility than the PD categories. The *DSM–5* alternative model for personality disorders (AMPD) addresses these shortcomings by comprising both dimensional and categorical aspects. The Criterion A of the AMPD aims at capturing general severity of personality pathology by focusing on characteristics that PDs have in common, for example, difficulties in self and interpersonal functioning. In this model, self-functioning includes identity and self-direction, and interpersonal functioning includes empathy and intimacy. These areas are rated on a continuum ranging from 0 (*no or minimal impairment of personality functioning*) to 4 (*severe impairment of personality functioning*), that is, the Level of Personality Functioning Scale (LPFS). Criterion B of the AMPD consists of 25 pathological trait facets that are organized within five trait domains, that is, negative affectivity, detachment, disinhibition, antagonism, and psychoticism. The structure of AMPD implies that the LPFS should be assessed first, before continuing to the Criterion B (Skodol et al., 2015).

The AMPD has retained six specific PDs, including AvPD (AM-AvPD), which is defined by a combination of specific impairment of personality functioning ("AvPD-specific impairment") and specific personality trait facets. AvPD-specific impairment covers the four areas of the LPFS adapted to be more prototypical for AvPD: *Identity* includes (a) low self-esteem and

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feelings of inferiority and (b) excessive feelings of shame; *self-direction* includes (a) unrealistic high standards for behavior with reluctance to follow goals and take personal risks and (b) reluctance to engage in new activities involving interpersonal contact; *empathy* comprises (a) preoccupation with, and sensitivity to, criticism or rejection and (b) distorted interpretation of others perspective as negative; and finally *intimacy* is described by (a) reluctance to get involved with people unless being certain of being liked and (b) diminished mutuality within intimate relationships because of fear of being shamed or ridiculed. Moderate or greater impairment in personality functioning (Criterion A) in at least two of these areas must be present for an AM-AvPD diagnosis to be made, along with three out of four AvPD-specific trait facets (Criterion B), that is, anxiousness, withdrawal, anhedonia, and intimacy avoidance.

The decision to include these four specific trait facets has received à posteriori empirical evidence. A meta-analysis focusing on the continuity between Section II of *DSM–5* and the AMPD showed that three of the four proposed AvPD traits had moderate correlations with Section II AvPD, that is, anxiousness (r = .49), anhedonia (r = .48), and withdrawal (r = .51; Watters et al., 2019). However, intimacy avoidance did not reach the threshold for a moderate degree of association (r = .27), whereas eight other trait facets showed moderate levels of association, most of these from the negative affectivity domain. Most studies presented in this meta-analysis did not include measures to assess Criterion A. Because the presence of Criterion A is a prerequisite for a PD diagnosis, it is of clinical and scientific interest to conduct a review that focuses particularly on the relationship between Section II AvPD and Criterion A of the AMPD. This review aims to address the following questions:

1. To what degree is Criterion A of the AMPD, that is, the LPFS and its four areas, able to capture AvPD according to Section II of *DSM–5*?

2. Is AvPD-specific impairment in the AMPD better able to capture Section II AvPD as compared with global LPFS?

3. Is a combination of Criterion B (pathological personality traits) and Criterion A better able to predict Section II AvPD than Criterion A alone? In more technical terms, does Criterion B increment the prediction of Section II AvPD after the effect of Criterion A is accounted for? And vice versa, does Criterion A increment the prediction of AvPD after the effect of Criterion B is accounted for?

Method

A literature search was conducted using Google scholar including the following terms: "*DSM–5*," "Alternative Model," "Avoidant," and "Personality Functioning." Google Scholar was used because this search engine scans the entire content of the article, making it possible to identify relevant articles that did not mention AvPD specifically in the title or abstract. This search resulted in 730 hits (July 1, 2021). In addition, a PsycINFO search was performed using the following terms: "*DSM–5*" and "personality functioning," resulting in 140 hits. If it was clear from the title that the article concerned a case study, a comment, a study on adolescents, or a study that was restricted to the trait model, the abstract was not read. If there still was uncertainty after reading through the abstract, the full article was scanned. We also contacted research groups that conduct clinical research on the AMPD, resulting in one additional study, besides two studies of our own research milieu. The final selection consisted of 13 studies (Table 2). Weighted correlation coefficients (r_w) were computed by multiplying the correlation coefficient for each study by sample size and dividing the sum of these products by the total number of participants of all 13 studies.

