**Universidade de Brasília**

**Instituto de Psicologia**

**Departamento de Psicologia Clínica**

**Programa de Pós-Graduação em Psicologia Clínica e Cultura**

# Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF): Psychometric Evaluation and Severity Profiles in Brazil

Lídia Figueiredo dos Santos

BRASÍLIA – DF

2026

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# Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF): Psychometric Evaluation and Severity Profiles in Brazil

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Master's thesis submitted to the Graduate Program in Clinical Psychology and Culture of the Institute of Psychology at the University of Brasília as a partial requirement for obtaining the master's degree.

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## List of Abbreviations

| | |
|---|---|
| AIC | Akaike Information Criterion |
| AMPD | Alternative Model for Personality Disorders |
| ANOVA | Analysis of Variance |
| APA | American Psychiatric Association |
| BIC | Bayesian Information Criterion |
| BPS | Borderline Pattern Scale |
| CFI | Comparative Fit Index |
| CVC | Content Validity Coefficient |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| E-TRAP | Entrevista Diagnóstica para Transtornos da Personalidade |
| GFP | General Factor of Personality |
| ICC | Intraclass Correlation Coefficient |
| ICD | International Classification of Diseases |
| IRT | Item Response Theory |
| LPA | Latent Profile Analysis |
| LPFS-BF-2.0 | Level of Personality Functioning Scale–Brief Form 2.0 |
| PDS-ICD-11 | Personality Disorder Severity ICD-11 |
| PDS-ICD-11-CRF | Personality Disorder Severity ICD-11 Clinician-Rating Form |
| PID5BF+M | Personality Inventory for DSM-5 – Brief Form Plus Modified |
| RMSEA | Root Mean Square Error of Approximation |
| SASPD | Standardized Assessment of Severity of Personality Disorder |
| SRMSR | Standardized Root Mean Square Residual |
| TLI | Tucker–Lewis Index |
| WHO | World Health Organization |

**Abstract**

The dimensional model of personality disorders presented in the 11th edition of the International Classification of Diseases (ICD-11) establishes the severity of personality dysfunction as the central axis of diagnosis, highlighting the need for reliable, valid, and clinically informative assessment instruments. Despite advances in dimensional models of personality pathology, there remains a shortage of clinical tools aligned with the ICD-11 in the Brazilian context, particularly for capturing different levels and expressions of impairment in personality functioning. This master's thesis aimed to examine the psychometric properties of the Brazilian version of the Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF) and to investigate latent severity profiles associated with different configurations of personality dysfunction. Two studies were conducted with a clinical sample of 197 participants. The first study provided evidence of a robust unidimensional structure of the PDS-ICD-11-CRF, with high internal consistency, strong interrater reliability, and adequate item functioning across a broad range of the severity continuum, with greater precision at moderate to high levels of dysfunction. Evidence of convergent validity was demonstrated through significant associations with other personality disorder constructs assessed using both self-report instruments and clinical evaluations. The second study revealed four latent severity profiles, ranging from adaptive personality functioning to severe impairment, each characterized by distinct patterns of dysfunction in the self and interpersonal domains. These profiles were also associated with different pathological personality traits and levels of personality disorder severity as assessed by external measures, further reinforcing the distinc characteristics of each latent profile. Overall, the findings provide robust empirical support for the PDS-ICD-11-CRF as a psychometrically sound clinical instrument for the assessment of personality pathology severity and the differentiation of distinct impairment profiles in personality functioning, consistent with the ICD-11 framework.

**Keywords:** Personality Disorder Severity; ICD-11; Clinician-Rated Assessment; Dimensional Models; Psychometrics.

## Resumo


### *Personality Disorder Severity ICD-11 Clinician-Rating Form* (PDS-ICD-11-CRF): Avaliação Psicométrica e Perfis de Severidade no Brasil

O modelo dimensional dos transtornos da personalidade apresentado na 11ª edição da Classificação Internacional de Doenças (CID-11) estabelece a gravidade da disfunção da personalidade como o eixo central do diagnóstico, destacando a necessidade de instrumentos de avaliação confiáveis, válidos e clinicamente informativos. Apesar dos avanços nos modelos dimensionais da patologia da personalidade, ainda há escassez de instrumentos clínicos alinhados à CID-11 no contexto brasileiro, especialmente para captar diferentes níveis e expressões de prejuízo no funcionamento da personalidade. Esta dissertação de mestrado teve como objetivo examinar as propriedades psicométricas da versão brasileira do Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF) e investigar perfis latentes de gravidade associados a diferentes configurações de disfunção da personalidade. Foram conduzidos dois estudos com uma amostra clínica de 197 participantes. O primeiro estudo forneceu evidências de uma estrutura unidimensional robusta do PDS-ICD-11-CRF, com alta consistência interna, forte confiabilidade entre avaliadores e funcionamento adequado dos itens ao longo de uma ampla faixa do continuum de gravidade, com maior precisão em níveis moderados a altos de disfunção. Evidências de validade convergente foram demonstradas por meio de associações significativas com outros construtos de transtornos da personalidade avaliados tanto por instrumentos de autorrelato quanto por avaliações clínicas. O segundo estudo revelou quatro perfis latentes de gravidade, variando de funcionamento adaptativo da personalidade a prejuízo grave, cada um caracterizado por padrões distintos de disfunção nos domínios do self e interpessoal. Esses perfis também estiveram associados a diferentes traços

patológicos da personalidade e a distintos níveis de gravidade do transtorno da personalidade avaliados por medidas externas, reforçando ainda mais as características distintivas de cada perfil latente. De modo geral, os achados fornecem suporte empírico robusto para o PDS-ICD-11-CRF como um instrumento clínico psicometricamente sólido para a avaliação da gravidade da patologia da personalidade e para a diferenciação de perfis distintos de prejuízo no funcionamento da personalidade, em consonância com o modelo proposto pela CID-11.

**Palavras-chave:** Severidade do Transtorno da Personalidade; CID-11; Avaliação Clínica; Modelos Dimensionais; Psicometria.

# Introduction

## Personality and its contemporary classification

The conceptualization of the personality construct is a complex endeavor that cuts across multiple theoretical lenses and approaches. There is broad consensus among scholars that personality refers to a consistent and enduring pattern (i.e., relatively stable over time) of thoughts, feelings, behaviors, and modes of interaction with oneself, with others, and with the surrounding world (Oliveira, 2019). Nevertheless, an individual's characteristic way of being may also constitute a source of significant suffering and impairment. When a person exhibits a pervasive pattern of maladaptive behaviors that results in psychological distress or psychosocial impairment for themselves and/or others, a personality disorder is identified. Such impairments involve clinically significant disturbances in behavior, cognition, or emotional regulation (Oliveira et al., 2023; Oliveira, 2019).

Given the complexity and heterogeneity of personality manifestations and their associated impairments, diagnostic classification systems play a central role in organizing diagnostic information and facilitating both research and clinical decision-making. In essence, diagnostic classifications provide a shared language among professionals, allowing for the organization and systematization of clinical information, the description of recurrent patterns of symptom presentation, the grounding of clinical inferences and prognostic predictions, support for intervention planning, and the development of psychological theories, in addition to addressing sociopolitical demands (Keeley et al., 2023; Lima et al., 2023). By offering a standardized vocabulary, these systems facilitate concise communication among clinicians and enable the efficient retrieval of relevant information concerning etiology, treatment, and prognosis. From a sociopolitical perspective, classification systems are embedded within specific social contexts and may serve different groups and interests. In the mental health field, they function to identify individuals deemed in need of care and treatment. However, these

functions are not exclusively altruistic, as they are also shaped by institutional, economic, and political interests. Consequently, the application of diagnostic criteria, far from being a straightforward procedure, requires a critical and context-sensitive use of classification systems (Keeley et al., 2023).

Among the major systems for the taxonomy of psychopathology, the International Classification of Diseases (ICD; World Health Organization [WHO], 2020) and the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association [APA], 2022) constitute foundational tools in contemporary mental health practice. In its previous edition, the ICD-10 (WHO, 2004), personality disorders were classified according to a categorical model comprising eight diagnostic categories (Paranoid, Schizoid, Dissocial, Emotionally Unstable, Histrionic, Anankastic, Anxious, and Dependent Personality Disorders). Similarly, the DSM-5-TR (APA, 2022) retains a categorical framework including ten personality disorder diagnoses. Within this approach, each disorder is defined by a prototypical description of characteristic behavioral patterns. However, the current edition of the ICD (ICD-11; WHO, 2020) has moved away from this categorical system and adopted a dimensional model of personality disorder. The traditional categorical approach conceptualizes disorders as discrete and clearly bounded entities, relying on a dichotomous logic of symptom presence versus absence. In addition to diverging from clinical observation, this model presents several well-documented limitations, including substantial within-category heterogeneity (i.e., individuals with markedly different characteristics receiving the same diagnosis), high rates of comorbidity (individuals meeting criteria for multiple diagnoses simultaneously), limited empirical support for the proposed categories, and insufficient clinical utility (Bach & First, 2018; Oliveira et al., 2023). In clinical practice, many individuals do not adequately fit the predefined diagnostic categories, which has contributed, for example, to Personality Disorder-

Not Otherwise Specified becoming the most frequently assigned diagnosis among personality disorder categories (Keeley et al., 2023).

Over recent decades, research in psychopathology and clinical practice have undergone a transition from categorical models to dimensional approaches to mental health diagnosis. Whereas categorical models establish qualitative distinctions between individuals who do or do not meet criteria for a disorder, largely based on the consensus of expert committees, dimensional models differentiate individuals based on quantitative variations along a continuum of severity, grounded in the convergence of empirical findings regarding the natural organization of mental health. In this view, individuals differ in the degree of symptom severity they exhibit, rather than in the mere presence or absence of discrete, dichotomous symptom entities. Within this context, quantitative research plays a central role by identifying latent structures underlying psychopathology and by examining their external validity, steps that are considered essential and interdependent for the development of a scientifically grounded nosology (Hopwood et al., 2023; Kotov et al., 2021).

The first incorporation of dimensional models into diagnostic classification manuals is, in fact, already in effect, having been introduced in the DSM-5 and presented in Section III of the manual, which is devoted to Emerging Models and Measures (APA, 2013, 2022). The so-called Alternative Model for Personality Disorders (AMPD) is configured as a hybrid model, in which certain personality disorder categories are retained while a dimensional approach is incorporated for both the assessment and description of individuals who do not adequately fit a specific diagnostic category. It is important to note that the original proposal was for the AMPD to be included in the main section of the manual, however, due to debates and impasses of a predominantly political and institutional nature, the model was ultimately allocated to Section III (Keeley et al., 2023). Within this model, dimensional assessment is operationalized through Criterion A, which refers to personality functioning, and Criterion B, which refers to

pathological trait domains. Personality functioning is subdivided into self-functioning (impairments in Identity and Self-Direction domains) and interpersonal functioning (impairments in Empathy and Intimacy domains). Criterion B encompasses pathological personality traits organized into five broad domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. Diagnosis may therefore be established based on dimensional assessment and combined with prototypical, categorical profiles (Schizotypal, Antisocial, Borderline, Narcissistic, Avoidant, and Obsessive–Compulsive), thus constituting a hybrid classification system (APA, 2022; Krueger & Hobbs, 2020).

As part of an even more progressive movement toward conceptual updating in psychopathology, the 11th edition of the International Classification of Diseases (ICD-11; WHO, 2020) was published after nearly three decades, featuring a fundamentally revised classification of personality disorders. This new edition introduced paradigm shifts in the way personality disorders are conceptualized and classified (Bach & Mulder, 2022; Mulder, 2021) and is scheduled to come into force in Brazil in 2027. The following section will discuss the advances and assessment approaches associated with this new edition.

**The classification of personality disorders in the ICD-11**

Considering the widely recognized limitations of the categorical model in identifying personality disorders and the growing understanding of personality-related impairments as dimensionally distributed phenomena, a working group was established in 2010 to revise the classification of personality disorders in the ICD-11, even preceding the consolidation of the DSM-5 proposal. This group brought together experts from all regions of the World Health Organization (WHO), encompassing diverse areas of expertise, including the nosology of personality disorders, research on classification systems, and clinical practice across different stages of development, as well as the study of personality traits in both clinical and non-clinical populations. The central aim of this initiative was to develop a more streamlined dimensional

classification system, grounded in levels of severity and qualifier domains, with the potential for cross-cultural application. This effort was aligned with the goal of enhancing the clinical utility of diagnosis and facilitating its applicability across diverse contexts, thereby contributing to a more accurate identification of mental health needs on a global scale (Keeley et al., 2023; Tyrer et al., 2019).

Within the new classification model, assessment is centered on identifying the severity of personality pathology, which is considered the core axis of diagnosis. Severity may be classified as mild, moderate, or severe, resulting, respectively, in the diagnoses of Mild Personality Disorder (6D10.0), Moderate Personality Disorder (6D10.1), and Severe Personality Disorder (6D10.2), as well as Personality Disorder, Severity Unspecified (6D10.Z) when available information does not allow for a precise determination. In addition, the ICD-11 provides for a subclinical designation, termed Personality Difficulty (QE50.7), which applies to individuals who present clinically relevant personality traits or characteristics that may interfere with treatment and the provision of health services but do not reach the threshold required for a formal diagnosis of a personality disorder (Gamache et al., 2021; WHO, 2020).

The determination of severity is based on aspects of interpersonal functioning (such as the desire and ability to develop and maintain satisfying relationships with others and to manage interpersonal conflicts) and self-functioning (such as identity, self-perception, and self-direction) (WHO, 2020). Additional aspects must also be considered, including time (impairments in personality functioning must be present for two years or more), pervasiveness (impairments should be manifested across different personal and social situations), development and culture (impairments are not typical expressions of a given developmental stage and are not better explained by social or cultural factors), and distress and impairment (the impairments are associated with significant distress or substantial harm across different

areas of life) (Oliveira et al., 2023). Table 1 summarizes the main distinctions related to the severity levels of the proposed model.

**Table 1**

*Differences Between the Severity Levels of Personality Disorders in the ICD-11*

| Severity | Characteristics |
|---|---|
| Personality Difficulty (QE50.7) | Presence of personality traits with the potential to impact treatment or the use of health services, without, however, meeting the criteria for a diagnosis of a personality disorder. Such difficulties tend to manifest occasionally or with low intensity and are not sufficiently severe to produce significant impairments in social, occupational, or interpersonal functioning, and may be confined to specific contexts or relationships. |
| Mild Personality Disorder (6D10.0) | Impairments affect only some domains of self-functioning or, when present across all domains, are expressed at a mild level. Certain difficulties are observed in interpersonal relationships or in the performance of social and occupational roles, although the individual is able to preserve part of these relationships and functions. In general, these impairments are not associated with significant harm to oneself or others, even though they may be accompanied by considerable distress or by restricted and circumscribed impairments in relevant areas of functioning. |
| Moderate Personality Disorder (6D10.1) | Alterations compromise multiple domains of self-functioning and are of moderate severity. Marked difficulties, such as frequent conflicts, patterns of avoidance, or excessive dependence, are observed in most relationships, and performance in the majority of social and occupational roles is affected to some degree. In certain situations, these alterations may be associated with harm directed toward oneself or others and are accompanied by significant impairments in the most relevant areas of functioning, although some specific areas may remain relatively preserved. |
| Severe Personality Disorder (6D10.2) | Severe impairments are observed across multiple domains of self-functioning. Intense problems affect virtually all interpersonal relationships, and the individual demonstrates an inability or unwillingness to fulfill expected social and occupational roles. These conditions are frequently associated with behaviors that involve risk or harm to oneself or others, as well as with severe impairments across all, or nearly all, relevant areas of life. |

*Note.* Adapted from Gamache et al. (2021) and World Health Organization (2020).

