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PERSONALITY DISORDERS (K BERTSCH, SECTION EDITOR)

Clinical Implications of ICD-11 for Diagnosing and Treating Personality Disorders

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Abstract

Purpose of Review The International Classification of Diseases 11th revision (ICD-11) introduced a new approach to personality disorders and related traits. This paper reviews recent literature on the assessment of ICD-11 personality disorders and implications for clinical diagnosis, decision-making, and treatment.

Recent Findings We reviewed findings on two measures developed for the ICD-11 model of personality dysfunction and six inventories for the ICD-11 trait specifiers. The psychometric qualities of these tools are promising, and they allow for both rapid screening and fine-grained assessment. Implications for clinical diagnosis and treatment of personality disorders are reviewed including utility for forensic practice. Based on evidence and our experience, we provide some recommendations for severity- and trait-informed interventions.

Summary Initial evidence supports the available instruments for assessing ICD-11 personality disorders. More research is needed including development of clinician-rating forms and diagnostic interviews as well as treatment protocols and trials based on the new ICD-11 classification.

Keywords ICD-11 · Personality disorder · Assessment · Severity · Treatment · Trait

Introduction

The 10th revision of the *International Classification of Diseases* (*ICD-10*; "Blue Book") has explicitly acknowledged that "a new approach to the description of personality disorders is required" [1] (p. 17). A major issue that needed addressing was the utility of PD (PD) diagnoses for clinical practice [2]. After almost 30 years, a fundamentally new ICD-11 classification of PDs has been published [3]. It was initially proposed by the World Health Organization (WHO) work group [4] and eventually revised in response to discussions with representatives from the International Society for the Study of Personality Disorders (ISPPD), the European Society for the Study of Personality Disorders (ESSPD), and the North American Society for the Study of Personality Disorders (NASSPD) [5]. For a more detailed historical account, we refer to Reed [5], Tyrer et al. [6], and Huprich [7].

The new ICD-11 classification focuses on what it means to have a PD in general (i.e., general diagnostic requirements), followed by the classification of severity and then the option of specifying up to five trait domains along with a borderline pattern when applicable. The diagnostic procedure and codes are presented in Fig. 1.

In this article, we review recent literature on the assessment of ICD-11 classification of PDs and its clinical implications for diagnosing and treating PDs including utility in forensic practice. This literature review will be augmented with our own clinical experiences and recommendations with respect to severity- and trait-informed intervention. While previous publications have highlighted indirect evidence through research on the comparable DSM-5 alternative model for personality disorders (AMPD) [8, 9, 10•, 11•], this paper focuses on the emerging literature on the

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Fig. 1 Diagnostic procedure and Codes for ICD-11 Personality Disorders and Related Traits

Diagnostic hierarchy	*Code*	*Label*
Unspecified primary diagnosis	6D10.Z	Personality Disorder, Severity Unspecified
Severity classification codes	None	No Personality Disturbances
	QE50.7	Personality Difficulty
	6D10.0	Mild Personality Disorder
	6D10.1	Moderate Personality Disorder
	6D10.2	Severe Personality Disorder
Trait domain specifier codes	6D11.0	Negative Affectivity
	6D11.1	Detachment
	6D11.2	Disinhibition
	6D11.3	Dissociality
	6D11.4	Anankastia
Additional specifier code if applicable	6D11.5	Borderline Pattern

ICD-11 PD model itself. We will not review the empirical foundation of the ICD-11 PD classification, which is provided elsewhere [9].

Clinical Assessment of Personality Disorder Severity

It is established that the severity of PD is important with respect to prognosis, risk assessment, and treatment planning [11•, 12–15]. It allows clinicians to distinguish those who have the most severe personality disturbance from those with milder impairment, and enables services to target their interventions more effectively. To date, two instruments have been developed for the operationalization of PD severity according to the now official ICD-11 classification[1]: The Personality Disorder Severity ICD-11 (PDS-ICD-11) scale [16••] and Clark et al.'s Preliminary ICD-11 Scales for Self and Interpersonal Dysfunction [17••].

