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Self-Ratings of Personality Pathology:
Insights Regarding Their Validity and Treatment Utility

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Abstract

Purpose of Review: The validity of self-ratings of personality pathology often are questioned because personality disorders (PD) historically have been viewed as being characterized by poor insight. However, recent research indicates that PD self-ratings are valid in many ways and have significant clinical utility. Building upon this growing literature, our goal here is to provide practical discussion of how incorporating dimensional PD ratings into assessment protocols can benefit diagnosis and treatment. **Recent findings:** We first review evidence suggesting that PD self-ratings are particularly useful for assessing constructs related to individuals' own subjective experiences (e.g., propensities for experiencing negative mood states). We then highlight research indicating that PD self-ratings (a) change positively with intervention and (b) meaningfully inform diagnosis, treatment planning, and treatment outcome. Finally, we illustrate how freely available, well-validated self-report PD measures can be used to efficiently obtain clinically useful information in a manner comprehensible to both practitioners and patients. **Summary:** Self-ratings of personality pathology are valid and useful in many ways and can be efficiently incorporated into assessment protocols. Key future directions for advancing knowledge of self-report PD assessment include examining the extent to which self-ratings of antagonism—a core PD trait—are accurate across contexts.

Introduction

The view that individuals with personality pathology lack awareness of their problematic traits has been longstanding and significantly influenced how many researchers and clinicians conceptualize personality disorders (PDs). For example, the *Diagnostic and Statistical Manual of Mental Disorders* (currently 5th ed.; *DSM-5*) explains that histrionic PD is associated with “roleplaying” in interpersonal relationships without being aware of doing so (e.g., playing the role of a high-status person to appear desirable) [1]. This viewpoint also has influenced PD treatment approaches, as psychotherapy protocols such as transference focused psychotherapy conceptualize identify disturbance as core to personality pathology and seek to facilitate awareness of the self and others in treatment [2, 3].

These perceptions regarding poor insight characterizing personality pathology may be commonly held by researchers and clinicians despite surprisingly little research historically having directly examined the degree to which a lack of self-awareness characterizes PDs more so than other *DSM* disorders [4]. If PDs are thought to be characterized by poor self-awareness, it follows that individuals’ self-ratings of personality pathology also would be viewed with skepticism. Indeed, many scholars appear to espouse this perspective, as self-report assessment of personality and other psychopathology often is criticized and viewed as less rigorous than biological and/or behavioral assessment methods [5].

However, there has been keen interest in examining issues related to the validity of PD self-ratings in recent years. Interestingly, the growing body of research on this topic indicates that individuals with elevated levels of personality pathology may have greater insight into their problematic traits than previously thought [6, 7, 8]. Recent meta-analytic findings also indicate that personality ratings meaningfully predict various aspects of treatment outcome (e.g., therapeutic alliance), with much of this literature using self-reported personality assessment [9].

Guided by this recent literature, our goal is to provide practical discussion of how using self-reported assessment of PD traits can benefit clinical assessment, treatment planning, and treatment outcome. First, we discuss contemporary models of personality on which many self-report assessments are based, also providing more detailed discussion of research supporting the validity and clinical utility of self-rated PD assessment. Following that, we present concrete examples demonstrating how specific personality pathology measures (e.g., the Personality Inventory for *DSM-5* [PID-5]) [10] can benefit clinical assessment and treatment planning.

Self-Rated Personality Pathology: Validity and Clinical Utility

Contemporary Personality Pathology Frameworks

Although many PD measures have been developed, recent research examining the validity and clinical utility of self-rated personality pathology discussed here has focused on assessing basic personality dimensions that provide a common framework for studying PDs and other psychopathology [11, 12]. This has included an emphasis on examining the clinical utility of measures of the five-factor model, which assess “normal range” trait domains of extraversion, agreeableness, neuroticism, openness, conscientiousness and their facets (e.g., sociability, positive emotionality, dominance, and excitement seeking facets define extraversion) [13]. Measures such as the PID-5 [10] assessing pathological traits from the *DSM-5* Section III Alternative Model for Personality Disorders (AMPD), which currently is designated as a model requiring further study, also have been widely used in this body of research.