Although the severity of personality dysfunction constitutes the central axis of diagnosis, and may be sufficient for diagnostic formulation, the ICD-11 allows for the coding of stylistic trait qualifiers when these are particularly prominent in the personality organization of individuals classified as having a Personality Disorder or Personality Difficulty (Bach & First, 2018). In developing this model, researchers conducted empirical investigations aimed at examining the structure and distribution of these trait domains across different populations. The findings indicated that the proposed domains can condense core information previously

attributed to categorically defined personality disorders, while also demonstrating correspondence with normative personality traits described by the Five-Factor Model and evidence of cross-cultural validity (Tyrer et al., 2019). Based on this body of evidence, five trait domains were established: Negative Affectivity, Detachment, Antisociality, Disinhibition, and Anankastia. Despite their independent formulation, these domains show substantial convergence with those described in the AMPD, with the primary difference being the replacement of the Psychoticism domain with Anankastia. This distinction reflects the WHO's position that psychotic features are more appropriately conceptualized within the schizophrenia spectrum rather than as components of personality pathology (Tyrer et al., 2019).

For classification purposes, trait domains function as descriptors of the predominant pattern of personality functioning, providing additional information about how impairments are organized and manifested clinically, without constituting independent diagnoses. Although these traits are theoretically and empirically understood as continuous dimensions, the classification system operates, for practical purposes, with a dichotomous recording of their presence (Bach & First, 2018). By way of example, Negative Affectivity may be coded as 6D11.0, Detachment as 6D11.1, among other corresponding domains (WHO, 2020). In addition, more complex presentations, that is, cases marked by greater severity, tend to involve combinations of multiple trait domains, whereas less severe presentations are typically characterized by a more restricted profile (Bach & First, 2018). Table 2 presents the main characteristics of the pathological trait domains proposed in the ICD-11.

**Table 2**

*Prominent Personality Traits or Patterns in the ICD-11*

| Trait | Characteristics |
|---|---|
| Negative Affectivity (6D11.0) | A tendency to experience a wide range of negative emotions with a frequency and intensity disproportionate to situational demands, frequently associated with emotional lability, difficulties in emotional regulation, negativistic attitudes, low self-esteem and self-confidence, as well as suspiciousness. |

| | |
|---|---|
| Detachment (6D11.1) | A tendency to maintain interpersonal and emotional distance, manifested by avoidance of social interactions, a paucity of close relationships and intimacy, as well as by emotional reserve, indifference, and restricted emotional expression and experience. |
| Dissociality (6D11.2) | Disregard for the rights and feelings of others, involving patterns of self-centeredness and deficits in empathy, expressed through attitudes of entitlement, excessive attention-seeking, prioritization of one's own needs, and indifference to the impact of one's actions on others. This may include manipulative, exploitative, aggressive, or cruel behaviors. |
| Disinhibition (6D11.3) | A tendency to act impulsively in response to immediate internal or external stimuli, such as sensations, emotions, or thoughts, with little consideration of potential negative consequences. This tendency is manifested through impulsivity, distractibility, recklessness, irresponsibility, and deficits in planning. |
| Anankastia (6D11.4) | A rigid focus on personal standards of perfection, rules of right and wrong, and the need to control one's own behavior, the behavior of others, and situations in order to ensure conformity to these criteria. This pattern is manifested through pronounced perfectionism, expressed as excessive preoccupation with rules, norms, details, organization, order, and planning, as well as through emotional and behavioral restriction, inflexibility, stubbornness, risk avoidance, and a tendency toward perseveration. |

*Note:* Adapted from Bach & First (2018) and World Health Organization (2020).

Beyond the assessment of personality dysfunction severity and characterization through pathological trait domains, the ICD-11 incorporated a specific qualifier for the borderline pattern of functioning. This is an optional specifier that may be used in conjunction with trait domains, and its definition differs substantially from the procedure adopted for the latter. Whereas trait domains are described dimensionally, the borderline qualifier is operationalized through polythetic criteria, requiring the identification of at least five out of nine characteristics derived from the DSM-5 criteria for Borderline Personality Disorder. This specifier describes a pattern of functioning characterized by pervasive instability in interpersonal relationships, self-perception, and affect regulation, associated with marked impulsivity, persistent efforts to avoid abandonment, dissociative experiences, and self-injurious behaviors (Bach & First, 2018; Oliveira et al., 2023; WHO, 2020). The inclusion of this qualifier aimed to facilitate the conceptual and clinical transition between categorical and dimensional systems (Oliveira et al., 2023). Recent empirical evidence further indicates a robust association between this pattern of functioning and the domains of Negative Affectivity and Disinhibition (Oliveira & Oliveira, 2023), suggesting that individuals presenting a borderline pattern tend, empirically, to exhibit

elevated levels of intense negative emotions and difficulties in behavioral control. Table 3 summarizes the main characteristics of the borderline pattern of functioning.

**Table 3**

*Borderline Pattern of Functioning in the ICD-11*

| Characteristics |
|---|
| Intense efforts to avoid real or perceived abandonment. |
| Unstable and intense interpersonal relationships. |
| Persistent instability of identity and self-image. |
| Impulsivity associated with intense negative affect, with risk of self-harming behaviors. |
| Recurrent self-injurious behaviors. |
| Emotional lability with marked mood reactivity. |
| Chronic feelings of emptiness. |
| Intense anger or difficulty controlling aggression. |
| Transient dissociative experiences or psychosis-like symptoms under intense emotional stress. |

*Note:* Adapted from World Health Organization (2020).

Together, the assessment of personality dysfunction severity, characterization through pathological trait domains, and the optional specification of the borderline pattern of functioning constitute an approach that allows for a more precise understanding of both the overall level of impairment and the ways in which these impairments are expressed, thereby overcoming the limitations of strictly categorical classifications. Within this new paradigm, the development, adaptation, and validation of psychological assessment instruments compatible with the ICD-11 model in the Brazilian context become essential, ensuring clinically useful, culturally congruent evaluations aligned with current guidelines. At the international level, instruments have already been developed in accordance with ICD-11 or AMPD guidelines for assessing personality functioning, such as the Level of Personality Functioning Scale–Brief Form 2.0 (LPFS-BF-2.0; Weekers et al., 2019), the Standardized Assessment of Severity of Personality Disorder (SASPD; Olajide et al., 2018), and the Personality Disorder Severity ICD-11 (PDS-ICD-11; Bach et al., 2021). In the Brazilian context, the Diagnostic Interview for Personality Disorders (E-TRAP; Carvalho et al., 2020) stands out, having been developed based on the AMPD. Despite the relevance of these initiatives, the PDS-ICD-11 remains, to date, the

only instrument specifically grounded in the ICD-11 that comprehensively assesses both self and interpersonal functioning domains, as well as the emotional, cognitive, and behavioral manifestations associated with personality dysfunction. However, its self-report version presents limitations inherent to this format, as typical deficits in insight among individuals with personality disorders may compromise assessment accuracy, and interpersonal behaviors, often better captured through clinical evaluation, may not be fully observed (Bach et al., 2020; Sellbom et al., 2024). In this regard, the following section presents the Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF; Sellbom et al., 2024), a tool developed for the clinical assessment of personality dysfunction severity in accordance with the ICD-11 framework, which has been adapted for the Brazilian context within the scope of this master's thesis.

**The Personality Disorder Severity ICD-11 Clinician-Rating Form**

The PDS-ICD-11-CRF was developed by Sellbom et al. (2024) with the aim of providing a brief measure for the clinical assessment of personality disorder severity, based on the self-report form of the PDS-ICD-11 (Bach et al., 2021). It evaluates impairments in self and interpersonal functioning, as well as maladaptive patterns of cognition, emotional experience and expression, and behavior, in accordance with the guidelines established in the ICD-11 (WHO, 2020). The instrument comprises 14 items. The first ten items require the clinician to select, on a five-point bipolar scale, the option that best describes the patient's functioning. An intermediate response reflects normal personality functioning, while impairments are represented at the extremes of each pole of the spectrum. The remaining items are rated on a four-point scale ranging from "0" to "3." Based on these responses, the total score indicates the overall severity of personality disorder (Sellbom et al., 2024). Table 4 summarizes the interpretation of the bipolar items, providing definitions and characterizations of the

dysfunctional poles and functional midpoints, while Table 5 presents the unipolar items, with definitions and descriptions of the continua ranging from functionality to dysfunction.

**Table 4**

*Interpretation of Bipolar Items with Definitions and Characterizations of Dysfunctional Poles and Functional Midpoints*

| Dimension (Definition) | Left Pole (Dysfunctional) | Midpoint (Healthy Functioning) | Right Pole (Dysfunctional) |
|---|---|---|---|
| Item 1. Identity (Capacity to maintain a coherent, stable, and continuous sense of self) | Diffuse, unstable (Does not know who they are; cannot differentiate themselves from others; presents an unstable self-image—frequently changes the way they see themselves) | Clear, stable, and integrated sense of self (Knows who they are; integrates multiple roles into a cohesive self) | Rigid, excessively fixed (Defines themselves exclusively through a single role—work, social, family, religion; holds a very fixed idea of self without considering nuances) |
| Item 2. Self-worth (Overall emotional evaluation of oneself, including self-worth and self-confidence) | Low self-esteem, self-devaluation (Dislikes themselves; highly self-critical and rigid; self-esteem fragile in response to criticism and others' opinions) | Realistic and stable self-esteem (Has appropriate self-regard; values the self in a balanced manner; demonstrates emotional security regarding the self) | Inflated self-esteem, arrogance (Holds unrealistic self-regard; excessively values the self; exhibits disproportionate self-confidence, believing they are capable or skilled in areas where they lack ability) |
| Item 3. Self-Perception (The individual's image of themselves, including their traits, abilities, and limitations) | Self-deprecating, excessively negative (Focuses on personal flaws; overemphasizes mistakes; believes they are inadequate; underestimates their own abilities) | Balanced and accurate self-image (Has a realistic perception of their abilities and limitations; appropriately recognizes both strengths and weaknesses; has a clear understanding of what they can and cannot do) | Grandiose, exaggerated self-view (Sees themselves as more capable than they actually are; fails to acknowledge mistakes, minimizing personal flaws and attributing errors to external factors; overestimates their own abilities) |
| Item 4. Goals (Capacity to set and pursue objectives effectively and realistically) | Aimless, lacking direction (Does not know who they want to be in life; unable to set life goals; fails to pursue objectives, abandoning them; frequently changes goals) | Purposeful goal pursuit with appropriate flexibility (Knows who they want to be in life; sets life goals that are realistic and can be adjusted in response to life's contingencies; persists in striving to achieve objectives even in the face of challenges) | Rigid, unrealistic goals (Sets exaggerated, unrealistic life goals; becomes obsessed with pursuing objectives to the detriment of other areas of life; struggles to adjust unattainable goals, persisting in excessive pursuits; rigid in the idea of achieving personal goals) |
| Item 5. Interest in relationships (Social engagement and desire to maintain meaningful connections) | Social isolation, disinterest (Actively avoids interactions with others; shows marked discomfort in social situations; lacks interest in forming relationships with others) | Engaged, values and maintains reciprocal relationships (Appreciates the relationships they have; even if shy, enjoys being with people with whom they share affinity and values interpersonal moments; shows interest in others and a desire to maintain meaningful connections) | Excessively dependent, clingy (Cannot be alone; has an excessive need for others' reassurance when making decisions; relies on others for personal well-being; perceives relationships as closer than they actually are; overly dependent |

| | | | |
|---|---|---|---|
| | | | and demanding of others; uses relationships for personal security) |
| Item 6. Perspective-taking (Ability to understand and consider the feelings and viewpoints of others) | Egocentric, lacking perspective (Has difficulty considering others' viewpoints; indifferent to others' feelings; reacts aggressively when someone disagrees, interpreting disagreement as a threat; self-centered, concerned only with their own needs) | Considers others' viewpoints while maintaining distinction between self and other (Able to consider and respect multiple perspectives; balances the fulfillment of their own needs with those of others; knows when to yield and when to assert personal desires; can differentiate their own needs from those of others) | Overidentification, blurred boundaries (Submits to others; excessively concerned with others' well-being to the point of self-negation; overly preoccupied with what others think or feel about them; excessively focused on others; engages in actions they do not desire to please others) |
| Item 7. Mutuality in relationships (Ability to maintain intimate and balanced relationships in terms of give-and-take) | Distant, emotionally cold (Uses relationships for personal satisfaction and gain; takes more than they give in relationships; manipulates others to get what they want; relationships are not genuine but utilitarian, serving personal advantage) | Balanced intimacy and autonomy (Forms reciprocal relationships; relationships provide mutual support and are satisfying for both self and others; maintains a balance between giving and receiving in relationships) | Enmeshed, excessively involved (Relationships are symbiotic; the person gives much more than they receive; feels dissatisfied in relationships but cannot assert themselves for a more balanced dynamic; submits to others without the ability to set boundaries) |
| Item 8. Disagreement management (Ability to recognize, confront, and resolve tensions or disagreements with others in a constructive and balanced manner) | Confrontational, argumentative (In tense interpersonal situations, tends to be hostile and confrontational; loses temper and escalates conflict; stubborn and unwilling to yield, insisting on having the last word) | Assertive and respectful in communicating disagreements (Maintains a diplomatic stance, able to manage conflicts with respect and assertiveness; can set clear boundaries, assert themselves while still showing respect and care in conflict situations) | Conflict-avoidant, submissive (In interpersonal conflict situations, avoids or withdraws from the situation; submits to others to prevent disagreements; unable to assert themselves effectively in conflicts; may display maladaptive behaviors, such as freezing in fear or crying due to difficulty managing their own emotions) |
| Item 9. Emotional control and expression (Ability to express emotions appropriately and regulate them when necessary) | Suppressed, detached (Struggles to accurately identify their own emotions; exhibits limited emotional experience and expression; displays a narrow range of emotions, typically with few positive or negative reactions; tends to feel | Emotionally aware, expresses and regulates emotions appropriately (Able to accurately recognize their own emotions, describe them, and express them appropriately; experiences positive and negative emotions proportionally to situations; expresses emotions in a controlled manner) | Dysregulated, excessively intense (Experiences positive and negative emotions disproportionately; is hyper-emotionally reactive; has difficulty controlling emotional expression for both positive and negative affects; highly sensitive, as even minor, everyday events significantly impact them) |

| | | | |
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| | displeasure in life; shows emotional coldness) | | |
| Item 10. Behavioral control (Ability to manage impulses and behaviors appropriately within the context) | Impulsive, reckless (Fails to self-regulate behavior; acts impulsively; engages in reckless behaviors, unable to adequately consider risks; irresponsible and easily distracted, failing to fulfill obligations) | Adaptive and flexible behavioral regulation (Able to balance behavior flexibly and appropriately, integrating self-control and spontaneity; can adjust the level of self-control according to context—for example, increasing control in formal settings and relaxing it in leisure situations) | Excessively controlled, rigid (Extremely controlled, meticulously managing their behavior and expression; desires and seeks to control everything, rigid in the way they speak and interact with others; lacks spontaneity in actions; tends to be inauthentic, constantly calculating words, gestures, and expressions) |

*Note:* Santos & Oliveira (2025).