The PDS-ICD-11 Scale

The 14-item Personality Disorder Severity ICD-11 (PDS-ICD-11) scale was developed by a Danish-–New Zealand group to encompass disturbances in functioning of aspects of the self and interpersonal dysfunction as well as emotional, cognitive, and behavioral manifestations and psychosocial impairment (see Table 1). In comparison to the well-established Level of Personality Functioning Scale (LPFS) framework included in the AMPD, this approach also captures features of impaired reality testing (i.e., cognitive manifestations), harm to self- and others (i.e., behavioral manifestations), and global psychosocial impairment. This content, defined by ICD-11, is also consistent with features that were recommended by an international workgroup to be included in patient-reported outcomes for PD [18••].

The initial evaluation of the PDS-ICD-11 scale supported its utility for capturing a single dimension of personality dysfunction with the exception of item 13 covering harm to others, which was rarely endorsed in the community sample. In addition, the PDS-ICD-11 scale showed substantial convergence with other established measures of personality functioning, including the Level of Personality Functioning Scale—Brief Form (LPFS-BF) ($r = 0.68$) and a global PD symptom score based on DSM-5 criteria ($r = 0.68$). With regard to categorical PDs, the PDS-ICD-11 was most strongly associated with borderline ($r = 0.65$) followed by avoidant and schizotypal, and had weaker associations with histrionic, obsessive–compulsive, and schizoid PDs. This pattern is consistent with previous research [19] as well as the psychodynamic perspective on how PD types are organized according to their level of functioning [20]. Thus, those with mild PD are thought to have more mature defenses and less immature defenses, while those with severe PD have more immature defenses and less mature defenses. As expected, the obsessive–compulsive type is characterized by more mature neurotic defenses (e.g., suppression and perfectionism) while borderline is characterized by more immature splitting-based defenses (e.g., dissociation and projective identification) [20]. Moreover, using a small clinical subsample, the study also demonstrated that the

[1] The Standardized Assessment of Severity of Personality Disorder (SASPD) has been proposed as a measure of PD severity according to an earlier draft of the ICD-11 [100]. However, the scale does not fully capture the now official ICD-11 definition of personality disturbance.

Table 1 ICD-11 personality functioning according to the PDS-ICD-11 operationalization

Capacities and manifestations	Healthy functioning
1. Identity	Stability and coherence of one's sense of identity (e.g., extent to which identity or sense of self is variable and inconsistent or overly rigid and fixed)
2. Self-worth	Ability to maintain an overall positive and stable sense of self-worth
3. Self-perception	Having a good sense of own strengths and weaknesses
4. Goals	Capacity for self-direction (e.g., ability to plan, choose, and implement appropriate goals)
5. Interest in relationships	An appropriate balance of seeking to be alone versus with others
6. Perspective taking	Ability to understand and appreciate others' perspectives without thinking too much into how they think and feel
7. Mutuality in relationships	Ability to develop and maintain close and mutually satisfying relationships
8. Disagreement management	Ability to manage disagreements in relationships in a cooperative manner
9. Emotional control and expression	Ability to control and express own emotions in an appropriate way
10. Behavioral control	Ability to be spontaneous while keeping appropriate control of own actions
11. Experience of reality during stress	Accurate situational and interpersonal appraisals under stress
12. Harm to self	Appropriate behavioral responses to intense emotions and stressful circumstances
13. Harm to others	
14. Psychosocial impairment	Functioning in personal, family, social, educational, occupational or other important areas of life

PDS-ICD-11, Personality Disorder Severity ICD-11

PDS-ICD-11 scale was useful for differentiating individuals with a PD diagnosis versus those without. Finally, as an important precondition for clinical interpretation, the study provided tentative cut-scores based on standard deviations from the latent mean score of PDS-ICD-11 in the normative U.S. community sample. It appears that a PDS-ICD-11 sum score of 17.5 may indicate significant dysfunction.