The collection of AMPD trait domains (i.e., negative affectivity, detachment, antagonism, disinhibition, and psychoticism) and facets was informed by PD research from the five-factor model perspective [1], such that assessment using the PID-5 closely parallels that of traditional five-factor model measures in many ways [11, 12, 14]. For example, negative affectivity from

the AMPD is synonymous with five-factor model neuroticism, and antagonism measures reflect low levels of agreeableness (e.g., many antagonism measures assess a *lack* of sympathy, whereas many agreeableness measures assess sympathy and compassion). Thus, although there traditionally has been a distinction between “normal range” and “pathological” personality, measures of each assess many of the same basic constructs. In fact, research conducted using these interrelated measures is synthesized within the Hierarchical Taxonomy of Psychopathology framework (HiTOP), an emergent dimensional framework for psychiatric nosology representing an alternative to the *DSM* [15].

The Validity of Self-Report Assessment

As stated, recent work suggests that individuals may possess more insight into the nature of their personality pathology than thought previously. For example, one recent study found that clients report higher levels of many trait dimensions assessed by the PID-5 than their therapists [8], which would be unexpected if clients lacked insight. Other research indicates that individuals report higher levels of pathological traits and psychosocial impairment than do their informants [16], and individuals with elevated PD traits appear to show some capacity to recognize that these traits require intervention [7]. To provide an example involving specific PD traits, studies examining self-awareness of narcissistic traits indicate that individuals who are narcissistic describe themselves as arrogant and recognize that they behave narcissistically (e.g., by bragging and being exhibitionistic) [6, 17].

Of course, it is important to recognize that individuals’ awareness may be better for some traits than for others. Specifically, self-ratings are perhaps the most valid assessment method for assessing traits reflecting subjective, emotional (e.g., tendencies toward feeling worried) and other experiences (e.g., dissociative experiences such as daydreaming and observation) that are

challenging for others to detect accurately [18, 19, 20]. Therefore, it may be difficult for clinicians to accurately rate traits of this nature based on information gathered during relatively brief patient interactions (e.g., diagnostic intakes). This may partially account for why clinicians' judgments of their patients often show poor convergence with patients' self-rated traits, particularly when clinicians use unstructured assessment methods [21, 22].

However, clinicians' perceptions of trait constructs that are more objective and behavioral appear to provide important incremental information beyond self-ratings. Research focused on borderline PD traits from the Collaborative Longitudinal Personality Disorders Study (CLPS) conforms to this pattern, as self-ratings may be optimal for assessing pathological traits reflecting individuals' subjective experiences (e.g., feelings of emptiness) [21]; this same research also found that diagnostic interview ratings' of traits reflecting concrete behaviors (e.g., self-harm) provided useful information beyond patients' self-ratings in regard to predicting outcomes such as psychosocial functioning (e.g., occupational functioning). Furthermore, self-reported assessment of traits that are highly evaluative in nature (e.g., traits related to intellect, competence) may be distorted to some degree [20], and therefore, it may be useful to gather ratings from other sources such as romantic partners and/or family members when assessing such traits.

Additionally, research using ambulatory assessment designs wherein participants complete repeated assessments over the course of their daily lives offers intriguing insights into individuals' self-awareness. For example, ambulatory assessment research using self-ratings, informant-ratings and audio recordings of real-world interactions indicates that individuals appear to show good awareness of how sociable and conscientious they are acting over the course of everyday interactions [23]; however, awareness may be poorer regarding how

considerately and kindly one is behaving moment-to-moment. This latter finding is interesting given other research reviewed indicating that individuals possess considerable insight into their antagonistic tendencies [16, 17]. Therefore, although self-rated assessment may be more valid than previously recognized, it will be important for future research integrating multiple assessment methods to determine ways in which PD self-ratings may be inaccurate or biased (e.g., determining the extent to which self-ratings of antagonism are accurate across contexts).