Results

Instruments

Table 1 gives an overview over the instruments used in the articles included in the review. Surveys using community (CM) or undergraduates (UG) samples always used self-report questionnaires for all clinical variables, for example, the LPFS-SR (80 items) for assessing the LPFS. Clinical studies used a variety of methods for the assessment of the LPFS, including clinical rating scales, self-report questionnaires (LPFS-BF; 12 items), and clinical interviews (Semi-structured Interview for Personality Functioning *DSM–5* (STiP-5.1) or Structured Clinical Interview for *DSM–5* AMPD, Module 1 (SCID-5-AMPD-I)). Most clinical studies used structured clinical interviews for assessing AvPD, either the Structured Clinical Interview for DSM–IV Axis II PDs (SCID-II) or its modernized version, the Structured Clinical Interview for DSM–5 PDs (SCID-5-PD). For the assessment of the trait model, the 220-items version of the Personality Inventory for *DSM–5* was used in all CM/UG studies and most clinical studies.

Research Question 1

As shown in Table 2, the correlations between AvPD and global LPFS ranged from .01 to .61 (r_w = .39; AvPD-specific impairment not included). Six articles reported separate correlations for the four areas of the LPFS. These correlations were strongest for identity (r_w = .63) and weakest for empathy (r_w =.43; AvPD-specific impairment not included).

We further investigated the association between Section II AvPD and the LPFS for two different types of samples. In the CM/UG samples, the correlations between Section II AvPD and global LPFS ranged from .46 to .64 (r_w =.55), whereas in the clinical samples, these correlations ranged from .01 to .36 (r_w =.17).

Research Question 2

Two studies, both using CM/UG samples, presented the correlations between self-reported Section II AvPD criteria and self-reported AvPD-specific impairment (Table 2). These correlations were .66 and .67 (r_w =.67). It should also be noted that Weekers et al. (2021) examined the overlap between Section II AvPD and AM-AvPD as assessed by the Semi-Structured Interview for Personality Functioning *DSM–5* (for Criterion A) and the second module of the SCID-5-AMPD (for Criterion B) and found a correlation of .59 between these two diagnoses.

Table 1
Instruments Used in the Articles

Acronym	Type[a]	No[b]	Full name
		Section II AvPD	
PDQ-4	SR	99	Personality Diagnostic Questionnaire
ADP-IV	SR	94	Assessment of *DSM–IV* PDs
SCID-II-PQ	SR	120	SCID-II-Personality Questionnaire
SCID-II	CR	—	Structured Clinical Interview for *DSM–IV* Axis II PDs
SCID-5-PD	CR	—	Structured Clinical Interview for *DSM–5* PDs
		Criterion A; Level of Personality Functioning Scale	
LPFS-SR	SR	80	LPFS–Self-Rating
LPFS-BF	SR	12	LPFS–Brief From
SCID-5-AMPD-I	CR	—	Structured Clinical Interview for *DSM–5* AMPD, Module I
STIP-5.1	CR	—	Semi-structured Interview for Personality Functioning *DSM–5*
CR	CR		Rating based on thorough knowledge or patient or on SCID-II
		Criterion B; pathological personality traits	
PID-5	SR	220	Personality Inventory for *DSM–5*
PTRF	CR	—	Personality Trait Rating Form
SCID-5-AMPD-II	CR	—	Structured Clinical Interview for *DSM–5* AMPD, Module II
		AvPD-specific impairment of personality functioning	
AVPD-IQ	SR	8	AVPD Impairment Questionnaire

Note. CR = clinician rated. AMPD = alternative model for personality disorders; AvPD = avoidant personality disorder.
[a] SR = self-report. [b] Number of items; only provided for self-report questionnaires.