The PDS-ICD-11 scale has also demonstrated acceptable psychometric properties in a German general population sample ($N=1228$) [21]. This study also showed a strong correlation between PDS-ICD-11 and LPFS-BF ($r=0.74$). The PDS-ICD-11 scale showed moderate to large associations with negative affectivity, detachment, disinhibition, and dissociality, in that order. No significant association was found for anankastia, which is consistent with the weak association with the obsessive–compulsive type reported in the U.S. sample [16••] including the theoretical justification for this finding (i.e., anticipation of more mature defenses and thereby less severe disorder). Based on the German normative data, a cut-score of 17 (i.e., 2 standard deviations from the normative mean) was found to indicate significant personality dysfunction, which is directly comparable to the suggested cut-score of 17.5 derived from U.S. normative data [16••].

The PDS-ICD-11 scale is currently being evaluated in ongoing international research and has been included in an upcoming UK trial seeking to investigate whether clinical awareness of personality status influences outcome and satisfaction [22••]. Recently, a clinician-rating form of the scale has been developed, which is also currently being evaluated.

Clark and Colleagues' Scales of Self and Interpersonal Dysfunction

Clark et al. [17••] have developed a combined set of preliminary scales for ICD-11 PD, which include 65 items that cover aspects of self- and interpersonal dysfunction. The measure delineates the six ICD-11 components of self- and interpersonal functioning including identity problems, low self-worth, low self-accuracy, low self-directedness, relationship difficulties, and dysfunctional engagement. However, emotional, cognitive, and behavioral manifestations as well as global psychosocial impairment are not covered in this approach. The scale demonstrated promising factorial validity, and a substantial correlation between aspects of self- and interpersonal functioning suggests that together they reflect a higher order dimension of personality pathology. Interestingly, the scale showed moderate to large associations with negative affectivity, detachment, disinhibition, anankastia, and dissociality, in that order, which is largely consistent with the pattern identified in the previously mentioned German PDS-ICD-11 study [21].

General Considerations of PD Severity Assessment

As a common issue with both measures of ICD-11 PD severity, more research is needed to establish validity and utility in samples characterized by externalizing behaviors including the risk of harm to others. In general, it seems important to collect more data in diverse samples. Finally, a number of other measures originally developed for the AMPD criterion A have recently been used in research as a reasonable proxy

Table 2 Alignment of facet-level information across four measures of ICD-11 trait domains

#items	**FFiCD** 121 items	**PID-5 algorithm** 158 items	**Clark et al. scales** 181 items	**PID5BF + M** 30 items
Negative Affectivity	Emotional Lability Anxiousness Mistrustfulness Anger Depressiveness Shame Vulnerability	Emotional lability Anxiousness Suspiciousness Depressivity (Hostility)	Emotional lability Negative outlook Mistrust	Emotional lability Anxiousness Separation insecurity
Detachment	Social Detachment Emotional Detachment Unassertiveness	Withdrawal Intimacy avoidance Restricted affectivity	Social detachment Emotional Detachment	Withdrawal Intimacy avoidance Anhedonia
Dissociality	Lack of Empathy Self-centeredness Aggression	Callousness Grandiosity Manipulativeness Attention seeking Hostility	Low Empathy Entitled Superiority	Deceitfulness Grandiosity Manipulativeness
Disinhibition	Irresponsibility Rashness Disorderliness Thrill-Seeking	Irresponsibility Impulsivity Distractibility Risk taking	Reckless Impulsivity Distractibility	Irresponsibility Impulsivity Distractibility
Anankastia	Inflexibility Perfectionism Workaholism	Rigid perfectionism Perseveration	Hypercontrol Perfectionism	Rigidity Perfectionism Order*liness*

FFiCD Five-Factor inventory for ICD-11, *PID-5* Personality Inventory for DSM-5, *PID5BF + M* Personality inventory for DSM-5 and ICD-11—Brief Form Plus—Modified

for determining ICD-11 PD severity. These instruments include the Semi-Structured Interview for DSM-5 Personality Functioning (STiP 5.1) [23], the Self and Interpersonal Functioning Scale (SIFS) [24], the Level of Personality Functioning Scale—Brief Form (LPFS-BF) [25], the Level of Personality Functioning Scale—Self-Report (LPFS-SR) [26], and the Levels of Personality Functioning Questionnaire for adolescents (LoPF-Q12–18) [27]. Most of these measures have been reported to correlate with one another suggesting that they may serve as measures to describe most of the information needed for determining ICD-11 PD severity [28]. However, they do not capture the exact ICD-11 definitions including features of impaired reality testing and harm to self and others.