**Table 5**

*Interpretation of Unipolar Items with Definitions and Characterizations of the Continua Ranging from Functionality to Dysfunctionality*

| Dimension (Definition) | Left Pole (Healthy Functioning) | Right Pole (Dysfunctional) |
|---|---|---|
| Item 11. Experience of reality during stress (Accuracy in assessments and ability to make decisions in uncertain situations) | Accurate, realistic perception (Able to assess stressful situations accurately; does not experience mental confusion under stress, remaining capable of broadly and clearly understanding what is happening) | Loss of contact with reality, distorted thinking (In stressful situations, exhibits biased ideas of mistrust or expects the worst to happen; loses touch with reality, experiencing mental confusion and inability to think clearly; may show paranoid thoughts or even experiences of disconnection from reality) |
| Item 12. Harm to self (Tendency toward self-injury and making decisions that are detrimental to one's own well-being) | Self-care and self-protection (Takes care of oneself; safeguards personal well-being; does not intentionally or unintentionally harm oneself physically or emotionally; makes decisions that respect one's psychological and physical integrity) | Self-sabotage, suicidality (Experiences suicidal thoughts and engages in suicidal behaviors; intentionally or unintentionally harms oneself physically and emotionally; engages in self-sabotaging behaviors by making decisions that are detrimental to one's own well-being). |
| Item 13. Harm to others (Behaviors or actions that cause suffering, damage, or discomfort to other people) | Care and consideration for others (Shows concern for others; values the psychological and physical well-being of others; makes decisions that ensure the psychological and physical integrity of others) | Hostile and aggressive toward others (Exhibits hostile, antagonistic, and unfriendly behaviors toward others; disregards the psychological and physical well-being of others; makes decisions, intentionally or unintentionally, that harm or cause suffering to others) |
| Item 14. Psychosocial impairment (Distress or impairments in various | Healthy psychosocial functioning (Personality characteristics do not negatively interfere with one's life; | Significant psychosocial impairment or distress (Personality characteristics cause substantial personal dissatisfaction; wishes to be different due to suffering from who they are; experiences major |

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| areas of life due to personality characteristics) | personality functioning supports personal satisfaction and enables a psychologically healthy life) | impairments in family, social, romantic, work, or other life domains because of their personality traits) |

*Note:* Santos & Oliveira (2025

The original validation study demonstrated robust psychometric properties, including a consistent internal structure, high interrater reliability, and strong criterion validity (Sellbom et al., 2024). Additionally, a recent meta-analysis indicated that the instrument shows the highest internal consistency for assessing personality disorder severity according to ICD-11, compared to other measures available in the literature (Hualparuca-Oliveira et al., 2024). Together, these findings support the potential of the PDS-ICD-11-CRF as a valuable tool for both clinical practice and research, particularly for assessing severity and monitoring changes in personality functioning over time (Sellbom et al., 2024).

Considering the previous evidence of validity and reliability of the original version of the instrument (Sellbom et al., 2024) and the need for tools aligned with the ICD-11 model in Brazil, the present mater's thesis aims to investigate the psychometric performance of the PDS-ICD-11-CRF in the Brazilian context. Accordingly, this work is organized into two manuscripts. Manuscript 1 aims to investigate evidence of validity and reliability of the Brazilian version of the PDS-ICD-11-CRF, specifically regarding its internal structure, interrater reliability, and convergent validity. Manuscript 2, in turn, seeks to identify personality disorder severity latent profiles reflecting different configurations of impairment expression in the PDS-ICD-11-CRF and examine how these profiles relate to overall severity, maladaptive traits, and the borderline pattern specifier. Together, these studies strive to contribute to the advancement of personality assessment according to the ICD-11 model, enhancing its clinical and scientific applicability in the national context.

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# Manuscript 1: Clinical Assessment of Personality Disorder Severity in Brazil: Psychometric Properties of the PDS-ICD-11 Clinician-Rating Form


## Abstract

The dimensional classification of personality disorders presented in the 11th edition of the International Classification of Diseases (ICD-11) places severity of personality dysfunction at the core of diagnosis, highlighting the need for reliable and valid clinician-rated assessment tools. The present study aims to examine evidence of validity related to internal structure and convergent validity of the Brazilian version of the PDS-ICD-11-CRF, in addition to assessing the scale's reliability via internal consistency and interrater reliability. A clinical sample of 197 individuals was assessed by licensed psychologists, trained undergraduate psychology students, and the project's lead researcher. Results showed that the PDS-ICD-11-CRF items are best described by a unidimensional structure, and convergent validity was supported by significant associations with external measures of personality functioning and pathological personality traits. Reliability coefficients were satisfactory, indicating that the scale yields good precision in estimating personality disorder severity. Item discrimination and difficulty parameters estimated using the graded response model from Item Response Theory were also satisfactory, and the scale demonstrated greater measurement precision for individuals with higher levels of latent trait severity, particularly in the moderate to high dysfunction range. Overall, the findings support the Brazilian PDS-ICD-11-CRF as a valid, and reliable instrument for assessing the severity of personality pathology within the ICD-11 framework.


*Keywords:* Personality Disorders; Dimensional Model; Assessment Instrument; Psychometrics; International Classification of Diseases.

## Introduction

The classification of personality disorders has undergone significant changes with the introduction of the Alternative Model for Personality Disorders (AMPD) in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013, 2022) and the 11th edition of the International Classification of Diseases (ICD-11; World Health Organization [WHO], 2020). In the AMPD, personality disorders are conceptualized using a hybrid model that evaluates personality functioning alongside five pathological trait domains, namely, Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism, which capture the core elements of basic personality structure (APA, 2022; Krueger & Markon, 2014). In a further development, the ICD-11 framework centers on severity of personality disorder, defined as the degree of impairment in personality functioning as the core diagnostic criterion, and allows for the specification of five pathological personality trait domains to characterize the particular manner in which the dysfunction is expressed: Negative Affectivity, Detachment, Dissociality, Disinhibition, and Anankastia (WHO, 2020). The system thus abandons the former specific diagnostic categories in favor of a single general category of personality disorder, while still allowing the inclusion of a borderline pattern specifier, to ensure a smoother transition between categorical and dimensional models. Both the AMPD and the ICD-11 classifications are similar to each other (Bach et al., 2017; Bach & First, 2018; Bach & Mulder, 2022).

As the core aspect of diagnosis, severity of personality disorder is assessed based on the degree of impairment in self-functioning (e.g., identity, self-esteem, goal direction) and/or interpersonal functioning (e.g., the ability to establish and maintain close, mutually satisfying relationships, understand others' perspectives, and manage conflict). These impairments are reflected in maladaptive, rigid, or dysregulated patterns of cognition, emotional experience and expression, and behavior. Classification occurs along a continuum of severity, ranging from no

impairment, followed by Personality Difficulty, which is a subclinical level of dysfunction, Mild, Moderate, and Severe Personality Disorder (Gamache et al., 2021; WHO, 2020). To assess this construct, researchers have sought to develop measures to capture impairments in self and interpersonal functioning across both the AMPD and the ICD-11 frameworks. Among these are the Level of Personality Functioning Scale-Brief Form 2.0 (LPFS-BF-2.0; Weekers et al., 2019), the Standardized Assessment of Severity of Personality Disorder (SASPD; Olajide et al., 2018), and the Personality Disorder Severity ICD-11 (PDS-ICD-11; Bach et al., 2021). Notably, the PDS-ICD-11 was the first published instrument to comprehensively capture all diagnostic features defined by the ICD-11, including aspects of self- and interpersonal functioning, as well as emotional, cognitive, and behavioral manifestations. The measure has demonstrated robust psychometric properties across different cultures (Bach et al., 2021; Brown & Sellbom, 2023; Doubková et al., 2025; Gutiérrez et al., 2023; Lorentzen et al., 2024; Martin et al., 2025; Zimmermann et al., 2023), including its Brazilian version (Oliveira et al., 2025a).

In addition to self-report measures, the development of standardized tools for the clinical assessment of severity of personality disorder is essential, considering that individuals with personality dysfunction may lack insight into their own symptoms and that clinical assessments generally provide greater accuracy and validity, particularly for social and interpersonal behaviors observable by others (Bach et al., 2020; Sellbom et al., 2024). Accordingly, Sellbom et al. (2024) developed the Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF), which has demonstrated robust psychometric properties, including a well-supported internal structure, high interrater reliability, and strong criterion validity. In a meta-analysis, the instrument also exhibited the highest internal consistency in assessing the overall severity construct of the ICD-11 compared with other instruments available in the literature (Hualparuca-Oliveira et al., 2024).

**The Current Study**

Given that the ICD-11 has been adopted as the global standard diagnostic system for health conditions following its endorsement by the World Health Assembly, Brazil, as a Member State of the World Health Organization, has committed to its implementation and is in the process of integrating the ICD-11 into national health systems. It is therefore crucial for Brazilian clinicians and researchers to have instruments that are rigorously adapted to Brazilian Portuguese and culturally relevant, with psychometric properties empirically verified, to ensure their appropriate applicability and interpretability in the Brazilian context. Therefore, the present study aims to examine evidence of validity related to internal structure and convergent validity of the Brazilian version of the PDS-ICD-11-CRF, in addition to assessing the scale's reliability via internal consistency and interrater reliability. In order to accomplish these aims, we will test five hypotheses.

Hypothesis 1 (structural validity): We expect to find a unidimensional structure of the Brazilian version of the PDS-ICD-11-CRF. The construct of personality disorder severity in the ICD-11 has been empirically established as unidimensional, encompassing both self- and interpersonal functioning (Bach et al., 2021; Lorentzen et al., 2024; Zimmermann et al., 2023). In line with this framework, the original validation study of the PDS-ICD-11-CRF conducted by Sellbom et al. (2024) confirmed its unidimensional structure. Therefore, we expect the Brazilian version to replicate this structure, as there are no strong cultural hypotheses suggesting a different factorial configuration, consistent with findings from the Brazilian self-report version of the instrument (Oliveira et al., 2025a).

Hypothesis 2 (internal consistency): We expect to find internal consistency reliability indices for the PDS-ICD-11-CRF. In the instrument's original development study of the clinician-rating form, both McDonald's ω and Cronbach's α were .91, indicating strong internal

consistency (Sellbom et al., 2024). Thus, we anticipated that the Brazilian version would exhibit similar levels of reliability.

Hypothesis 3 (interrater reliability): We anticipated that the PDS-ICD-11-CRF would demonstrate satisfactory interrater reliability (Intraclass Correlation Coefficient [ICC] ≥ .60), reflecting the degree to which independent clinicians provide consistent ratings of the same individuals. Although thresholds for acceptable interrater reliability can vary by field, coefficients of at least .60 are often regarded as indicative of moderate agreement and values approaching or exceeding .80 as strong agreement (Faherty et al., 2020). Response styles, such as tendencies toward acquiescence or socially desirable responding, can influence psychological assessments and are shaped by individuals and sociocultural factors (Silva & Rocha, 2025). In the context of clinician-rated instruments, reliability may be compromised when variability, across evaluators leads to inconsistent scoring, which can undermine the interpretability of results. An ICC of .94 was reported in the original development study of the PDS-ICD-11-CRF, indicating excellent interrater reliability (Sellbom et al., 2024). High interrater reliability indicates that scoring criteria are clear, operationally defined, and consistently applied, supporting the instrument's utility for both research and clinical decision-making (McHugh, 2012).Hypothesis 4 (item parameters): We hypothesize that the items of the Brazilian version of the PID-ICD-11-CRF items will exhibit satisfactory discrimination values ($a > .65$) and difficulty parameters broadly distributed along the latent trait continuum, in accordance with the recommendations of Baker (2001) and Nguyen et al. (2022). In the original study, all items showed acceptable discrimination and a range of difficulty parameters from below-average to above-average levels, supporting their capacity to differentiate among individuals with varying severity of personality pathology (Sellbom et al., 2024). Additionally, item 13 (Harm to Others) was previously associated with the highest difficulty estimates, suggesting that elevated scores on this item are more likely among individuals with more severe

personality dysfunction (Sellbom et al., 2024). Hence, we expect similar patterns of item functioning in our study.

Hypothesis 5 (convergent validity): We predict that the Brazilian version of the PDS-ICD-11-CRF will show significant and strong correlations ($r \geq .50$; indicating convergent validity according to Carlson and Herdman, 2012) with other measures of personality disorder severity (PDS-ICD-11 and E-TRAP Criterion A) and significant and moderate correlations ($r \geq .30$) with pathological personality traits (PID5BF+M, BPS, and E-TRAP). Convergent validity reflects the degree to which theoretically related measures correlate, and it is typically interpreted within a multitrait-multimethod framework (Campbell & Fiske, 1959), where correlations among measures of the same construct should be higher than among dissimilar constructs. Because this study includes both self-report and clinician-rated measures, we also expect that correlations will tend to be stronger when the same method is used due to common method influences, whereas correlations across different methods may be attenuated. These expectations are supported by findings from the original validation study, which reported a correlation of .73 between the PDS-ICD-11-CRF and the PDS-ICD-11 self-report version (Sellbom et al., 2024), and by the empirical overlap between ICD-11 personality disorder model and the AMPD, which suggests that measures of personality functioning and pathological traits should be substantially related (Bach et al., 2017; Bach & First, 2018; Banerjee et al., 2009; Hualparuca-Oliveira et al., 2023; McCabe & Widiger, 2020).

## Method

### Participants

A total of 75 licensed psychologists, 25 undergraduate psychology students from the University of Brasília, Brazil, and the project's lead researcher administered research protocols to 197 individuals. Most of the psychologists worked primarily in psychotherapy (53.3%) and

had a specialization degree as their highest level of education (66.7%). They were from 12 different states of Brazil, with the majority residing in the Federal District (41.3%). The total clinical sample comprised 197 individuals, including 132 patients of the participating psychologists and 65 research volunteers who were assessed by the lead researcher and the undergraduated psychology students. The sample size is consistent with the original study of the PDS-ICD-11-CRF (Sellbom et al., 2024). Participants' ages ranged from 18 to 73 years old (M = 31.1, SD = 10.4). The majority of the participants were women (70.1%) and 59.4% of participants self-reported their ethnicity as white. Details of participants' characteristics are provided in Table 1.

**Table 1**

*Characterization of the Sample*

| | | |
|---|---|---|
| Age (*M*, *SD*) | 31.1 | 10.4 |
| Gender (*f, %*) | | |
| - Men | 48 | 24.4 |
| - Women | 138 | 70.1 |
| - Transgender Women | 1 | 0.5 |
| - Transgender Men | 1 | 0.5 |
| - Queer, non-binary, or gender-fluid | 9 | 4.6 |
| Race (*f, %*) | | |
| - White | 117 | 59.4 |
| - Black | 17 | 8.6 |
| - Mixed-race | 58 | 29.4 |
| - Indigenous | 1 | 0.5 |
| - Other | 1 | 0.5 |
| - Not reported | 3 | 1.5 |
| Education (*f, %*) | | |
| - Incomplete Elementary School | 1 | 0.5 |
| - Completed Elementary School | 11 | 5.6 |
| - Incomplete High School | 33 | 16.8 |
| - Completed High School | 29 | 14.7 |
| - Completed Undergraduate Degree | 33 | 16.8 |
| - Incomplete Undergraduate Degree | 40 | 20.3 |
| - Incomplete Postgraduate Degree | 7 | 3.6 |
| - Completed Postgraduate Degree | 43 | 21.8 |
| Marital status (*f, %*) | | |
| - Single | 134 | 68.0 |
| - Domestic Partnership | 16 | 8.1 |
| - Married | 36 | 18.3 |

| | | |
|---|---|---|
| - Divorced | 8 | 4.1 |
| - Widowed | 1 | 0.5 |
| - Other | 2 | 1.0 |
| Region of residence (*f, %*) | | |
| - North | 2 | 1.0 |
| - Northeast | 17 | 8.6 |
| - Central-West | 123 | 62.4 |
| - Southeast | 42 | 21.3 |
| - South | 13 | 6.6 |
| Income (*f, %*) | | |
| - Low Income | 57 | 29.0 |
| - Medium Income | 102 | 51.8 |
| - High Income | 38 | 19.3 |
| Psychiatric diagnosis (*f, %*) | | |
| - No | 104 | 52.8 |
| - Yes | 93 | 47.2 |
| Psychiatric medication (*f, %*) | | |
| - No | 105 | 53.3 |
| - Yes | 92 | 46.7 |
| Psychiatric treatment (*f, %*) | | |
| - No | 116 | 58.9 |
| - Yes | 81 | 41.1 |
| Psychological treatment (*f, %*) | | |
| - No | 54 | 27.4 |
| - Yes | 143 | 27.4 |

**Instruments**

Sociodemographic Questionnaire (SQ): We developed the SQ to collect information on the sociodemographic and mental health characteristics of the sample included in this study.

Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF; Sellbom et al., 2024): This is a brief clinician-rated measure of personality disorder severity, based on the self-report version of the PDS-ICD-11 (Bach et al., 2021). The instrument comprises 14 items, with the first 10 items requiring clinicians to indicate, on a bipolar scale of five statements, which option best reflects the patient's functioning. In this context, an intermediate response reflects normal personality functioning, while impairments are captured at the extremes of each pole. The remaining items are rated on a 4-point scale ranging from 0 to 3. Total scores derived from the responses indicate the overall severity of the personality disorder (Sellbom et al., 2024). We performed the PDS-ICD-11-CRF adaptation into Brazilian-

Portuguese language and culture by following the guidelines available in literature (Beaton et al., 2000; Borsa et al., 2012; International Test Commission, 2017). A total of 22 individuals participated in the process of translation and adaptation. The original authors authorized the adaptation of the scale, and the items were translated into Brazilian Portuguese by two independent bilingual individuals, a psychologist and an English teacher. A synthesized version of the translations was created by the authors of this study. Subsequently, it was semantically reviewed by five psychologists (target population), being each one from each of the five regions of Brazil, to reduce specific cultural language bias. Then, the resulting version was evaluated by a committee of experts in terms of Linguistic Clarity (Content Validity Coefficient [CVC] = .92), Practical Relevance (CVC = .96), Theoretical Relevance (CVC = .96), and Semantic Equivalence (CVC = .93). To assess the operational adequacy of the PDS-ICD-11-CRF Brazilian version, 10 psychologists completed the scale with reference to a patient they had evaluated in psychological assessment. Finally, the items were backtranslated into English by two additional bilingual individuals, one of whom was a psychologist, and the researchers synthesized the two translations. The process demonstrated that the items were understandable for Brazilian psychologists, culturally appropriate, theoretically consistent, and equivalent to the original version.

Entrevista Diagnóstica para Transtornos da Personalidade (E-TRAP; Carvalho et al., 2020. [Diagnostic Interview for Personality Disorders]): This instrument is a computerized semi-structured interview developed in Brazil to assist mental health professionals in the diagnosis of personality disorders. The E-TRAP is designed to evaluate personality pathology according to both the categorical and hybrid models described in the DSM-5, addressing impairments in personality functioning (Criterion A) as well as specific pathological traits (Criterion B), namely: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. The interview consists of two main parts: The first part assesses the level of

impairment in personality functioning (Criterion A), using structured questions that guide the clinician's ratings of the individual's self- and interpersonal functioning. The second part evaluates pathological personality traits (Criterion B) including questions related to maladaptive patterns of affect, cognition, interpersonal behavior, and impulse control. Responses are scored by the clinician using a computer interface, and an automated report of the individual's scores is generated at the end of the interview (Carvalho et al., 2020). The reliability indices observed in this study ranged from $\omega$ = .58 (Psychoticism) to $\omega$ =.83 (Negative Affectivity).

Personality Disorder Severity ICD-11 (PDS-ICD-11; Bach et al., 2021): This is a 14-item self-report instrument. The first 10 items are bipolar, where respondents are instructed to indicate one of five statements that best reflects their level of functioning along the assessed spectrum. The middle option represents healthy functioning, while responses above or below this midpoint indicate mild to moderate impairment, and the options at the extreme poles represent more severe dysfunction. These items are scored on a three-point scale: 0 for adaptive functioning, 1 for mild impairment, and 2 for severe impairment, so that both ends of the spectrum receive the same severity score. The remaining four items are unipolar and scored from 0 to 3, with higher scores indicating greater personality dysfunction. The sum of all scores is used as the total score to assess severity according to ICD-11 guidelines (Bach et al., 2021). We used the Brazilian version adapted by the Clinical Psychological Assessment Research Center (NEAPSIC) of the University of Brasília (Oliveira et al., 2025a). In the current study reliability was $\omega$ = .81.

Personality Inventory for DSM-5 – Brief Form Plus Modified (PID5BF+M; Bach et al., 2020): This instrument comprises 36 items that assess the pathological personality domains of both the DSM-5 and ICD-11 personality disorder models in an integrated manner. It evaluates the traits of Negative Affectivity, Detachment, Antagonism/Dissociality, Disinhibition,

Anankastia, and Psychoticism. Each of these domains includes three facets, each represented by a pair of items. Respondents rated the 36 items on a four-point scale ranging from 0 ("does not describe me at all") to 3 ("describes me very well"). This measure has proven to be valid and reliable for estimating pathological personality traits according to the DSM-5 and ICD-11 models (Bach et al., 2020). We used the Brazilian version (Oliveira et al., 2025b). In the current study, reliability indices ranged from $\omega$ =.82 (Antagonism) to $\omega$ =.90 (Anankastia).

Borderline Pattern Scale (BPS; Oltmanns & Widiger, 2019): This measure consists of 12 items rated on a five-point scale, ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). The instrument was developed based on the descriptive components of the borderline specifier pattern according to the ICD-11 personality disorder model. We used the Brazilian version adapted by Oliveira and Oliveira (2023). In this study, reliability coefficient was $\omega$ =.90.

**Procedures**

The study was approved by the Research Ethics Committee of the University of Brasília (protocol number 81181424.2.0000.5540). All participants signed an informed consent form before participating. Data collection consisted of three stages. The first stage involved data collection conducted by licensed psychologists who received standardized training through a free online course offered by the research team. The course was delivered as an extension project of the University of Brasília and provided both theoretical and practical instruction, ensuring comprehensive coverage of personality disorder assessment as well as specific training in the administration and interpretation of the PDS-ICD-11-CRF and the E-TRAP. The training comprised 10 hours of theoretical content. In addition, participating psychologists had access to ongoing supervision during the period of instrument administration, totaling five hours per psychologist, to address questions related to assessment procedures and scoring.

As part of the training process, psychologists were instructed to invite patients who were willing to participate voluntarily in the study. With the patients' consent, psychologists provided the researchers with their contact information. So, psychologists who volunteered for the study indicated between one and three patients for participation. The research team then contacted these patients and sent them a link to complete the research protocol hosted on the FormR platform (Arslan et al., 2020), where they responded to self-report measures: QS, PDS-ICD-11, PID5BF+M, and BPS. Embedded within the protocol were quality control items designed to detect inattentive responding (e.g., *"Select the number three to show that you are paying attention"*), and participants received an automatically generated personality feedback report after finishing all of the self-report questionnaires to improve both engagement and data quality. Participants whose responses passed the quality control checks were then invited to proceed to the next stage of the study. In this stage, the participating psychologists completed a training course and subsequently administered the E-TRAP to these patients, after which they completed the PDS-ICD-11-CRF based on the narrative information obtained during the interview.

The second stage involved data collection conducted by undergraduate psychology students from the University of Brasília and the project's lead researcher. This stage aimed at examining interrater reliability. Students were selected based on an interview process and their academic performance in a course taught by the project's lead researcher. The course comprised a total of 60 hours and addressed both theoretical and practical aspects of personality disorder assessment across categorical, hybrid, and dimensional models, including evaluative activities. In addition, selected students participated in the same training course provided to the licensed psychologists. For this stage, a call for volunteers was disseminated online through the researchers' contact networks, inviting participants to attend an in-person data collection at the University of Brasília. At the time of registration, volunteers provided informed consent and

completed the self-report instruments. Those who did not fail the control items were invited to continue in the study. A total of 26 volunteers were selected to be assessed by the students and the project's lead researcher at this stage. Volunteers were assigned to students in a non-systematic manner, aiming to include individuals with varying severity levels as measured by the PDS-ICD-11. Students and the lead researcher formed pairs and contacted the volunteers. Participant identities were protected at all stages, and students did not have access to information about volunteers from other pairs, ensuring confidentiality. Each pair assessed two volunteers: while one administered the E-TRAP, the other observed the session. Both then independently rated the volunteer using the PDS-ICD-11-CRF.

Finally, the third stage consisted of the individual assessment of the remaining 39 volunteers who had initially enrolled in the second stage of data collection. These assessments were conducted by the project's lead researcher in collaboration with two trained undergraduate psychology students. The E-TRAP was administered to each participant, and based on the information obtained through the interview, the PDS-ICD-11-CRF was completed for all cases. This stage aimed to ensure clinical evaluation of participants who had not been assessed at the previous stage, thereby strengthening the overall dataset and supporting the robustness of the study's findings.

**Data Analysis**

All analyses were conducted using RStudio software, version 4.4.2 (R Core Team, 2025). Descriptive statistics were conducted to examine the characteristics of the sample. To investigate Hypothesis 1 (structural validity), we first assessed the suitability of the data for factor analysis using the Kaiser-Meyer-Olkin (KMO) measure and Bartlett's test of sphericity to ensure sufficient inter-item correlations for latent factor extraction (Kaiser, 1974). Multiple criteria were used to determine the number of factors to retain, including minimum average

partial test (MAP), parallel analysis (PA), the empirical Kaiser criterion (EKC), and the traditional eigenvalue-greater-than-one rule (e>1), following current best practices for dimensionality assessment (e.g., O'Connor, 2000). Exploratory Structural Equation Modeling (ESEM), with weighted least squares mean and variance adjusted (WLSMV) estimator, was then employed to investigate the underlying factor structure (Asparouhov & Muthén, 2009; Marsh et al., 2014). Model fit was evaluated using widely accepted indices including the Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA), and Standardized Root Mean Square Residual (SRMR), with conventional thresholds guiding interpretation (e.g., CFI and TLI ≥ .95, RMSEA ≤ .06, SRMR ≤ .08). Analyses of factor dimensionality were performed using EFA.dimensions package (Lorenzo-Seva & Ferrando, 2019), and structural modeling was conducted with the lavaan package (Rosseel, 2012) in R.. For Hypothesis 2 (internal consistency), we assessed the reliability of the PDS-ICD-11-CRF using McDonald's ω and Cronbach's α coefficients, two widely used indices of internal consistency that estimate how consistently the items of a scale measure a common construct (Cronbach, 1951; McDonald, 1999). Values of both coefficients ≥ .70 were considered indicative of acceptable internal consistency. Analyses were performed using psych package in R (Revelle, 2023).

Interrater reliability (Hypothesis 3) for the PDS-ICD-11-CRF was quantified using the ICC, a variance-based index of agreement appropriate for continuous ratings from multiple observers (Koo & Li, 2016; Shrout & Fleiss, 1979). Given that each case was scored by the same specific pair of raters and the objective was absolute agreement rather than generalization to a larger population of raters, a two-way mixed-effects model with single measures and absolute agreement (ICC [3,1]) was used (Koo & Li, 2016). For the 10 bipolar items, ICCs were computed twice: first using the original 5-point response scale including both poles of the spectrum, and second using a severity recoding in which extreme opposite scores (e.g., –2 and

+2) were coded equivalently on a 0–2 severity scale to reflect magnitude regardless of polarity. ICC values were interpreted according to established thresholds where values < .50 indicate poor reliability, .50–.75 moderate reliability, .75–.90 good reliability, and > .90 excellent reliability (Koo & Li, 2016). Analysis was performed using the irr package (Gamer et al., 2019). For Hypothesis 4 (item parameters), we used Item Response Theory (IRT) to examine the psychometric properties of the PDS-ICD-11-CRF items through Samejima's graded response model (GRM), a widely used IRT model for ordered categorical response data that estimates item discrimination (slope) and threshold (location) parameters reflecting how well items differentiate respondents and where response probabilities transition across the latent trait continuum (Samejima, 1969). In addition to parameter estimates, we examined item and test information curves to identify regions of the latent trait where individual items and the overall instrument provide the greatest measurement precision, ensuring that the scale reliably captures variation in the latent construct across its continuum. These analyses were performed using the mirt package in R (Chalmers, 2012). Finally, for Hypothesis 5 (convergent validity), we performed Pearson correlation analyses to assess the association between the clinician-rated and self-report versions of the PDS-ICD-11 and all other measures used in this research (PID5BF+M, BPS, and E-TRAP) using the psych package in R (Revelle, 2023).

## Results

### Hypothesis 1: Structural Validity

Preliminary checks indicated that the data were suitable for factor analysis: KMO = .92, and Bartlett's test of sphericity was significant ($\chi^2(91) = 1046.13$, $p < .001$). Multiple criteria agreed on a single latent factor solution, including MAP, PA, EKC, Hull, and e>1, all suggesting one factor should be retained. An ESEM solution with one factor showed good model fit: $\chi^2(77) = 120.86$, $p = .001$; CFI = .983; TLI = .980; RMSEA = .054 (90% CI = .034–

.072); and SRMR = .059, supporting a one-factor solution. These results are consistent with prior research demonstrating the unidimensional structure of the PDS-ICD-11 measure (Bach et al., 2021; Sellbom et al., 2024). Further details about the factor loadings can be found in Table 2.

**Table 2**

*Exploratory Structural Equation Modeling (n = 197)*

| Items | Factor loading | Variances |
|---|---|---|
| 1. Identity | .63 | .61 |
| 2. Self-worth | .76 | .43 |
| 3. Self-perception | .79 | .38 |
| 4. Goals | .61 | .63 |
| 5. Interest in relationships | .74 | .45 |
| 6. Perspective-taking | .65 | .58 |
| 7. Mutually in relationships | .75 | .45 |
| 8. Disagreement management | .75 | .44 |
| 9. Emotional control and expression. | .77 | .40 |
| 10. Behavioral control | .71 | .49 |
| 11. Experience of reality during stress | .67 | .55 |
| 12. Harm to self | .63 | .60 |
| 13. Harm to others | .61 | .63 |
| 14. Psychosocial impairment | .89 | .20 |
| Cronbach's alfa | .90 | |
| McDonald's ômega | .91 | |

**Hypothesis 2: Internal Consistency**

The scale demonstrated high internal consistency reliability, (see bottom part of Table 2), which is in line with findings reported for the original PDS-ICD-11-CRF and supports the robustness of the instrument's measurement properties (Sellbom et al., 2024). High internal consistency indicates that the items coherently reflect the same underlying construct and provides confidence that the total scores reliably represent severity of personality dysfunction, which is essential for both research applications and clinical interpretation.

**Hypothesis 3: Interrater Reliability**

We found good interrater reliability for the total score of the PDS-ICD-11-CRF (ICC = .86, 95% CI [.71, .93]), indicating strong absolute agreement between the raters (Koo & Li, 2016). Most individual items demonstrated moderate reliability, which is generally considered acceptable within complex clinical assessments (Faherty et al., 2020), although, a few items showed lower levels of agreement, particularly Emotional Control and Expression (Item 9), Mutuality in Relationships (Item 7), and Harm to Others (Item 13). A detailed overview of item-level ICC estimates is presented in Table 3. The results partially confirmed Hypothesis 3, in which a minimum value of .60 was expected for the total score and for the individual items.