Research Question 3

Two CM/UG studies and three clinical studies examined whether Criterion B (trait model) had incremental utility over Criterion A (LPFS/AvPD-specific impairment) in predicting Section II AvPD. In a CM sample of 271 participants, Sleep et al. (2019) found that the four areas of the LPFS explained 44% of the variance in predicting Section II AvPD. By including the five trait domains in the model, an additional 7% of the variance was explained (ΔR^2 = .07). The incremental utility of the LPFS was identical; that is, by reversing the order of entry, the five trait domains explained 44% of the variance and the four areas of the LPFS an additional 7%. Using LPFS ratings based on the SCID-II, Few et al. (2013) showed that the total number of traits incremented prediction of Section II AvPD by 14% after including the LPFS in the model. When this regression model was conducted in reverse, the LPFS did not increment the total number of traits significantly (ΔR^2 = .02). The full model explained 34% of the variance. In a study combining the SCID-5-AMPD-I and Personality Inventory for the *DSM–5*, Nysæter et al. (in press) applied hierarchical logistic regression (AvPD rated dichotomously) and found that the five trait domains incremented prediction of AvPD by 17% as computed by Nagelkerke Pseudo-R^2. The full model explained 34% of the variance. When the order of entry was reversed, the LPFS incremented the five trait domains by only 3%.

Anderson and Sellbom (2018) used hierarchical count regression in a UG study in which AvPD-specific impairment and AvPD-specific personality traits were the independent variables. They found that the four AvPD traits did not increment the prediction of the number of Section II AvPD criteria after AvPD-specific impairment was included in the model ($\Delta\chi^2$ = 2.82, total χ^2 = 45.0). Reversing the order of these two steps, AvPD-specific impairment incremented the prediction of the number of Section II AvPD criteria ($\Delta\chi^2$ = 10.24, total χ^2 = 45.1).

Morey et al. (2016) also investigated AvPD-specific impairment and found that the four AvPD traits incremented the prediction of AvPD by 8% after the four AvPD-specific impairment indicators were entered in the model (ΔR^2 = .08). When this regression model was conducted in reverse, the four AvPD-specific impairment indicators incremented prediction by 21% (ΔR^2 = .21). The full model explained 59% of the variance, that is, the model with the AvPD-specific impairment and all 25 trait facets.

Discussion

The heterogeneity across studies was large with respect to a number of factors, such as sample characteristics, sample size, assessment procedures, and analytic strategies. Moreover, the number of studies included in this review was low, and sample sizes were generally small, especially for the clinical studies. Thus, the extent to which conclusions can be drawn based on this review is limited. Nevertheless, it seems obvious that global LPFS was moderately correlated with Section II AvPD. These correlations were substantially larger in the CM/UG studies than in the clinical studies. One possible explanation for this discrepancy could be related to the fact that the CM/UG studies only used self-report for the assessment of both AvPD and LPFS, whereas most clinical studies used structured diagnostic interviews for the assessment of AvPD, which was assessed by different raters than the LPFS in most studies. Thus, the stronger association in the CM/UG studies could be explained by both common rater effect and measurement context effects (Podsakoff et al., 2003).

With respect to studies using self-report questionnaires for the LPFS, the CM/UG studies always used the LPFS-SR and clinical studies the LPFS-BF, with the exception of the clinical subsample of Hemmati et al. (2020). The LPFS-SR consists of 80 questions that aim at assessing all aspects of the LPFS, whereas the LPFS-BF includes only 12 questions, which may make it difficult to capture the entire range of personality functioning. Thus, the stronger correlations in CM/UG studies could also be due to the use of a more comprehensive self-report instrument. Of note, all CM/UG studies used dimensional ratings of the AvPD criteria in the correlation analyses, whereas some clinical studies used categorical AvPD diagnoses, which tend to give smaller correlation coefficients.