Clinical Assessment of Trait Specifiers

The specification of trait domains helps describe individual expressions of the PD severity, which allows clinicians to understand the kind of problems that causes the dysfunction and should be considered when planning clinical management and treatment. For example, it makes a substantial difference whether a patient with moderate PD is characterized by prominent features of negative affectivity and anankastia (e.g., anxiousness and perfectionism) or features of dissociality and disinhibition (e.g., manipulativeness and recklessness). Thus, two individuals with the same level of PD severity may need different interventions because of their different trait compositions. In general, the interpretation of trait domain combinations says more about the person than interpretation of trait domains individually. For example, two persons characterized by negative affectivity may clearly share features of this trait domain. However, the first person has a combination with dissociality (e.g., externalized anger and blaming others), whereas the other person has a combination with detachment (e.g., internalized anger and self-blaming). In addition, the complexity or number of trait domain specifiers is expected to mirror global PD severity. Severe PD is likely to be associated with several trait domains, while a mild PD may only be characterized by one or two trait domains.

Six Different Instruments: From Rapid to Fine-grained Assessment

At least six different approaches have been developed for the assessment of ICD-11 trait domains and features. An overview of four of these measures along with their facet-level descriptors is provided in Table 2. The 60-item Personality Inventory for *ICD-11* (PiCD) [29] has been developed to capture the five *ICD-11* trait domains, and a corresponding Informant-Personality Inventory for ICD-11 (IPiC) is also available [30•, 31]. The utility of both

instruments has been supported in a number of studies [30•, 31–40, 41•, 42, 43].

For clinicians or researchers who need a rapid assessment instrument, the 17-item *Personality Assessment Questionnaire for ICD-11 personality traits* (PAQ-11) [44] is a measure developed in Korea that captures the five trait domains. A slightly revised version is available from the authors (PAQ-11R). The Personality Inventory for DSM-5 and ICD-11 Plus Modified (PID5BF + M) is a 36-item measure that efficiently captures the combined six trait domains of both *DSM-5* and *ICD-11*, including 18 subfacet scales [45, 46]. The PID5BF + M has shown robust psychometric properties in more than 17 samples and 12 languages [40, 45, 47–50]. For practitioners who only need a profile of ICD-11 trait features, a reduced 30-item form can be used to portray the 5 domains including 15 facets as shown in Table 2.

For clinicians who desire a more fine-grained and clinically informative portrait of personality traits, the 121-item Five-Factor inventory for ICD-11 (FFiCD) [51, 52] not only measures the 5 domains but also 20 facets (e.g., anxiousness, self-centeredness) and 47 nuances (e.g., separation insecurity, vanity). For clinicians who are already familiar with the AMPD model, an ICD-11 algorithm for the Personality Inventory for DSM-5 (PID-5) can be used to derive the *ICD-11* domains including 18 designated PID-5 facets that are based on 158 items [53, 54]. This algorithm has been used and evaluated in a number of studies [54–59]. Most recently, Clark and colleagues [17••] developed and evaluated a set of preliminary scales for the ICD-11 personality trait model based on 181 items, which cover the 5 domains as well as 11 facet-like subscales.

Continuity with Familiar Traits and Types

All the described methods for measuring ICD-11 trait features have reported acceptable psychometric properties, and a number of studies support conceptually coherent associations with normal Five-Factor Model traits and AMPD trait domains [29, 32, 33, 35–37, 39, 44, 51, 60, 61] as well as consistency with established PD types [39, 45, 52, 54, 56, 57, 62]. Research also suggests that other gold standard instruments such as the MMPI may aid clinicians in the assessment of ICD-11 personality trait dysfunction [63].