The Clinical Utility of Self-Rated Personality Pathology

Two other key issues related to the validity and clinical utility of self-ratings of personality pathology are important to discuss. First, although personality traits are conceptualized as relatively enduring patterns of behavior, affect, and cognition [24], mounting research indicates they are amenable to change with psychotherapeutic and psychopharmacological intervention [25, 26, 27, 28]. Second, recent meta-analytic findings indicate that self-ratings of personality offer clinically useful information and predict various aspects of treatment outcome [9]. Related to these issues, we also review research directly examining the degree to which clinicians perceive trait scores assessed by self-report measures as clinically useful.

Personality change. It is interesting that positive changes in personality are yielded by an array of treatments (e.g., cognitive behavioral therapy [CBT], psychotropic medication), even though changing personality often is not an explicit treatment goal [12]. That being said, these positive personality changes are intuitive at some level. For example, if a client is presenting for treatment to address interpersonal difficulties, psychotherapy may focus on improving behavioral responses to intense emotional experiences in interpersonal situations. If this client learns to respond more adaptively to internal experiences across a range of everyday situations on a

relatively consistent basis (e.g., by communicating one's feelings calmly rather than becoming aggressive), it follows that changes in antagonism/agreeableness would occur.

Exciting meta-analytic findings indicate that traits such as neuroticism and extraversion appear to be especially positively impacted by treatment (i.e., levels of neuroticism decrease and extraversion increase) [27]. Notably, despite PDs traditionally being regarded as unchanging, "Axis II" variants of psychopathology, individuals presenting for treatment for personality pathology appear to show *more* positive personality change than do individuals presenting for some other issues such as substance use and eating disorders [27]. Other recent research has built upon these meta-analytic findings, indicating that positive personality change is possible even over relatively short intervals [25, 29]. For example, a recent study found that conscientiousness and extraversion levels significantly increased and neuroticism scores significantly decreased over the course of a 10-week coaching program focused on values-based living [25]. Importantly, these positive personality changes observed across many interventions appear to be maintained for periods of over a year post-treatment [27]. Given that traits such as neuroticism/negative affectivity confer risk for a host of mental and physical health outcomes (e.g., quality of life, frequency of physical health service use), reducing levels of such traits has the potential to positively impact patients' lives in many ways and reduce provider burden [30].

We should note an additional issue to consider when interpreting prior research examining personality change with intervention. Specifically, this research has focused heavily on self-report assessment, which is encouraging given the scope of our article, but may not actually reflect positive, real-world change in some ways. For example, even if PD self-ratings appear more positive post-treatment, it is possible that other types of ratings (e.g., indicators of psychosocial functioning) and ratings obtained from other sources (e.g., from clinicians, family

members) may not also indicate positive change. It will be important for future research to address this key issue, but at the same time, we hope that this mounting body of research will alter widely held views that maladaptive personality traits are fixed and of limited relevance to treatment. Researchers and clinicians holding a more flexible view regarding the potential for positive personality change may also help to reduce provider stigma—and patient self-stigma—that is associated with personality pathology [31], which may be maintained at least in part by viewing PD traits as undesirable and unchangeable.

Treatment outcome. Self-ratings of personality are not only valid in many ways and appear to change in treatment, but also provide clinicians with valuable information as they meaningfully predict treatment outcome. In regard to this latter point, self-ratings of personality are associated with a rich array of real-world variables, including work performance, spirituality political ideology, and relationship quality [32]. Other results from the CLPS also indicate that PD self-ratings show substantial incremental validity beyond clinician’s naturalistic impressions of personality pathology when predicting key outcomes such as later psychosocial functioning over a 5-year period [33]. Importantly, these findings held even when focusing only on data from patients who had seen the same clinician for year or longer, suggesting that they were not due merely to clinicians lacking knowledge about patients they had only just begun treating. Thus, integrating self-rated personality assessment into diagnostic protocols provides a wealth of information not explicitly available in the PD diagnostic criteria sets in *DSM-5* Section II that is relevant to treatment planning and outcome.