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Table 2
Studies Included in This Review

Authors	Sample (AvPD%)[a]	Instruments	r	Other findings and comments
Studies using community and/or undergraduate samples				
Liggett et al. (2017)	313 CM/UG	SCID-II-PQ PDQ-4A VPD-IQ –	$r = .67^{b}$	Identity, self-direction, empathy, and intimacy (AvPD-specific impairment) correlated .64, .53, .58, and .59, respectively, with AvPD criteria count.
Hopwood et al. (2018)	1,976 CM	PDQ-4 LPFS-SR PID-5	$r = .61$	Identity, self-direction, empathy, and intimacy correlated .66, .52, .47, and .54, respectively, with AvPD criteria count.
Anderson and Sellbom (2018)	277 UG	PDQ-4 AVPD-IQ. PID-5	$r = .66^{b,c}$	Identity, self-direction, empathy, and intimacy correlated .57, .61, .63, and .53, respectively.
Sleep et al. (2019)	371 CM	PDQ-4 LPFS-SR PID-5	$r = .61^{c}$	Identity, self-direction, empathy, and intimacy correlated .64, .53, 42, and .53, respectively.
Hemmati et al. (2020)	471 CM/142 CL	SCID-II-PQ LPFS-SR –	$r = .39$	In the college sample, AvPD criteria count correlated .38 with LPFS-SR, and in the clinical sample, the AvPD correlated .22[d].
Pedone et al. (2021)	775 CM	ADP-IV LPFS-SR –	$r = .46$	Study on mediating role of metacognitions with respect to level of personality functioning and pathological personality traits.
Studies using clinical samples; self-reported LPFS				
Hutsebaut et al. (2016)	240 CL (20%)	SCID-II LPFS-BF –	$r = .17^{e}$	Self and interpersonal component correlated .10 and .12, respectively, with the AvPD diagnosis.
Hummelen et al. (2021)	1,673 CL (36%)	SCID-5-PD LPFS-BF –	r=.15	The self and interpersonal component correlated .21 and .07, respectively, with AvPD criteria count.
Studies using clinical samples; clinician-rated LPFS				
Few et al. (2013)	109 CL (19%)	SCID-II SCID-II-based LPFS PTRF	$r = .36^{c}$	Identity, self-direction, empathy, and intimacy correlated .44, 28, .17, and .36, respectively, with AvPD criteria count[d].
Morey et al. (2016)	337 CL (27%)	Clinical Rating scale	$r = .11^{b,c}$	Online survey in which mental health clinicians provided information on one of their patients, including rating of separate criteria for section II PDs and the criteria for all three parts of the AMPD, i.e., LPFS, pathological traits, and specific diagnostic criteria for the six AMPD diagnoses.
Hutsebaut et al. (2016)	80 CL (14%)	SCID-II STIP-5.1 –	$r = .01^{e}$	The self and interpersonal correlated −.09 and −.03 with the AvPD diagnosis. 18 CM participants not included in the analyses.
Weekers et al. (2021)	189 CL (21%)	SCID-5-PD STIP-5.1 SCID-5-AMPD-II	$r = .59^{b}$	AM-AvPD diagnosis was determined by combining the results from the STiP-5.1 and the SCID-5-AMPD-II. The correlation of .59 concerns the association between criteria counts for the two AvPD diagnoses, i.e., Section II AvPD and AM-AvPD.
Nysaeter et al. (in press)	282 CL (29%)	SCID-II SCID-5-AMPD-I PID-5	$r = .39^{c}$	Identity, self-direction, empathy, and intimacy correlated .44, 31, .23, and .38, respectively.

Note. AMPD = alternative model for personality disorders; SCID-II = Structured Clinical Interview for *DSM–IV* Axis II PDs; SCID-II-PQ = SCID-II-Personality Questionnaire; SCID-5-PD = Structured Clinical Interview for *DSM–5* PDs; SCID-5-AMPD-II = Structured Clinical Interview for *DSM–5* AMPD, Module II; PDQ-4 = Personality Diagnostic Questionnaire; AvPD = avoidant personality disorder; AVPD-IQ = AVPD Impairment Questionnaire; LPFS = Level of Personality Functioning Scale; LPFS-SR = LPFS–Self-Rating; LPFS-BR = LPFS–Brief Form; PID-5 = Personality Inventory for *DSM–5*; STIP-5.1 = Semi-structured Interview for Personality Functioning *DSM–5*; PTRF = Personality Trait Rating Form; ADP-IV = assessment of *DSM–IV* PDs.
[a] Percentage AvPD provided for the clinical studies. [b] AvPD-specific impairment in italics. [c] Results of the regression analyses provided in the running text. [d] Correlation coefficients provided by the authors. [e] Categorical AvPD.