Therefore, clinicians who are either familiar with FFM traits, AMPD traits, MMPI dimensions, or traditional PD types may find a way to translate their familiar system into the new ICD-11 framework. For example, a cross-walk for translation between categorical ICD-10 types and ICD-11 dimensions is available [64]. Perhaps of most relevance to clinicians, is that the traits can simply be rated based on a clinical interview, observations, and other available clinical information [12, 31, 65, 66].

Clinical Management and Treatment

It is beyond the scope of the present paper to review all the clinical implications of the ICD-11 model for diagnosing and treating PDs. For more in depth clinical guidelines we recommend that readers consult other publications [8, 11•, 64, 67–71] and refer to reviews of the clinical utility of the ICD-11 PD model [72–74].

The clinical rationale for assessing both severity and individual trait expressions in ICD-11 may be explained through a comparison with the measurement of weather. Bad weather may be considered a global severity dimension while temperature, wind, air pressure, and precipitation mirror specific expressions of bad weather. The global dimension of bad weather may predict whether people will go hiking in the mountains, while the specific expressions of bad weather may further explain what people wear when they go hiking. Thus, PD severity is a general indicator and predictor of psychosocial problems while trait domains give flavor to these problems. Moreover, the ICD-11 approach could make communication with patients easier by not focusing on diagnostic labels but by providing a language for both intact and impaired capacities of personality functioning in general [71]. For example, instead of talking about narcissism it may be more meaningful to talk about the patient's ability to maintain an overall positive and stable sense of self-worth, and how this unfolds as traits of both self-centeredness (i.e., dissociality) and low self-esteem (i.e., negative affectivity). Now, we provide some suggestions for interventions based on PD severity and traits.

Severity-informed Intervention

Recent research suggests that the global severity of personality dysfunction may be altered by circumstances or interventions while stylistic traits tend to remain constant [75, 76]. For example, a patient with mild PD and prominent features of negative affectivity may only experience some distress in interpersonal relationships, while a patient with severe PD and prominent features of negative affectivity may experience hatred, self-harm, and perhaps dissociation. While both patients share the same stylistic trait of negative affectivity, their severity of personality dysfunction makes a difference. Accordingly, it has been argued that treatment should generally target the global aspects of dysfunction such as mentalizing problems [77], identity disturbances [78••, 79••], and alexithymia [80] rather than the stylistic traits [67]. In this way, patients can be helped to find new more adaptive ways of expressing and coping with their personality traits. Treatment may therefore benefit from focusing attention on understanding the traits while attempting to change dysfunction and manifestations in terms of PD severity. Nevertheless,

since the prominent trait specifiers delineate maladaptive trait expressions (e.g., negative affectivity and disinhibition), their presence and intensity often go hand in hand with PD severity and related distress [28, 60].

Some general recommendations for clinical interpretation of the three severity levels have been provided elsewhere [8, 11•], which we now summarize. For mild PD, treatment can be less structured and less intensive as less effort is needed for maintaining alliance. At this level, group treatment may be sufficient. For moderate PD, treatment must usually be more structured, and clinicians must be prepared for handling ruptures in alliance as well as dropout. For severe PD, treatment is recommended to be highly structured and transparent with clear boundaries, while clinicians must work consciously on building alliance, repairing ruptures, and preventing dropout. At this most severe level, attention must often be given to risk of harm to self or others and therapy-interfering behaviors. In general, PD severity may serve as a target of treatment shared by different therapy models and types of patients, a decision tool for clinical management and required treatment intensity (e.g., strength of alliance, risk of dropout), and a common variable for measuring change [11•].

Trait-informed Intervention

Beyond treatment recommendations for the three levels of severity, it has also been suggested that treatment may be informed by prominent trait domains [8, 67, 70].

For negative affectivity, treatment should focus on emotion regulation, anxiety, and sadness by building up distress tolerance, self-compassion, mentalization, acceptance of negative emotions, and implementation of stress management skills. In cases of self-harm, distraction techniques and alternative coping strategies may be helpful.