**Table 3**

*Intraclass Correlation Coefficients for Interrater Reliability (n = 26)*

| Variables | ICC | 95% CI | | ICC | 95% CI | |
|---|---|---|---|---|---|---|
| | | Low. | Upp. | | Low. | Upp. |
| PDS-ICD-11 CRF Total Score | .86*** | .71 | .93 | | | |
| | 5-point scale | | | 3-point scale | | |
| 1. Identity | .75*** | .52 | .88 | .68*** | .39 | .84 |
| 2. Self-worth | .57** | .24 | .78 | .57** | .24 | .78 |
| 3. Self-perception | .54** | .19 | .76 | .41* | .02 | .69 |
| 4. Goals | .42* | .06 | .69 | .40* | .01 | .68 |
| 5. Interest in relationships | .71*** | .45 | .86 | .63*** | .32 | .81 |
| 6. Perspective-taking | .49** | .14 | .73 | .57** | .24 | .78 |
| 7. Mutually in relationships | .36* | .01 | .64 | .36* | .00 | .65 |
| 8. Disagreement management | .59** | .26 | .79 | .42* | .03 | .69 |
| 9. Emotional control and expression. | .29 | -.11 | .61 | .55** | .22 | .77 |
| 10. Behavioral control | .42* | .05 | .69 | .36* | -.03 | .65 |
| | 4-point scale | | | | | |
| 11. Experience of reality during stress | .64*** | .35 | .82 | | | |
| 12. Harm to self | .53** | .19 | .76 | | | |
| 13. Harm to others | .15 | -.23 | .50 | | | |
| 14. Psychosocial impairment | .67*** | .39 | .83 | | | |

*Note.* * $p < .05$; ** $p < .01$; *** $p < .001$; ICC = Intraclass Correlation Coeficient; 95% CI = 95% Confidence Interval; Low. = Lower Boundary; Upp. = Upper Boundary.

**Hypothesis 4: Item Parameters**

The IRT analysis revealed an adequate model fit: $\chi 2 = 88.49$, $df = 59$, $p = .008$, RMSEA = .050, SRMSR = .051, TLI = .980, and CFI = .983 (Meade et al., 2008). Table 4 presents the item discrimination and difficulty parameters. All items showed acceptable discrimination, with Psychosocial Impairment (Item 14), Emotional Control and Expression (Item 9), and Disagreement Management (Item 8) demonstrating the highest values, indicating that these items most effectively differentiate individuals across levels of personality disorder severity. The Harm to Others item (Item 13) showed the lowest, yet still adequate, discrimination parameter. Difficulty (threshold) parameters ranged from below- to above-average levels, with the Harm to Others item (Item 13) being the most difficulty to endorse, such that high scores on this item were observed primarily among individuals with severe personality dysfunction, consistent with the findings of Sellbom et al. (2024).

**Table 3**

*Item Discrimination and Item Difficulty Parameters (n = 197)*

| Items | A | b1 | b2 | b3 |
|---|---|---|---|---|
| 1. Identity | 1.363 | 0.200 | 2.223 | - |
| 2. Self-worth | 1.875 | -0.707 | 1.247 | - |
| 3. Self-perception | 1.989 | 0.192 | 2.179 | - |
| 4. Goals | 1.341 | -0.481 | 2.312 | - |
| 5. Interest in relationships | 1.961 | -0.419 | 1.603 | - |
| 6. Perspective-taking | 1.484 | -0.319 | 2.147 | - |
| 7. Mutually in relationships | 1.952 | -0.457 | 1.832 | - |
| 8. Disagreement management | 2.010 | -0.335 | 1.849 | - |
| 9. Emotional control and expression | 2.178 | -0.853 | 1.100 | - |
| 10. Behavioral control | 1.791 | -0.604 | 1.559 | - |
| 11. Experience of reality during stress | 1.638 | -0.800 | 1.279 | 2.365 |
| 12. Harm to self | 1.464 | -0.038 | 1.273 | 2.813 |
| 13. Harm to others | 1.301 | 1.340 | 2.817 | 4.093 |
| 14. Psychosocial impairment | 3.688 | -0.366 | 0.618 | 1.762 |

Figure 1 illustrates the test information function and corresponding standard error of measurement, indicating that the instrument provides reliable estimates for θ values ranging

approximately from −2 to +4. This interval encompasses low to very high levels of personality disorder severity, with optimal measurement precision observed for individuals exhibiting moderate to high severity.

**Figure 1**

*Test Information Curve for the PDS-ICD-11-CRF*

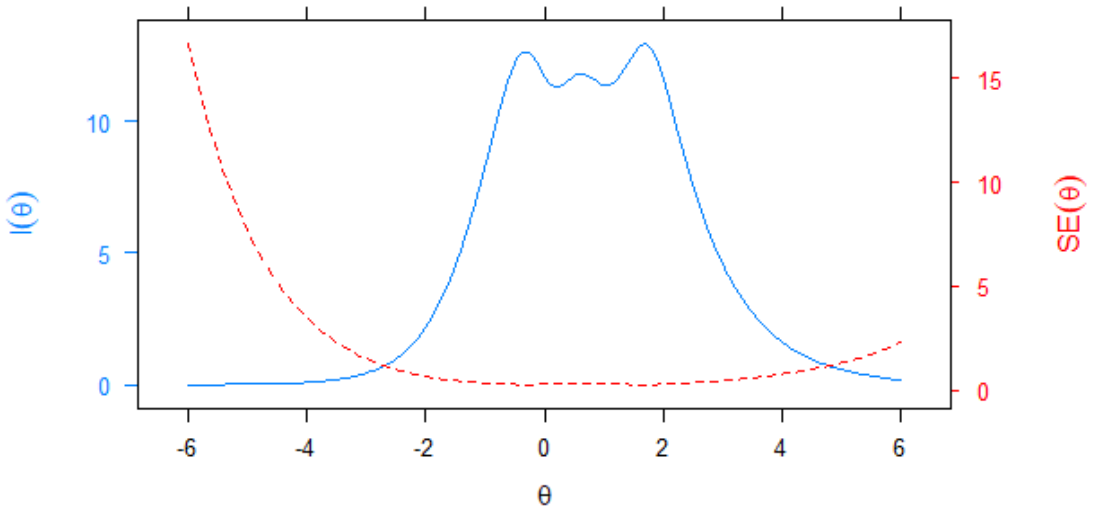



Figure 2 depicts the relationship between the latent trait (θ) and the expected total score (T(θ)). The curve follows the typical sigmoidal pattern, indicating that the instrument effectively differentiates individuals across a broad range of severity levels. The steepest portion of the curve, between approximately θ = −2 and θ = +4, reflects the range of greatest measurement sensitivity, where the instrument provides the most precise estimates of personality dysfunction severity. At the upper end of the continuum (θ > 4), the curve approaches a plateau, suggesting that individuals with very high severity levels tend to achieve consistently high scores.

**Figure 2**

*Expected Total Score Curve for the PDS-ICD-11-CRF*

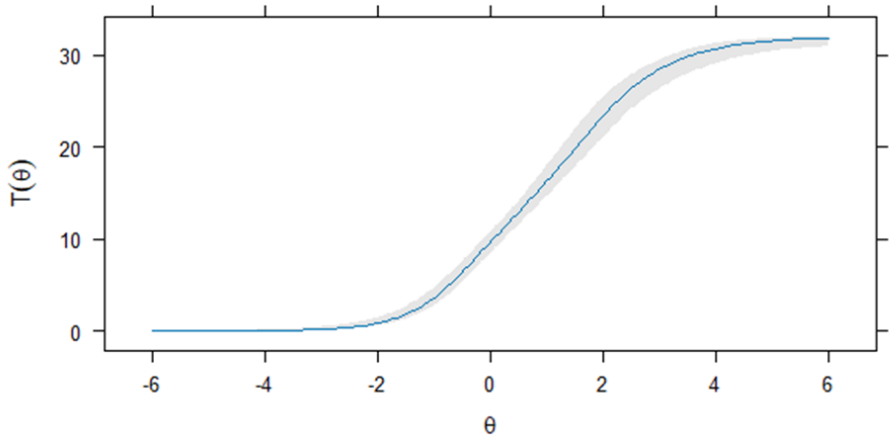
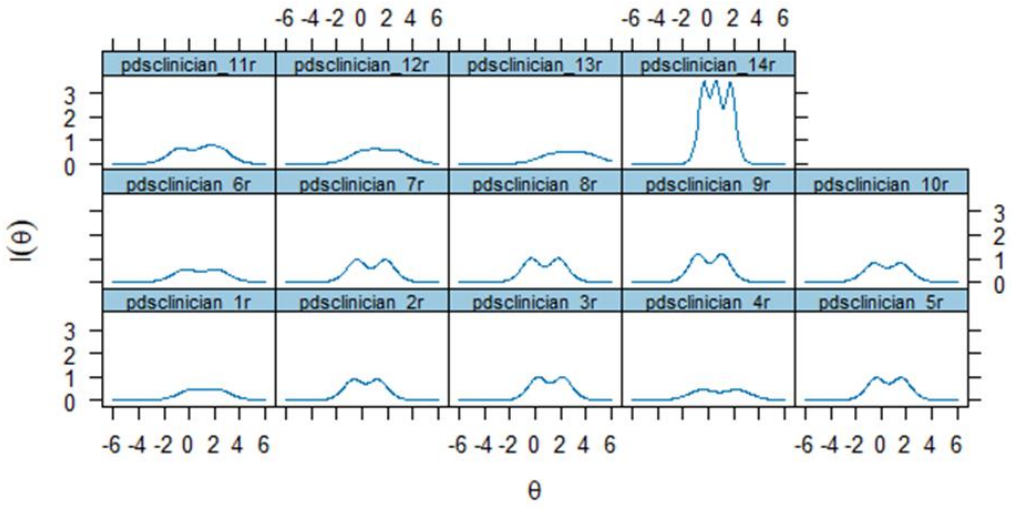



Figure 3 presents item information functions across levels of the latent trait (θ). The Psychosocial Impairment item (Item 14) exhibited the highest amount of information, suggesting strong discriminative power at moderate to high severity levels. Conversely, Harm to Others (Item 13) provided greater information at the higher end of the continuum, indicating that this item is particularly sensitive to severe personality dysfunction.

**Figure 3**

*Item Information Curves for the PDS-ICD-11-CRF*



Overall, the pattern of item parameters suggests that the instrument is psychometrically well-designed to assess a wide range of personality dysfunction severity. These results support Hypothesis 4, as items vary systematically in their discrimination and difficulty, collectively ensuring that the scale captures meaningful differences from low to very high trait levels. The diversity of item characteristics observed enhances the overall precision of the scale, supporting its utility for nuanced clinical assessment rather than merely screening at a single severity level.

### Hypothesis 5: Convergent Validity

Evidence of convergent validity was first examined by correlating the PDS-ICD-11-CRF with its self-report counterpart, the PDS-ICD-11, revealing a significant moderate association ($r$ = .61), which indicates convergence between clinician-rated and self-reported assessments (see Figure 4). Convergent validity was additionally supported by a meaningful association between the PDS-ICD-11-CRF scores and the personality functioning score of the E-TRAP (Criterion A) (see Table 5).

**Figure 4**

*Correlation Between the PDS-ICD-11-CRF and PDS-ICD-11*

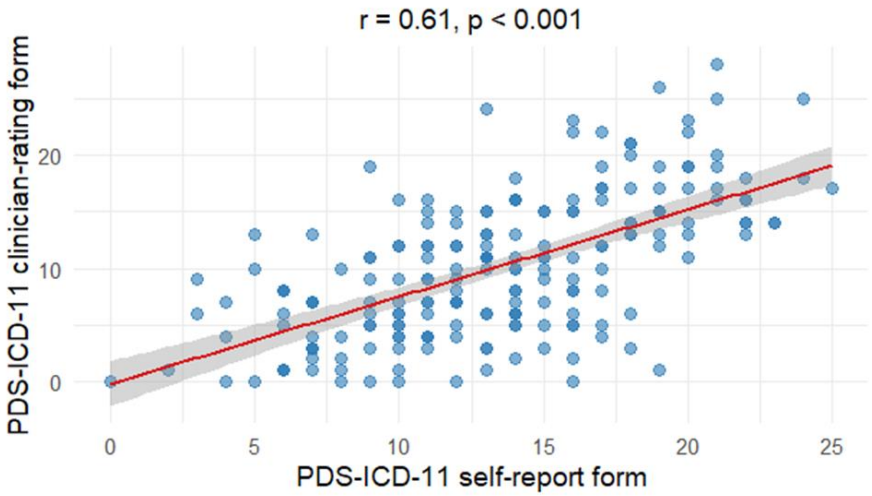


Table 5 presents the correlation coefficients between both the PDS-ICD-11-CRF and the PDS-ICD-11 with all other measures used in this study. The PDS-ICD-11-CRF showed statistically significant correlations with all external criterion measures, with one exception: the Anankastia dimension as measured by the PID5BF+M did not correlate significantly with the clinician-rated scores. A method bias effect was also observed, such that measures sharing the same method of assessment (i.e., clinician-rated instruments) tended to correlate more strongly with each other. Overall, these findings provided substantial support for the majority of Hypothesis 5.

**Table 4**

*Convergent Validity of the PDS-ICD-11-CRF with the Trait Domains of the PID5BF+M, the Borderline Pattern Scale, and the E-TRAP*

| Variable | ω | PDS-ICD-11-CRF | PDS-ICD-11 |
|---|---|---|---|
| PID5BF+M | | | |
| - Negative Affectivity | .86 | .45*** | .56*** |
| - Detachment | .86 | .26*** | .31*** |
| - Disinhibition | .87 | .42*** | .55*** |
| - Antagonism | .82 | .32*** | .45*** |
| - Anankastia | .90 | .06 | .13 |
| - Psychoticism | .84 | .25*** | .42*** |
| BPS | | | |
| - Borderline Pattern Scale | .90 | .64*** | .78*** |
| E-TRAP | | | |
| - Personality Functioning | .81 | .80*** | .59*** |
| - Negative Affectivity | .83 | .72*** | .58*** |
| - Detachment | .77 | .67*** | .59*** |
| - Antagonism | .82 | .49*** | .32*** |
| - Disinhibition | .68 | .47*** | .38*** |
| - Psychoticism | .58 | .35*** | .29*** |

*Note*. * $p < .05$; ** $p < .01$; *** $p < .001$.

## Discussion

The main objective of this study was to examine evidence of validity related to internal structure and convergent validity of the Brazilian version of the PDS-ICD-11-CRF, in addition to assessing the scale's reliability via internal consistency and interrater reliability. Overall, the

five hypotheses tested to gather evidence of validity and reliability for the PDS-ICD-11-CRF were largely supported. Consistent with Hypothesis 1, the scale demonstrated a unidimensional construct structure, indicating that the items collectively reflect a single underlying dimension of personality dysfunction. In line with Hypothesis 2, the instrument showed strong internal consistency, suggesting that its items function coherently as a set. Hypothesis 3 was also supported, as the scale exhibited reliable agreement between different evaluators, indicating that severity estimates are robust across raters. Regarding Hypothesis 4, the item parameters from the Samejima model revealed that all items effectively discriminate across levels of severity and that their difficulty thresholds span a broad range of the latent trait, ensuring accurate measurement along the continuum. Lastly, consistent with Hypothesis 5, the pattern of associations between PDS-ICD-11-CRF scores and external criterion measures was theoretically coherent across different assessment methods, further accumulating evidence that the constructs assessed by the instrument adequately capture the severity of personality pathology. The findings provide strong support for the instrument's utility in assessing the severity of personality disorders in Brazil, as further discussed in the following sections.