Recent meta-analytic findings also underscore that self-ratings of *different* traits provide unique information related to treatment outcome [9]. Traits related to agreeableness/antagonism (e.g., callousness, manipulativeness) predict therapeutic alliance, and describing oneself as

extraverted is associated with actively sharing in treatment [9]. Other key examples from this meta-analytic research include conscientiousness associating positively and neuroticism associating negatively with remaining abstinent from substance use after treatment completion. Thus, patients' reports of their personality provide clinically relevant information that can be used to identify client strengths as well as to predict subsequent issues that may interfere with treatment success.

Clinician perceptions of dimensional ratings. Many of the examples discussed are based on self-report measures yielding dimensional scores (e.g., using the PID-5 to determine the extent to which a patient is disinhibited versus categorizing a patient as either disinhibited or not), which have long been criticized as failing to be “user friendly” for clinicians [34]. We completely agree that this is an important issue, and a collection of studies now generally indicate that psychiatrists and other mental health professionals find dimensional conceptualizations *more* clinically useful than the categorical diagnoses provided in *DSM-5* Section II for comprehensively assessing personality pathology, formulating treatment approaches, and communicating assessment results to patients [35, 36, 37, 38; cf. 39]. Furthermore, a dimensional model of PD will be implemented into the 11th revision of the International Statistical Classification of Diseases and Related Health Problems (*ICD*) [40], which includes a collection of traits paralleling the five-factor model and AMPD in many ways [41].

Additionally, clinicians already routinely use many dimensional assessment measures, such that incorporating self-report PD measures may not represent as drastic of a shift in practice as some might imagine. For example, even though clinical decision making often requires using cutoffs and making categorical decisions, intellectual disability already is conceptualized in the

DSM-5 as being dimensional in nature [1]. The text of the *DSM-5* associated with intellectual disability diagnosis indicates how clinical cutoffs can be applied, describing that IQ scores of 70 (+/- 5 points; assuming use of a test with a mean of 100 and standard deviation of 15) present with adaptive functioning difficulties may be indicative of intellectual disability. Furthermore, measures such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) yield dimensional scores, provide clinical cutoffs to inform decision making, and already are widely used in practice [42].

Self-rated personality dimensions also align well with key psychotherapy treatment targets such as experiential avoidance (e.g., avoiding situations that cause one to feel anxious), emotion regulation difficulties, perfectionism, and rumination. These constructs collectively referred to as “social cognitive vulnerabilities” represent transdiagnostic vulnerabilities that lead to the onset and maintenance of an array of symptoms [43], and they overlap especially strongly with neuroticism/negative affectivity [44, 45]. Table 1 provides example items from facet scales of the 120-item International Personality Item Pool-NEO (IPIP-NEO) [46], a widely used five-factor model measure. This example material in Table 1 illustrates that (a) these neuroticism facet scale items provide information pertinent to treatment and (b) the content of neuroticism facet scales closely parallels that of many social cognitive vulnerability measures (e.g., the first item shown in Table 1 assesses avoiding others, a manifestation of experiential avoidance) [45].

Therefore, these Table 1 examples show that self-rated, dimensional personality scores do not represent constructs that would be foreign to clinicians, but rather, reflect trait dimensions relevant to many contemporary evidence-based psychotherapies [43]. Similarly, research indicates that treatment providers prescribe psychotropic medication to treat dimensions aligning with neuroticism facets rather than heterogeneous *DSM* diagnoses per se [47]. For example,

individuals identified as high scorers on the IPIP-NEO neuroticism Anxiety (e.g., “worry about things”), Depression (e.g., “often feel blue”), and Vulnerability facet scales may be likely to receive antidepressant medication to improve transdiagnostic symptoms of sadness, worry, and low self-esteem, whereas various generalized anxiety disorder (GAD) symptoms might be treated with different medications (e.g., a selective serotonin reuptake inhibitor may be used to treat worry, whereas an anxiolytic medication might be used to treat physiological arousal and tension characteristic of GAD) [47].