For detachment, therapy may focus on disinterest in or avoidance of relationships in terms of withdrawal, mistrust, independence, emotional inhibition, and interpersonal ambivalence. Such issues may be targeted using behavioral activation, social skills and assertiveness training, confrontation of defenses, and sometimes exposure therapy. In many cases, it may be best to help the patient manage their innate need for withdrawal in an adaptive manner, while shielding from too much social stimuli.

For dissociality, interventions may include empathic confrontation while using rational and utilitarian arguments that focus on the benefits of prosocial behavior. Coping behaviors of self-aggrandizement and dominance may gradually be exchanged with healthy adult behavior while gaining access to some underlying vulnerability. Predominant features of dissociality for moderate-severe PD may suggest that clinicians should take precautions due to the risk of harmful antagonistic behavior.

For disinhibition, it may be helpful to use behavior-focused therapy where the therapist identifies what is rewarding or punishing for the patient when the disinhibited behavior takes place. Individuals with this trait benefit from learning similar skills for everyday life as those with ADHD. Regulation skills are particularly relevant in cases where there is potential harm to self or others.

For anankastia, treatment may focus on increasing flexibility and tolerance of imperfection, lack of control, and emotional spontaneity in relationships. Therapist insufficiencies and mistakes (e.g., not using correct language, forgetfulness, or not being on time) may cause ruptures in therapy that eventually reveal important issues that should be dealt with. While the patient may be highly conscientious by nature, maladaptive features of anankastia (e.g., workaholism) are often conceptualized as internalized parental demands or overcompensation for underlying vulnerability [81–83], which need gentle confrontation.

Treatment Guided by Blends of Traits

In real-world clinical practice, it is probably more meaningful to focus on blends or compositions of prominent traits domains. The ICD-11 explicitly takes into account that traits may be dynamically manifested in different ways based on the presence of other traits [84]. For example, when negative affectivity co-occurs with detachment it probably indicates "internalized" aspects of negative affectivity (e.g., anxiousness, inferiority, depression, and self-blame), whereas co-occurrence with dissociality probably indicates "externalized" aspects of negative affectivity (e.g., anger, envy, hostility, and blaming others) [85, 86]. Moreover, the fine-grained facet-level information presented in Table 2 may also help clinicians pinpoint individual problems across domains (e.g., grandiosity, anxiousness, and perfectionism), thereby increasing the chance that the patient feels recognized by the assessment.

Patients with predominant traits of disinhibition or dissociality may benefit from interventions focusing on aspects of underregulation of affect, aggression, and impulses, while patients with predominant traits of detachment or anankastia may benefit from interventions that target overregulation of affect and behavior. Consequently, in addition to considering PD severity, treatment may also be targeted according to either *underregulation* (e.g., Dialectical Behavior Therapy; DBT) or *overregulation* (e.g., Radical Openness—Dialectical Behavior Therapy; RO-DBT) [87]. In some cases, patients may be characterized by both under- and overregulation, which would often indicate a complex or severe case corresponding to a borderline pattern. Taken together, the overall goal of trait-informed treatment is to help the patient find more adaptive expressions of their maladaptive traits.

Perceived Implications for Forensic Practice

The ICD-11 also has significant implications for forensic practice and correctional services [88, 89]. Findings suggest that trustworthy and informative assessment of ICD-11 aspects of personality dysfunction should be especially prioritized in such settings [23, 25]. Accordingly, a group of forensic and legal experts [90••] has reported that they believe that the ICD-11 PD classification is particularly useful in forensic practice for at least three reasons. First, from a legal standpoint, the focus on one global severity dimension makes it clear to the court that personality dysfunction exists on a continuum with non-disordered personality, and that a threshold has been crossed based on diagnostic requirements. Second, in contrast to traditional PD types, the descriptive features of the ICD-11 capacities of personality functioning and trait domain specifiers are provided in plain language, which increases the chance that they will be understood by non-clinicians. Such ICD-11 definitions and descriptions have the potential to be more readily integrated into expert reports. Third, ICD-11's emphasis on real-world dysfunction is informative for legal decision-makers and the courts. For example, severe PD can often involve inappropriate behavior such as fits of temper or insubordination. Likewise, it may be informative for courts to understand what ICD-11 defines as propensity to self-harm or violence as well as psychotic-like perceptions under stress (and exclusively when decompensating).