**Unidimensionality of the Construct (Hypothesis 1)**

Cultural factors may influence the ways in which personality pathology symptoms are expressed, assessed, and diagnosed across populations, ranging from the impact of gender- and race-related norms to broader critiques concerning the boundaries between what is considered normal and pathological (Alarcón, 2009; Munson et al., 2022). In addition, cross-cultural comparisons pose substantial challenges due to issues related to scale translation, culturally patterned response biases, and differing levels of familiarity with assessment instruments across cultural contexts (Terracciano & McCrae, 2006). Despite these challenges, the structural organization of the construct was not affected in our study.

Consistent with findings from the original validation (Sellbom et al., 2024), the Brazilian version of the PDS-ICD-11-CRF demonstrated a clear and robust unidimensional structure. This convergence across cultural contexts supports the ICD-11 conceptualization of personality pathology severity as a single overarching dimension that integrates self- and interpersonal dysfunction. Beyond impairments in these domains, the severity dimension also encompasses emotional, cognitive, and behavioral manifestations, as observed in our study and in accordance with the guidelines established by the WHO (WHO, 2020). Collectively, these findings suggest that the latent architecture of personality impairment is structurally stable, even in the presence of culturally shaped variations in symptom expression and diagnostic assessment.

**PDS-ICD-11-CRF as a Reliable Tool to Assess Personality Disorder Severity (Hypotheses 2 and 3)**

The PDS-ICD-11-CRF demonstrated compelling evidence of reliability in terms of both internal consistency and interrater agreement, consistent with Hypotheses 2 and 3, respectively. Strong internal consistency indicates that the items of the PDS-ICD-11-CRF operate coherently as a unified set, capturing a common underlying construct and minimizing measurement error. This pattern suggests that the total score reflects a stable latent trait rather than random variance, thereby enhancing the interpretability and trustworthiness of severity estimates at both group and individual levels (McCrae et al., 2011). Notably, this finding aligns closely with evidence reported by Sellbom et al. (2024), further supporting the scale's internal reliability. In addition, the robust agreement observed between different raters reinforces that personality disorder severity estimates are not dependent on a specific evaluator, but rather represent reproducible clinical judgments. High interrater reliability is essential for instruments designed for clinical contexts where multiple clinicians may independently assess the same individual, as it ensures

that observed score differences reflect true variability in the construct rather than rater inconsistency (Maffei et al., 1997). Although our interrater reliability coefficients were slightly lower than those reported by Sellbom et al. (2024), they still demonstrate that the PDS-ICD-11-CRF can reliably assess personality disorder severity across different evaluators.

It is important to acknowledge that a few specific items yielded lower interrater agreement, particularly Harm to Others (Item 13) and Emotional Control and Expression (Item 9). Despite systematic training of undergraduate psychology student raters, consensus on these items proved challenging, suggesting that these constructs may be especially abstract or complex or that the current scoring guidelines require further refinement. When codified scores (0–2 points), which emphasize impairment severity regardless of directional polarity (−2 to +2), were used, agreement for Emotional Control and Expression improved, indicating that raters were consistent in identifying the presence of impairment but differed in interpreting its qualitative direction (e.g., undercontrol vs. overcontrol). Furthermore, our findings demonstrate that the PDS-ICD-11-CRF yields dependable and consistent severity estimates across both items and evaluators, reinforcing its suitability for both clinical and research applications.

**Item Parameters and Measurement Precision in the PDS-ICD-11-CRF (Hypothesis 4)**

The pattern of item discrimination and difficulty parameters observed in the PDS-ICD-11-CRF provides robust support for Hypothesis 4, suggesting that the instrument is psychometrically well-designed to assess a wide range of personality dysfunction severity. In the context of IRT, the first threshold ($b_1$) parameters for the bipolar items recoded on a 0–2 scale ranged from below zero (e.g., Emotional Control and Expression) to slightly positive values (e.g., Identity). Values below zero indicate that even individuals with relatively low levels of personality dysfunction are likely to begin endorsing some degree of impairment on these constructs, which enhances sensitivity in the lower range of the latent severity continuum

(Embretson & Reise, 2013). Conversely, the second threshold ($b_2$) parameters for these bipolar scales were elevated, indicating that only individuals with moderate to high personality disorder severity receive higher category scores, consistent with clinical expectations that more substantial dysfunction is required before severe item responses are observed.

When considered the unipolar items (0–3), the difficulty parameters further highlight the range of severity captured by the instrument. For example, $b_1$ values for these unipolar thresholds ranged from markedly negative (e.g., Experience of Reality During Stress) to positive values exceeding 1.0 (e.g., Harm to Others), whereas the highest thresholds ($b_3$) were observed for items such as Harm to Self and Harm to Others. These high thresholds suggest that only individuals with very elevated personality dysfunction severity were rated at the most extreme response categories, pointing to these behaviors as markers of severe pathology within the continuum. Overall, these distributions of threshold parameters indicate that the PDS-ICD-11-CRF captures gradations of severity from mild to extreme levels of dysfunction, which is essential for instruments intended for both clinical characterization and differential diagnosis.

Item discrimination parameters also contributed meaningfully to the overall measurement precision of the scale. The most discriminative item was Psychosocial Impairment (Item 14), indicating that this item had the greatest capacity to distinguish between individuals with similar levels of the latent trait. High discrimination values enhance measurement precision, particularly in regions of the latent continuum where small differences in severity need to be differentiated. Notably, this pattern mirrors findings reported for the original PDS-ICD-11 in its development study, where global impairment was also among the most informative indicators of personality dysfunction severity (Bach et al., 2021). This convergent evidence suggests that global functional impairment, rather than any single domain-specific behavior, may serve as a key marker for distinguishing levels of personality disorder severity. From a clinical measurement perspective, items indexing broad psychosocial

impairment evidently function as strong anchors for a severity continuum, providing rich information that enhances the scale's utility in both research and applied contexts.

**Bridiging Personality Disorder Severity and Pathological Personality Traits in a Multi-method Approach (Hypothesis 5)**

As the ICD-11 framework conceptualizes personality pathology in terms of severity of personality disorder, maladaptive personality traits, and a borderline pattern qualifier (Bach & First, 2018; WHO, 2020), our findings align with these theoretical expectations and empirical research supporting dimensional models of personality disorders. Specifically, the PDS-ICD-11-CRF demonstrated significant correlations with measures of personality functioning impairment, including its self-report counterpart (the PDS-ICD-11) and Criterion A of the AMPD (E-TRAP), indicating convergence between clinician-rated and self-reported assessments and supporting the nottion that personality disorder severity and personality functioning impairment represent overlapping features of personality pathology (e.g., Hualparuca-Olivera et al., 2023; Zimmermann et al., 2020).

We also found that personality dysfunction was assossiated with a range of pathological personality traits, including Negative Affectivity, Detachment, Antagonism/Dissociality, Disinhibition, Psychoticism, and Borderline pattern qualifier, reflecting that higher severity of personality disorder co-occurs with elevated emotional disturbances and interpersonal problems. Convergence between PDS-ICD-11-CRF and Negative Affectivity (E-TRAP), Detachment (E-TRAP) and Borderline pattern (BPS) suggests that these constructs, while distinct, share meaningful variance with global personality disorder severity, consistent with models proposing that severe personality impairment often entails heightened maladaptive traits. The strong relationship between personality disorder severity and Borderline pattern is well documented, as features such as instability in self and interpersonal functioning are central

to borderline presentations across dimensional frameworks (Clark et al., 2018; Oltmanns & Widiger, 2019; Tyrer et al., 2019).

The absence of a significant correlation with Anankastia is consistent with prior findings showing that anankastic features tend to exhibit weaker associations with global personality disorder severity than other trait domains (Oltmanns & Widiger, 2019), possibly because traits like perfectionism and rigidty may not always translate into broader psychosocial impairmtent (Hualparuca-Olivera et al., 2023). Studies suggest that perfectionistic qualities may even be socially or professionally reinforced in academic and occupational settings, thereby reducing their direct association with functional impairment (Limburg et al., 2016). Thus, the weaker correlation observed in our study likely reflects the relative distinctiveness of anankastic traits from broader personality dysfunction severity in clinician ratings.

**Implications for Theory and Practice**

Accurate assessment of personality dysfunction severity is central to contemporary dimensional models such as the ICD-11 and the AMPD classification (APA, 2022; WHO, 2020), and our findings support the PDS-ICD-11-CRF as a robust clinical tool. Our results underscore the value of clinician-rated instruments within comprehensive psychological assessment frameworks, in which the integration of multiple data-gathering methods supports more accurate and informed clinical decision-making (Oliveira & Silva, 2019). Clinician- or informant-based assessments have been shown to be more sensitive to interpersonal difficulties (Bach et al., 2020) and externalizing features (Bradley et al., 2007), and the strong psychometric performance of the PDS-ICD-11-CRF reinforces the utility of clinician judgment in capturing complex aspects of personality disorder severity.

Moreover, significant but modest correlations were observed between self-report and clinician-rated measures, indicating that results derived from different assessment modalities

do not necessarily fully converge (Cataldo et al., 2024; Bach et al., 2020; Bornstein & Hopwood, 2014), a pattern consistent with prior evidence showing systematic discrepancies between informant sources (Cruitt & Oltmanns, 2017; Samuel et al., 2018). Such discrepancies may be partly attributable to social desirability (Hauck-Filho et al., 2025), differences in subjective experience of personality features, such as egosyntonic versus egodystonic patterns (Hart et al., 2018), and information processing biases (Wrzus, 2021). Prior work also suggests that self-report instruments may overestimate impairment relative to clinician ratings (Bach et al., 2020; Samuel et al., 2018).

Overall, these considerations highlight the importance of integrating self-report instruments and clinician- or informant-rated assessments in multimethod studies to capture both internal subjective experience and observable dysfunction, thereby reducing bias, enhancing construct validity, and strengthening the precision and clinical utility of personality assessments (Bach et al., 2020; Bradley et al., 2007; Bornstein & Hopwood, 2014). Ultimately, the results support the applicability of the Brazilian version of the PDS-ICD-11-CRF as a valid and reliable indicator of overall personality pathology severity.

**Limitations and Future Directions**

The results of this study are promising, despite several limitations that should be acknowledged. First, the sample size was relatively small and obtained through convenience sampling, which limits the generalizability of the findings. In the Brazilian research context, recruitment challenges are often related to the requirement for participant voluntariness in compliance with national human subjects research regulations overseen by institutional ethics committees. To facilitate recruitment, we offered a complementary course designed to train psychology professionals in the assessment and diagnosis of personality disorders. Although this strategy aimed to support volunteer participation and professional training, enrollment and

completion rates were limited, resulting in a smaller than anticipated sample. Moreover, because sampling was non-probabilistic, future studies should aim to recruit larger and more representative samples.

We recognize that the training provided may not have been as comprehensive as more extensive programs typically employed in clinical research. Due to practical constraints, including lack of funding, the training consisted of 10 hours of instruction on diagnostic models (categorical, hybrid, and dimensional) and on the administration of the E-TRAP and the PDS-ICD-11-CRF, delivered synchronously online to increase accessibility. Although optional supervision sessions were offered to clarify administration and scoring procedures, the limited duration and format of the training may have introduced variability in scoring that contributed to measurement error. Despite these limitations, results remained theoretically consistent, suggesting that random errors were not of sufficient magnitude to compromise interpretation. Future research should examine the impact of more comprehensive training on PDS-ICD-11-CRF scores.

Regarding interrater reliability, some disagreement between raters may have resulted from undergraduate psychology students completing PDS-ICD-11-CRF ratings based on a single interview per participant, which may have limited their ability to capture complex interpersonal and personality features. It is expected that clinicians with greater longitudinal information about an individual would generate more accurate PDS-ICD-11-CRF ratings. We used the E-TRAP to standardize the collection of personality data and to reduce the impact of limited participant information. Despite the limited prior information available about participants, the results indicated substantial informant agreement, both when two graduate psychology students independently evaluated the same individual and when clinicians' ratings aligned with those of their respective clients. Future studies should evaluate how the amount and depth of information available about the individual influence clinician-rated severity

scores. Additional research could also explore structured clinical interviews or extended assessment protocols to enhance diagnostic reliability and clarify how information quality impacts severity ratings.

## Conclusion

Brazil is one of the signatory countries to the World Health Organization and, as such, is expected to align with the diagnostic guidelines of the ICD-11. The present study makes an important contribution in this context by providing psychometric data on the PDS-ICD-11-CRF based on a clinical sample of Brazilian participants. This study provides comprehensive psychometric evidence for an instrument that was cross-culturally adapted for use in Brazil, enabling clinicians to reliably assess personality functioning within the Brazilian clinical context. The findings of this study support the adequacy of the PDS-ICD-11-CRF for use in Brazil. The validity and reliability evidence presented here indicate that the instrument can produce dependable results and may be useful both for diagnostic assessment and for monitoring intervention outcomes. Moreover, these findings contribute to the growing international literature supporting the validity of the dimensional model of personality disorders as described in the ICD-11.

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# Manuscript 2: Identifying Patient Profiles on the Personality Disorder Severity ICD-11 (PDS-ICD-11) Clinician-Rating Form: A Latent Profile Analysis Approach


## Abstract

Contemporary models of psychopathology increasingly support a dimensional rather than categorical conceptualization of personality disorders, a perspective formally adopted in the 11th edition of the International Classification of Disease (ICD-11) through its emphasis on severity of personality dysfunction. Within this framework, the present study aimed to identify latent profiles based on the PDS-ICD-11-CRF scores and to examine how these profiles differ in overall personality disorder severity, maladaptive personality traits, and the borderline pattern specifier. Self- and clinician-report measures were used. Results supported a four-profile solution: one profile reflecting adaptive personality functioning, one moderately impaired profile, and two severely impaired profiles differing in self- and interpersonal dysfunction, maladaptive traits, and borderline features. Overall, the findings support the conceptualization of personality pathology as a continuum of severity with heterogeneous expressions of impairment and underscore the clinical utility of clinician-rated, severity-based, person-centered approaches for assessment and treatment planning within the ICD-11 framework.


*Keywords:* Personality, Severity, Dimensional Models, Clinical Assessment, Latent Profiles.

## Introduction

It is now well established that psychopathology is best conceptualized dimensionally rather than categorically (Caspi et al., 2024; Hopwood et al., 2023; Kotov et al., 2021; Krueger et al., 2021; Watson et al., 2022). Despite this broad consensus, the formal adoption of a dimensional framework as the primary basis for diagnosis occurred only with the 11th edition of the International Classification of Diseases (ICD-11; World Health Organization [WHO], 2020) for personality disorders classification. This adoption was driven by well-documented limitations of categorical diagnostic systems, including substantial heterogeneity within diagnostic categories, high rates of comorbidity, limited empirical support for discrete disorders, and reduced clinical utility for case formulation and treatment planning (Bach & First, 2018). Thus, the ICD-11 diagnostic framework for personality pathology is now organized around a global indicator of personality disorder severity, evaluated in terms of self- and interpersonal impairments. This severity rating is complemented by five maladaptive personality trait qualifiers (Negative Affectivity, Detachment, Dissociality, Disinhibition, and Anankastia) as well as a borderline pattern specifier, which together provide a nuanced description of the stylistic expression of personality pathology (Bach & First, 2018; WHO, 2020).

With the widespread adoption of the ICD-11 across multiple countries, substantial efforts have been undertaken to develop assessment instruments aligned with its dimensional framework. In this context, the Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF; Sellbom et al., 2024) was developed as a brief clinician-rated measure of personality disorder severity. The instrument assesses impairments in self- and interpersonal functioning, as well as maladaptive patterns of cognition, emotional experience and expression, and behavior, in accordance with the ICD-11 diagnostic guidelines. The original version of the PDS-ICD-11-CRF demonstrated robust psychometric properties, including a well-supported

internal structure, high interrater reliability, and strong criterion-related validity (Sellbom et al., 2024).