Specific Self-Report Assessment Measures and Treatment Considerations

Example Measures and Treatment Relevant Information

Finally, we offer other practical suggestions for selecting and integrating self-report assessment measures into practice and research. Many well-validated, non-proprietary measures are available for use to inform diagnosis, treatment, and case conceptualization in the ways described [15]. First, the 220-item PID-5 provides assessment of domain and facet traits of the AMPD as stated. The Comprehensive Assessment of Traits relevant to Personality Disorder (CAT-PD) [48] is another measure offering assessment of pathological traits in a manner similar to the PID-5 [14]. Furthermore, the recently developed Personality Inventory for *ICD-11* (PiCD) can be used to assess *ICD-11* PD dimensions [41], and an array of five-factor model measures have been validated for use in PD research (e.g., the previously mentioned 120-item IPIP-NEO) [46]. On this note, various Five Factor Model Personality Disorder measures (FFMPD) also are available for assessing PD features described in *DSM-5* Section II as maladaptive variants of five-factor model traits (e.g., exhibitionistic and domineering behavior as manifestations of extreme extraversion) [49].

We appreciate that researchers and clinicians may not always have the time and resources to integrate omnibus trait inventories into assessments (e.g., the PID-5 may require most clients 30-60 minutes complete). Fortunately, there are many brief self-report assessments available. For example, a 25-item brief form of the PID-5 (PID-5-BF) [50] can be used to assess AMPD trait domains, and the self-report version of the Five Factor Model Rating Form provides assessment of five-factor model domains and facets using 30 items [51]. These efficient measures require most patients several minutes at most to complete and are straightforward to score (e.g., each PID-5-BF domain score is computed by summing five items each rated on a 0-3 scale). Clinically, these measures therefore could be administered in conjunction with structured diagnostic interviews at intake sessions to inform treatment planning and could be re-administered at follow-up sessions to monitor personality change if desired.

Other Potential Treatment Benefits

Building from the extensive literature reviewed [9, 27] and the Table 1 examples, Table 2 presents examples of clinically useful information that could be obtained from elevated PID-5 or PID-5-BF domain scores. For example, consider a patient referred for interpersonal issues who is diagnosed with *DSM-5* Section II borderline PD. Imagine this patient completes the PID-5-BF and obtains low antagonism and psychoticism scores but maximum scores of 15/15 on the negative affectivity, disinhibition, and detachment domains (again, each domain score is computed by summing five items each rated on a 0-3 scale). Among other treatment relevant information provided, elevated detachment and a lack of antagonism suggest that this patient may be avoidant and passive interpersonally rather than attention seeking and aggressive. Detachment would not otherwise be assessed if focusing solely on the *DSM-5* Section II

borderline PD criteria, so in this case, key incremental information is efficiently obtained by using the PID-5-BF.

Communicating trait information. As stated, it may be helpful to communicate to patients that a growing body of research indicates that positive changes in personality are possible. Recent work suggests that following through on treatment goals appears key to observing positive personality change [29], which may be helpful to communicate to patients to encourage active engagement and follow-through in treatment. Therefore, discussing this information with patients may help to reduce stigma about PD traits and enhance motivation and positive treatment expectancies [52].

It is also important to consider the specific manner in which researchers and providers can communicate trait information to patients and research participants given that psychopathology assessment and diagnosis traditionally has relied on the *DSM* [53]. Our examples in Tables 1 and 2 illustrate that trait information can be interpreted and applied by providers and researchers in straightforward ways, and much of this information also applies for patient interactions. For example, returning to Table 2, a provider could communicate to a patient that elevated negative affectivity scores indicate being prone to mood swings, reactive to stressors, and having a history of symptoms such as sadness and worry, while again emphasizing that improvement is possible. With use of self-report assessment, these individual pieces of information would be provided by the patient of course, but providers can use well-validated measures such as the PID-5-BF to interpret and present this information in an empirically-guided, coherent manner that facilitates understanding and treatment planning (e.g., many individuals may not intuitively understand that elevated disinhibition explains why they have tendencies to be irresponsible *and* impulsive).