The relatively weak association between Section II AvPD and the Empathy domain of the LPFS underlines the challenge of assessing empathy in individuals with avoidant personality pathology. Here, findings from the field of social anxiety disorders might be relevant for AvPD as well. The complexity of assessing empathy in individuals with social anxiety has been highlighted in several meta-analyses (O'Toole et al., 2013; Pittelkow et al., 2021). For instance, O'Toole et al. (2013) found that social anxiety was

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associated with a decreased ability to understand complex emotions rather than to recognize basic emotions. Knowing that one has this ability may lead to a false belief of having good emphatic capacities. Realizing that this might not be true may constitute a serious threat to one's self-esteem. Such dynamics may make it challenging to assess empathic impairment in these patients, especially when descriptions do not resonate well with their self-image. For instance, the Level 3 description for empathy "is confused or unaware of own actions on others" might be considered as applicable to AvPD, whereas patients may not recognize themselves in being "confused" or "unaware." Rather, they may feel certain that other people think negatively about them or that their own actions have a negative effect on others. Moreover, they may in fact be unaware that their social withdrawal may cause difficulties in other persons, for example, when declining an invitation to a social event, which may elicit an emotional reaction in the other person, such as disappointment, feeling rejected, worry, or concern. According to our own clinical experience, it is often unthinkable for patients with AvPD that they may elicit such emotions in other persons.

Because AvPD-specific impairment seems to be able to capture Section II AvPD quite well, it could be considered to use the AvPD Impairment Questionnaire in situations where it is important to capture avoidant personality pathology. This instrument consists of just eight items, covering the eight aspects of AvPD specific impairment. The self-report version is provided in the article by Liggett et al. (2017) and could easily be modified for interviewing purposes.

The usefulness of AvPD-specific impairment in capturing Section II AvPD is supported by the studies on the incremental utility of Criteria A and B. The two regression studies using AvPD-specific impairment showed that Section II AvPD was almost entirely captured by the Criterion A when entered in the first step of the analyses. When AvPD-specific impairment was entered in the second step, it had a substantial incremental utility over the trait model. The two clinical regression studies using global LPFS, however, showed that the trait model had incremental utility in predicting Section II AvPD, whereas the LPFS had no substantial incremental utility over the trait model. This may partly be due to the fact that the entire trait model was included in these analyses, that is, all five trait domains or all 25 trait facets, which makes it easier for the trait model to capture all the explained variance. Some support for this position is provided by the study by Sleep et al. (2019), who found that by using the four areas of the LPFS instead of global LPFS, there were no differences in incremental utility between Criteria A and B.

In summary, it appears to be challenging to identify Section II AvPD by global LPFS, which may be due to a number of factors, including the challenge of assessing impairment of interpersonal functioning in individuals with avoidant personality pathology. In nonclinical studies, the association between LPFS and Section II AvPD is stronger than in clinical studies, which could partly be due to the use of self-report questionnaires to identify AvPD. AvPD-specific impairment seems to be better able to capture AvPD than global LPFS, and the use of the AVPD-IQ is recommended in situations where it is important to capture avoidant personality pathology. Including the trait model in the assessment of AvPD in addition to global LPFS seems to have incremental utility, but this conclusion should be considered as preliminary because of the heterogeneity and the small number of studies. Future studies on the relationship between Section II AvPD and the AMPD should not only use correlation statistics but also examine the incremental utility of the LPFS, AvPD-specific impairment and specific AvPD traits in predicting Section II AvPD, preferably in clinical samples using structured diagnostic interviews.

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