From a clinical perspective, the PDS-ICD-11-CRF operationalizes personality pathology as a continuum of personality disorder severity, emphasizing its impact on overall functioning rather than the presence or absence of discrete diagnostic categories. Considering this dimensional framework, most empirical research has relied on variable-centered approaches, which are effective for testing personality taxonomies and examining predictors and outcomes of traits. While informative, these approaches implicitly assume that the same relationships among variables apply uniformly across individuals, thereby obscuring meaningful heterogeneity in how personality dysfunction is expressed. Person-centered methods, such as latent profile analysis (LPA), offer an alternative perspective by focusing on patterns of co-occurring impairments within individuals rather than associations between variables. Through the identification of latent profiles, LPA captures subgroups of individuals who share distinct configurations of impairment that may differ not only in overall personality disorder severity but also in the organization of personality dysfunction (Mathew & Doorenbos, 2023; De la Rosa-Cáceres et al., 2023; Yin et al., 2021). Recent studies have applied LPA to personality assessment across multiple dimensional frameworks, including the Five Factor Model (So et al., 2023; Yin et al., 2021), personality functioning in adolescents (Thomson et al., 2024), maladaptive personality traits (De la Rosa-Cáceres et al., 2023), and borderline features (Babinski et al., 2020; Gamache et al., 2021a). Importantly, latent profiles should not be interpreted as categorical diagnoses. In contrast to categorical models, based on expert consensus and dichotomous symptom thresholds (Hopwood et al., 2023; Kotov et al., 2021), person-centered quantitative approaches aim to identify empirically derived patterns of functioning in heterogeneous samples (Mathew & Doorenbos, 2023; Yin et al., 2021), and can guide individualized intervention strategies, improving clinical outcomes (De la Rosa-Cáceres

et al., 2023). Grounded in this perspective, the present study aims to identify latent profiles reflecting different configurations of personality impairment expression in the PDS-ICD-11-CRF and to examine how these profiles relate to overall personality disorder severity, maladaptive personality traits, and the borderline pattern specifier. Generally, the PDS-ICD-11-CRF total score is obtained by converting the 10 bipolar item responses into severity scores (0–2) and summing them with the four unipolar items in their original scoring (0–3). However, this recoding of bipolar items inherently reduces information about an individual's specific pattern of impairment. For instance, a severity score of 2 on the Identity item indicates significant dysfunction in that domain, but it does not distinguish whether the problem reflects identity diffusion versus identity restriction; two qualitatively distinct presentations. The present study instead aims to explore latent profiles of personality dysfunction severity using all 14 items in their original bipolar form, thereby preserving information from both poles of each bipolar spectrum and allowing for the identification of clinically meaningful response patterns across the measure.

## Method

### Participants

A total of 75 licensed psychologists, 25 undergraduate psychology students from the University of Brasília, Brazil, and the project's lead researcher administered research protocols to 197 individuals. Most of the psychologists worked primarily in psychotherapy (53.3%) and had a specialization degree as their highest level of education (66.7%). They were from 12 different states of Brazil, with the majority residing in the Federal District (41.3%). The total clinical sample comprised 197 individuals, including 132 patients of the participating psychologists and 65 research volunteers who were assessed by the lead researcher and the undergraduated psychology students. The sample size is consistent with the original study of

the PDS-ICD-11-CRF (Sellbom et al., 2024). Participants' ages ranged from 18 to 73 years old (M = 31.1, SD = 10.4). The majority of the participants were women (70.1%) and 59.4% of participants self-reported their ethnicity as white. Details of participants' characteristics are provided in Table 1.

**Table 1**

*Characterization of the Sample*

| | | |
|---|---|---|
| Age (*M, SD*) | 31.1 | 10.4 |
| Gender (*f, %*) | | |
| - Men | 48 | 24.4 |
| - Women | 138 | 70.1 |
| - Transgender Women | 1 | 0.5 |
| - Transgender Men | 1 | 0.5 |
| - Queer, non-binary, or gender-fluid | 9 | 4.6 |
| Race (*f, %*) | | |
| - White | 117 | 59.4 |
| - Black | 17 | 8.6 |
| - Mixed-race | 58 | 29.4 |
| - Indigenous | 1 | 0.5 |
| - Other | 1 | 0.5 |
| - Not reported | 3 | 1.5 |
| Education (*f, %*) | | |
| - Incomplete Elementary School | 1 | 0.5 |
| - Completed Elementary School | 11 | 5.6 |
| - Incomplete High School | 33 | 16.8 |
| - Completed High School | 29 | 14.7 |
| - Completed Undergraduate Degree | 33 | 16.8 |
| - Incomplete Undergraduate Degree | 40 | 20.3 |
| - Incomplete Postgraduate Degree | 7 | 3.6 |
| - Completed Postgraduate Degree | 43 | 21.8 |
| Marital status (*f, %*) | | |
| - Single | 134 | 68.0 |
| - Domestic Partnership | 16 | 8.1 |
| - Married | 36 | 18.3 |
| - Divorced | 8 | 4.1 |
| - Widowed | 1 | 0.5 |
| - Other | 2 | 1.0 |
| Region of residence (*f, %*) | | |
| - North | 2 | 1.0 |
| - Northeast | 17 | 8.6 |
| - Central-West | 123 | 62.4 |
| - Southeast | 42 | 21.3 |
| - South | 13 | 6.6 |
| Income (*f, %*) | | |
| - Low Income | 57 | 29.0 |
| - Medium Income | 102 | 51.8 |
| - High Income | 38 | 19.3 |
| Psychiatric diagnosis (*f, %*) | | |
| - No | 104 | 52.8 |
| - Yes | 93 | 47.2 |
| Psychiatric medication (*f, %*) | | |

| | | |
|---|---|---|
| - No | 105 | 53.3 |
| - Yes | 92 | 46.7 |
| Psychiatric treatment (*f, %*) | | |
| - No | 116 | 58.9 |
| - Yes | 81 | 41.1 |
| Psychological treatment (*f, %*) | | |
| - No | 54 | 27.4 |
| - Yes | 143 | 27.4 |

**Instruments**

Sociodemographic Questionnaire (SQ): We developed the SQ to collect information on the sociodemographic and mental health characteristics of the sample included in this study.

Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11-CRF; Sellbom et al., 2024): This is a brief clinician-rated measure of personality disorder severity, based on the self-report version of the PDS-ICD-11 (Bach et al., 2021). The instrument comprises 14 items, with the first 10 items requiring clinicians to indicate, on a bipolar scale of five statements, which option best reflects the patient's functioning. In this context, an intermediate response reflects normal personality functioning, while impairments are captured at the extremes of each pole. The remaining items are rated on a 4-point scale ranging from 0 to 3. Total scores derived from the responses indicate the overall severity of the personality disorder (Sellbom et al., 2024). The Brazilian version adapted by the Clinical Psychological Assessment Research Center (NEAPSIC) of the University of Brasília was used. Reliability indices ranged from $\omega$ = .91.

Entrevista Diagnóstica para Transtornos da Personalidade (E-TRAP; Carvalho et al., 2020. [Diagnostic Interview for Personality Disorders]): This instrument is a computerized semi-structured interview developed in Brazil to assist mental health professionals in the diagnosis of personality disorders. The E-TRAP is designed to evaluate personality pathology according to both the categorical and hybrid models described in the DSM-5, addressing impairments in personality functioning (Criterion A) as well as specific pathological traits (Criterion B), namely: Negative Affectivity, Detachment, Antagonism, Disinhibition, and

Psychoticism. The interview consists of two main parts: The first part assesses the level of impairment in personality functioning (Criterion A), using structured questions that guide the clinician's ratings of the individual's self- and interpersonal functioning. The second part evaluates pathological personality traits (Criterion B) including questions related to maladaptive patterns of affect, cognition, interpersonal behavior, and impulse control. Responses are scored by the clinician using a computer interface, and an automated report of the individual's scores is generated at the end of the interview (Carvalho et al., 2020). The reliability indices observed in this study ranged from $\omega$ = .58 (Psychoticism) to $\omega$ =.83 (Negative Affectivity).

Personality Disorder Severity ICD-11 (PDS-ICD-11; Bach et al., 2021): This is a 14-item self-report instrument. The first 10 items are bipolar, where respondents are instructed to indicate one of five statements that best reflects their level of functioning along the assessed spectrum. The middle option represents healthy functioning, while responses above or below this midpoint indicate mild to moderate impairment, and the options at the extreme poles represent more severe dysfunction. These items are scored on a three-point scale: 0 for adaptive functioning, 1 for mild impairment, and 2 for severe impairment, so that both ends of the spectrum receive the same severity score. The remaining four items are unipolar and scored from 0 to 3, with higher scores indicating greater personality dysfunction. The sum of all scores is used as the total score to assess severity according to ICD-11 guidelines (Bach et al., 2021). We used the Brazilian version adapted by the Clinical Psychological Assessment Research Center (NEAPSIC) of the University of Brasília (Oliveira et al., 2025a). In the current study reliability was $\omega$ = .81.

Personality Inventory for DSM-5 – Brief Form Plus Modified (PID5BF+M; Bach et al., 2020): This instrument comprises 36 items that assess the pathological personality domains of both the DSM-5 and ICD-11 personality disorder models in an integrated manner. It evaluates

the traits of Negative Affectivity, Detachment, Antagonism/Dissociality, Disinhibition, Anankastia, and Psychoticism. Each of these domains includes three facets, each represented by a pair of items. Respondents rated the 36 items on a four-point scale ranging from 0 ("does not describe me at all") to 3 ("describes me very well"). This measure has proven to be valid and reliable for estimating pathological personality traits according to the DSM-5 and ICD-11 models (Bach et al., 2020). We used the Brazilian version (Oliveira et al., 2025b). In the current study, reliability indices ranged from $\omega$ =.82 (Antagonism) to $\omega$ =.90 (Anankastia).

Borderline Pattern Scale (BPS; Oltmanns & Widiger, 2019): This measure consists of 12 items rated on a five-point scale, ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). The instrument was developed based on the descriptive components of the borderline specifier pattern according to the ICD-11 personality disorder model. We used the Brazilian version adapted by Oliveira and Oliveira (2023). In this study, reliability coefficient was $\omega$ =.90.

**Procedures**

The study was approved by the Research Ethics Committee of the University of Brasília (protocol number 81181424.2.0000.5540), Brazil. All participants signed an informed consent form before participating. Data collection was first conducted by psychologists who received standardized training through a free online course and ongoing supervision provided by the research team. Trained psychologists invited patients to participate voluntarily and, upon consent, shared their contact information with the research team. Participants were then contacted and completed the self-report instruments via the FormR platform (Arslan et al., 2020). To promote engagement and data quality, an automated feedback report was provided upon questionnaire completion, and embedded validity control items were used to identify random or inattentive responding. Participants who met these criteria proceeded to subsequent

study stages. Psychologists administered the E-TRAP and subsequently completed the PDS-ICD-11-CRF based on their clinical evaluations. An additional phase of data collection was conducted by undergraduate psychology students from the University of Brasília and the project's lead researcher. For this phase, volunteers were recruited through online announcements disseminated via the researchers' professional networks and invited to attend in-person data collection sessions. After providing informed consent, participants completed the self-report instruments, and those who met the validity criteria proceeded to the clinical assessment stage. The E-TRAP was administered, and the PDS-ICD-11-CRF was completed by the students and the lead researcher.

**Data Analysis**

The 14 items from the PDS–ICD-11-CRF were treated as continuous indicators for latent profile modeling. Prior to analysis, item responses were z-standardized to facilitate model estimation and scale comparability (Collins & Lanza, 2010). A Latent Profile Analysis (LPA) was conducted using the *tidyLPA* package (Rosenberg et al., 2018). LPA is a model-based clustering technique grounded in finite mixture modeling that identifies homogeneous latent subgroups based on response patterns on continuous indicators (Masyn, 2013; McLachlan & Peel, 2000). Models specifying 1- through 8-profile solutions were estimated. Model selection followed current recommendations for mixture modeling and relied on multiple fit indices, including the Akaike Information Criterion (AIC) and Bayesian Information Criterion (BIC). Lower values on these indices indicate better relative fit (Nylund et al., 2007). Additional decision criteria included entropy (with values ≥ .80 interpreted as adequate classification accuracy; Celeux and Soromenho, 1996).

Final model selection was based on the joint consideration of (a) statistical fit indices, (b) classification quality, (c) model convergence and stability, and (d) theoretical

interpretability. Posterior classification probabilities and most likely class membership were extracted and merged with the original dataset to facilitate descriptive and visual inspection of latent profiles. Standardized profile means and variable-wise density distributions were examined to characterize the nature of the retrieved latent subgroups.

To characterize the latent profiles, two one-way analyses of variance (ANOVAs) were conducted using the Welch model, which does not assume homogeneity of variances and is recommended when group variances are unequal or sample sizes differ (Delacre et al., 2019). First, a Welch one-way ANOVA examined differences between latent profiles on the 14 PDS-ICD-11-CRF items and the total score. For this analysis, the 10 bipolar items were coded on a −2 to +2 scale, whereas the 4 unipolar items retained their original 0 to 3 scoring. This analysis aimed to describe the internal differentiation of the profiles based on the same clinical indicators used for LPA.

Second, a Welch one-way ANOVA assessed differences between latent profiles on external measures, including self-report scores from the PDS–ICD-11, BPS, and PID5BF+M, as well as clinician-rated scores from the E-TRAP. This analysis evaluated convergent and criterion-related validity of the retrieved profiles. For both ANOVAs, Games–Howell post hoc comparisons were applied to examine pairwise differences, as this procedure is robust under variance heterogeneity and unequal sample sizes (Games & Howell, 1976). The Welch ANOVAs were computed using the oneway.test() function from base R, and Games–Howell post hoc comparisons were conducted using the rstatix package.

## Results

Based on AIC, BIC, and entropy values, the 4-profile solution demonstrated the best balance between statistical fit and model parsimony. Although higher profile solutions produced slightly lower AIC values, these models included very small classes (≤ 5% of the

sample), reducing interpretability and increasing the risk of overextraction. Therefore, the 4-profile solution was retained for subsequent analyses.