Conclusion

The growing body of literature reviewed here suggests that individuals with elevated levels personality pathology may have more insight into their problematic traits than previously thought. Indeed, self-report assessment may be the optimal method for assessing individuals' subjective experiences. Integrating the freely available, well-validated PD trait measures discussed into research and treatment settings can provide clinically useful diagnostic, treatment planning, and treatment outcome information that is complementary to data obtained from structured clinical interviews and other assessment methods (e.g., informant ratings obtained from romantic partners and/or family members).

As noted, there are still important questions that remain unanswered regarding the validity and clinical utility of self-rated PD traits. For example, it will be important for future research to determine the extent to which self-ratings of antagonism (e.g., being rude, unsympathetic) are accurate across different assessment methods and contexts (e.g., the extent to which self-ratings of how antagonistic one is in general converge with self-ratings of antagonism during patient-provider interactions or in other specific interpersonal relationships). Additional research examining the implementation and clinical utility of measures such as the PID-5 (e.g., examining the clinical utility of the AMPD versus *DSM-5* Section II categories and monitoring change in PD dimensions in large scale treatment studies) also will be crucial for addressing issues related to whether PDs and other forms of psychopathology should be conceptualized using categories or using dimensions, the latter of which is proposed in the AMPD and HiTOP frameworks. Most of the examples and research reviewed here also focused on individuals who were voluntarily seeking treatment, and it therefore will be necessary to determine the extent to which much of the research discussed regarding the validity and clinical utility of self-rated PD traits generalize to forensic and other settings wherein treatment often may be mandated. In conclusion, we are

encouraged that there is growing interest in examining the utility of self-reported PD assessment PD, and we hope that researchers will build upon this exciting body of research to advance PD assessment in the ways described.

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Table 1

Treatment Relevant Information Provided by Neuroticism Facet Scale Items and Scores

Neuroticism facet construct	Item paraphrase(s)	Relevance to Treatment Planning
Self-Consciousness	“Find it difficult to approach others” “Am unable to stand up for myself”	Clients who strongly endorse these items would be likely to report avoiding many types of social interactions (e.g., disagreeing with someone), which would be aspects of avoidance targeted in CBT protocols.
Immoderation	“Am unable to control my cravings” “Often eat too much”	Clients who strongly endorse items of this nature may cope with stressors and difficult internal experiences in maladaptive ways; these maladaptive responses again might be a concrete treatment target when using a CBT, ACT, or DBT treatment approach.
Vulnerability	“Feel I am unable to deal with things”	Clients who strongly endorse such an item may be prone to becoming wrapped up in negative thinking and/or avoid rewarding opportunities due to experiencing negative thoughts. Addressing links between these types of thoughts and behavior is emphasized in CBT and related approaches.

Note. All items shown are from the 120-item International Personality Item Pool-NEO. CBT = cognitive behavioral therapy; ACT = Acceptance and Commitment Therapy. DBT = Dialectical Behavior Therapy. Discussion of CBT and related treatment approaches such as ACT is provided in key study references [12, 43].

Table 2

Key Treatment Information Provided by Personality Inventory for DSM-5 Domain Scores

Domain	Treatment Planning and Outcome Information
Negative Affectivity	High likelihood of mood swings and strong reactions to stressors; may be likely to present with many internalizing symptoms (e.g., worry, sadness, sleep difficulties)
Disinhibition	May struggle with out of session medication and treatment compliance (e.g., completing psychotherapy exercises out of sessions); may be prone to attentional difficulties and have an increased likelihood of reporting substance use
Antagonism	May indicate that building rapport with the patient will be difficult and that patient may show reactivity in treatment sessions and interpersonal relationships; the patient may be less likely to take responsibility for personal factors and decisions contributing to presenting issues
Detachment	Patients high on this trait domain may be likely to display withdrawal and avoidance in relationships; may also indicate that the patient may have difficulty disclosing personal information and engaging actively in treatment
Psychoticism	May indicate the potential presence of unusual beliefs/experiences that may impair interpersonal functioning (e.g., if others find the patient odd or off-putting) and hamper treatment

Note. The treatment implications described assume high scores on each of these trait dimensions. These dimensions could be assessed using the full-length Personality for Inventory for *DSM-5* or its 25-item brief form as discussed in the main text.