Unanswered Questions and Future Directions

The ICD-11 PD assessment instruments and classification procedure are relatively novel and largely untested, although the framework can be said to stand upon the shoulders of giants with respect to the available science on personality functioning and traits [9]. In addition to the two patient-report instruments for ICD-11 PD severity, reviewed in the present paper, a standardized diagnostic interview specifically developed for the ICD-11 model appears necessary for clinical practice and future research. Longitudinal and intervention research based on the new PD classification is important [10•]. It is anticipated that researchers, clinicians, and patients may benefit from focusing on a global PD dimension where the disorder can improve gradually over time. For example, it seems more realistic to hope that a PD can recover gradually from severe PD to moderate PD rather than simply move from a PD diagnosis to "cured." Moreover, a dimension of functioning determined by various capacities and manifestations (see Table 1) not only describes impairments but also strengths, which are important aspects of resilience and recovery [91•]. Future studies should prioritize these new perspectives and evaluate their utility. A feasibility trial conducted in UK has already investigated low-intensity treatment for PD in general rather than focusing on traditional PD categories [92]. Another upcoming UK project seeks to determine whether self-rating scales for the ICD-11 PD model, including the PDS-ICD-11 and the PAQ-11, are feasible and informative for clinical practice [22••]. Additionally, neurobiological research using the ICD-11 personality dimensions may also provide valuable information that potentially can inform new interventions [93].

It is also evident that the new ICD-11 PD diagnosis overlaps with the novel ICD-11 Complex Post-Traumatic Stress Disorder (PTSD) diagnosis [94••], and future research could focus on their co-occurrence and differential diagnosis [22••]. The paths and mechanisms between developmental trauma and the new ICD-11 PD dimensions could be explored [95, 96]. Future work should further evaluate whether the borderline pattern specifier provides non-redundant clinical information or whether it is a superfluous specifier as initial findings suggest [19, 36, 41•]. Finally, evaluation of the usefulness of the classification in a diversity of WHO countries, cultures, populations, and age groups is vital [97–99].

Conclusion

The current paper reviewed recent literature on the assessment of ICD-11 Personality Disorders and Related Traits with respect to implications for clinical diagnosis, decision-making, and treatment. We focused on the PDS-ICD-11 scale [16••] and Clark et al.'s Preliminary Scales for Self- and Interpersonal Dysfunction [17••] since they are the only published measures specifically developed based on the ICD-11 definition of personality functioning [3]. These two instruments show promising psychometric abilities but further studies and possible modifications are needed. Additionally, we reviewed the available instruments for measuring the trait domain specifiers, which ranged from brief (i.e., PAQ-11, PID5BF + M, PiCD) to more extensive measures (i.e., FFiCD, Clark's scales for trait domains, PID-5 algorithm). These personality trait inventories have promising psychometric qualities and show meaningful associations with familiar Five-Factor Models and PD types. For the clinical implementations of ICD-11 in WHO member states, it is vital to offer practitioners and researchers a clinician-rating form or a diagnostic interview, which is currently being developed. In general, we need to see more research based on this new diagnostic framework, in particular treatment protocols and trials. It is not simply a question about whether it is useful, but rather a question about how clinicians take ownership and make it useful.

Meta-analytic evidence based on forthcoming research can hopefully guide clinicians in using the ICD-11 PD classification in the best way possible.

Declarations

Conflict of Interest BB has contributed to the preparation of ICD-11 field trials and served as advisor for the ICD-11 personality disorder workgroup. RM was a senior member of the ICD-11 personality disorder work group and has authored clinical guidelines for the ICD-11 personality disorder classification. Both BB and RM have contributed to the development of instruments and authored clinical guidelines for the ICD-11 personality disorder classification.

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