**Table 2**

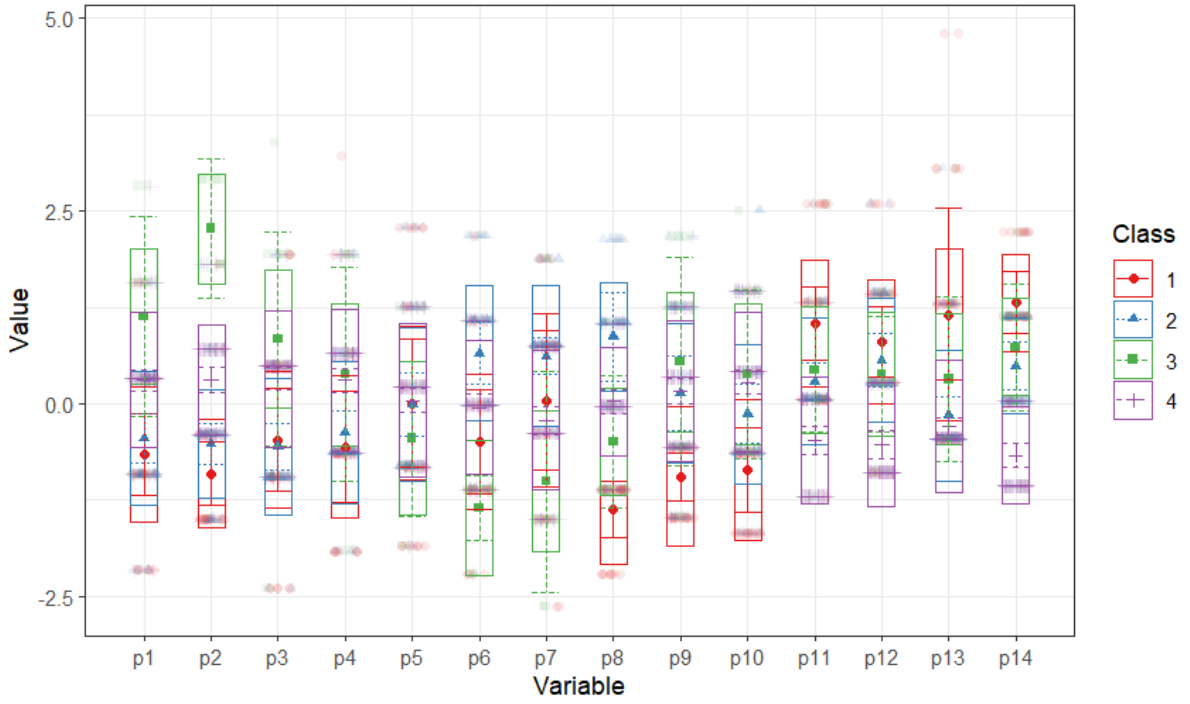
*Latent Profile Analysis Fit Indices*

| Model | Classes | AIC | BIC | Entropy |
|---|---|---|---|---|
| 1 | 1 | 7868.83 | 7960.76 | 1.00 |
| 1 | 2 | 7573.18 | 7714.36 | 0.84 |
| 1 | 3 | 7514.44 | 7704.86 | 0.90 |
| 1 | 4 | 7381.18 | 7620.85 | 0.91 |
| 1 | 5 | 7336.23 | 7625.15 | 0.91 |
| 1 | 6 | 7321.10 | 7659.27 | 0.92 |
| 1 | 7 | 7318.15 | 7705.57 | 0.93 |
| 1 | 8 | 7321.10 | 7757.77 | 0.89 |

Across the 14 PDS-ICD-11-CRF items (p1–p14), the latent profiles exhibited partially overlapping score distributions, with some systematic mean differences across indicators. As shown in Figure 1, all profiles displayed considerable within-class variability, and substantial overlap was observed among classes. These patterns suggest that profile separation is moderate, rather than sharply distinct, at the item level.

**Figure 1**

*Score Distributions of the PDS-ICD-11-CRF Indicators Across Latent Profiles*




To better distinguish the profiles, we conducted Welch's ANOVA to evaluate group differences on the 14 items of the PDS-ICD-11-CRF and on the total PDS-ICD-11-CRF score. Table 3 reports the corresponding results. Overall, the analysis indicated that the four latent profiles derived from the LPA represented three severity levels of personality functioning. Specifically, one profile reflected adaptive functioning (Profile 4, $n$ = 107), one reflected moderately impaired functioning (Profile 2, $n$ = 51), and two reflected severely impaired functioning (Profile 1, $n$ = 30; Profile 3, $n$ = 9). These two severe profiles differed in identity functioning (diffuse in Profile 1 vs. restricted in Profile 3), self-worth (self-devaluation in Profile 1 vs. grandiosity in Profile 3), and perspective-taking (mild empathy deficits in Profile 1 vs. severe empathy deficits in Profile 3).

**Table 3**

*Mean Scores and Between-Profile Differences on PDS-ICD-11-CRF Indicators*

| Variable | Profile 1 (*n* = 30) | Profile 2 (*n* = 51) | Profile 3 (*n* = 9) | Profile 4 (*n* = 107) | F, df1, df2 | Post hoc |
|---|---|---|---|---|---|---|
| Identity | -0,80 (0,92) | -0,65 (0,72) | 0,67 (1,12) | -0,01 (0,57) | 15.866, 3, 30.507[c] | P1=P2; P1<P3; P1<P4; P2<P3; P2<P4; P3=P4 |
| Self-worth | -1,47 (0,73) | -1,10 (0,64) | 1,44 (0,73) | -0,36 (0,64) | 50.795, 3, 32.262[c] | P1=P2; P1<P3; P1<P4; P2<P3; P2<P4; P3>P4 |
| Self-perception | -0,67 (0,92) | -0,73 (0,60) | 0,22 (1,30) | -0,11 (0,42) | 16.135, 3, 29.620[c] | P1=P2; P1=P3, P1<P4; P2=P3; P2<P4; P3=P4 |
| Goals | -0,97 (0,96) | -0,82 (0,65) | -0,22 (1,30) | -0,25 (0,60) | 11.851, 3, 30.516[c] | P1=P2; P1=P3; P1<P4; P2=P3; P2<P4; P3=P4 |
| Interest in relationships | -0,23 (1,50) | -0,16 (1,10) | -0,67 (1,12) | -0,20 (0,65) | 0.530, 3, 30.051 | P1=P2; P1=P3; P1=P4; P2=P3; P2=P4; P3=P4 |
| Perspective-taking | -0,47 (1,07) | 0,63 (0,92) | -1,22 (0,44) | -0,04 (0,66) | 30.494, 3, 35.301[c] | P1<P2; P1>P3; P1=P4; P2>P3; P2>P4; P3<P4 |
| Mutuality in relationships | 0,40 (1,22) | 0,88 (0,65) | -0,56 (1,51) | 0,13 (0,65) | 15.806, 3, 30.359[c] | P1=P2; P1=P3; P1=P4; P2=P3; P2>P4; P3=P4 |
| Disagreement management | -1,27 (0,45) | 0,82 (0,74) | -0,44 (0,88) | 0,07 (0,63) | 91.475, 3, 32.720[c] | P1<P2; P1=P3; P1<P4; P2>P3; P2>P4; P3=P4 |
| Emotional control and expression | -1,43 (0,68) | -0,31 (1,26) | 0,22 (1,72) | -0,17 (0,86) | 24.035, 3, 31.830[c] | P1<P2; P1=P3; P1<P4; P2=P3; P2=P4; P3=P4 |
| Behavioral control | -1,20 (0,92) | -0,59 (1,06) | 0,00 (1,22) | -0,11 (0,72) | 12.778, 3, 30.899[c] | P1<P2; P1=P3; P1<P4; P2=P3; P2<P4; P3=P4 |
| Experience of reality during stress | 1,77 (0,90) | 1,20 (0,49) | 1,33 (0,87) | 0,58 (0,63) | 24.346, 3, 31.501[c] | P1>P2; P1=P3; P1>P4; P2=P3; P2>P4; P3=P4 |
| Harm to self | 1,47 (0,94) | 1,27 (0,75) | 1,11 (0,78) | 0,30 (0,57) | 32.136, 3, 31.101[c] | P1=P2; P1=P3; P1>P4; P2=P3; P2>P4; P3=P4 |
| Harm to others | 0,93 (0,91) | 0,18 (0,43) | 0,44 (0,73) | 0,09 (0,29) | 8.759, 3, 29.529[c] | P1>P2; P1=P3; P1>P4; P2=P3; P2=P4; P3=P4 |
| Psychosocial impairment | 2,20 (0,61) | 1,43 (0,61) | 1,67 (0,87) | 0,36 (0,50) | 97.780, 3, 31.113[c] | P1>P2; P1=P3; P1>P4; P2=P3; P2>P4; P3>P4 |
| PDS-ICD-11-CFR total score | 18.67 (4.37) | 13.71 (2.87) | 16.67 (2.69) | 5.47 (3.24) | 149.870, 3, 72.340[c] | P1>P2; P1=P3; P1>P4; P2<P3; P2>P4; P3>P4 |

*Note.* [a] $p < .05$; [b] $p < .01$; [c] $p < .001$; P1 = profile 1; P2 = profile 2; P3 = profile 3; P4 = profile 4; PDS-ICD-11-CFR = Personality Disorder Severity ICD-11 Clinician-Rating Form.

To characterize the profiles more precisely, we examined only the PDS-ICD-11-CRF variables that differed significantly between at least two latent profiles. Profile 1 included individuals with globally impaired personality functioning. They showed identity diffusion (Identity: *M* = -0.80, *SD* = 0.92), self-devaluation (Self-Worth: *M* = -1.47, *SD* = 0.73), interpersonal conflict tendencies (Disagreement Management: *M* = -1.27, *SD* = 0.45), failures in emotional (Emotional Control and Expression: *M* = -1.43, *SD* = 0.68) and behavioral control (Behavioral Control: *M* = 1.20, *SD* = 0.92), impaired reality testing (Experience of Reality During Stress: *M* = 1.77, *SD* = 0.90), harm to others (Harm to Others: *M* = 0.93, *SD* = 0.18), and pronounced psychosocial impairments (Psychosocial Impairments: *M* = 2.20, *SD* = 0.61).

Profile 2 shared several impairments with Profile 1 but at generally lower levels. Participants showed identity diffusion (Identity: *M* = -0.65, *SD* = 0.72), self-devaluation (Self-Worth: *M* = -1.10, *SD* = 0.64), behavioral dyscontrol (Behavioral Control: *M* = -0.59, *SD* = 1.06), impaired reality testing (Experience of Reality During Stress: *M* = 1.27, *SD* = 0.49), and psychosocial impairments (Psychosocial Impairments: *M* = 1.43, *SD* = 0.61). This profile differed from the others by showing elevated concern about others' thoughts and feelings (Perspective-Taking: *M* = 0.63, *SD* = 0.92) and a conflict-avoidant pattern in relationships (Disagreement Management: *M* = 0.82, *SD* = 0.74), suggesting a dependent and submissive interpersonal style.

Profile 3 included individuals with restricted identity (Identity: *M* = 0.67, *SD* = 1.12), grandiose self-worth (Self-Worth: *M* = 1.44, *SD* = 0.73), and marked empathy deficits (Perspective-Taking: *M* = -1.22, *SD* = 0.44). In contrast, Profile 4 included individuals with adaptive personality functioning and consistently showed the lowest mean impairment across PDS-ICD-11-CRF indicators.

To strengthen profile characterization, we conducted a Welch's ANOVA using external measures (see Table 4). Profile 1 again showed the highest personality disorder severity (E-TRAP Personality Functioning: $M$ = 1.43, $SD$ = 0.48), with pronounced intrapersonal dysfunction (E-TRAP Self-Functioning: $M$ = 1.73, $SD$ = 0.72) and elevated negative affectivity (E-TRAP Negative Affectivity: $M$ = 2.12, $SD$ = 0.50). Profile 2 showed moderate levels of dysfunction, with intermediate scores between Profiles 1 and 3, including the lowest social–emotional detachment among the three impaired profiles (E-TRAP Detachment: $M$ = 0.97, $SD$ = 0.34). This pattern aligns with its dependent interpersonal style observed in the previous analysis. Finally, Profile 4 showed consistently healthy functioning across all external measures.

Self-report variables primarily distinguished Profiles 1, 2, and 3 collectively from Profile 4, whereas clinician-rated variables (E-TRAP) more clearly differentiated Profiles 1, 2, and 3 from each other. Profile 3 showed few statistically significant differences, likely due to its small sample size ($n$ = 9). Although the borderline pattern specifier did not significantly differentiate the latent profiles, the more severe profiles nonetheless exhibited higher mean scores on the BPS. In addition, profiles characterized by greater personality disorder severity showed elevated scores across most maladaptive personality trait domains, as well as convergence in personality pathology severity estimates across clinician-rated measures, indicating consistency across clinical perspectives. Importantly, the profiles also differed with respect to specific personality disorder severity features, with more severe profiles showing greater impairment across distinct poles of self- and interpersonal functioning.

**Table 4**

*Mean Scores and Between-Profile Differences on External Measures*

| Variable | Profile 1 (*n* = 30) | Profile 2 (*n* = 51) | Profile 3 (*n* = 9) | Profile 4 (*n* = 107) | F, df1, df2 | Post hoc |
|---|---|---|---|---|---|---|
| PDS-ICD-11 | | | | | | |
| - Severity of PD ($\omega$ = .81) | 17.67 (3.89) | 15.69 (4.43) | 17.00 (3.97) | 10.80 (4.02) | 32.568, 3, 33.125[c] | P1=P2; P1=P3; P1>P4; P2=P3; P2>P4; P3>P4 |
| BPS | | | | | | |
| - Borderline pattern ($\omega$ = .90) | 43.03 (8.88) | 40.2 (8.46) | 38.56 (8.26) | 28.49 (8.9) | 32.633, 3, 33.296[c] | P1=P2; P1=P3; P1>P4; P2=P3; P2>P4; P3>P4 |
| PID5BF+M | | | | | | |
| - Negative affectivity ($\omega$ = .86) | 4.54 (0.94) | 4.06 (0.96) | 3.63 (1.59) | 3.25 (1.17) | 14.820, 3, 32.506[c] | P1=P2; P1=P3; P1>P4; P2=P3; P2>P4; P3=P4 |
| - Detachment ($\omega$ = .86) | 2.36 (0.97) | 2.27 (1.28) | 3.19 (1.66) | 1.69 (1.12) | 6.139, 3, 32.123[b] | P1=P2; P1=P3, P1>P4; P2=P3; P2>P4; P3=P4 |
| - Disinhibition ($\omega$ = .87) | 3.47 (1.11) | 3.24 (1.41) | 2.52 (1.34) | 2.19 (1.28) | 12.423, 3, 33.102[c] | P1=P2; P1=P3; P1>P4; P2=P3; P2>P4; P3=P4 |
| - Antagonism ($\omega$ = .82) | 2.23 (1.45) | 1.52 (1.00) | 2.89 (1.92) | 1.40 (1.20) | 4.031, 3, 31.440[a] | P1=P2; P1=P3; P1>P4; P2=P3; P2=P4; P3=P4 |
| - Anankastia ($\omega$ = .90) | 3.13 (1.48) | 2.76 (1.38) | 3.56 (1.68) | 2.96 (1.54) | 0.815, 3, 32.687 | P1=P2; P1=P3; P1=P4; P2=P3; P2=P4; P3=P4 |
| - Psychoticism ($\omega$ = .84) | 3.08 (1.55) | 2.82 (1.5) | 2.96 (1.05) | 2.28 (1.42) | 3.311, 3, 34.645[a] | P1=P2; P1=P3; P1=P4; P2=P3; P2=P4; P3=P4 |
| E-TRAP | | | | | | |
| - Personality functioning ($\alpha$ = .81) | 1.43 (0.48) | 0.99 (0.46) | 1.57 (0.68) | 0.50 (0.36) | 44.114, 3, 30.787[c] | P1>P2; P1=P3; P1>P4; P2=P3; P2>P4; P3>P4 |
| - Self-functioning ($\alpha$ = .77) | 1.73 (0.72) | 1.27 (0.58) | 1.39 (0.85) | 0.54 (0.44) | 39.796, 3, 30.429[c] | P1>P2; P1=P3; P1>P4; P2=P3; P2>P4; P3=P4 |
| - Interpersonal functioning ($\omega$ = .61) | 1.14 (0.54) | 0.71 (0.56) | 1.76 (0.64) | 0.46 (0.39) | 23.890, 3, 30.822[c] | P1>P2; P1=P3; P1>P4; P2<P3; P2>P4; P3>P4 |
| - Negative affectivity ($\omega$ = .83) | 2.12 (0.50) | 1.75 (0.59) | 1.46 (0.71) | 1.04 (0.42) | 48.244, 3, 31.111[c] | P1>P2; P1=P3; P1>P4; P2=P3; P2>P4; P3=P4 |
| - Detachment ($\omega$ = .77) | 1.29 (0.54) | 0.97 (0.34) | 1.77 (0.67) | 0.58 (0.44) | 26.842, 3, 31.461[c] | P1>P2; P1=P3; P1>P4; P2<P3; P2>P4; P3>P4 |
| - Disinhibition ($\omega$ = .82) | 1.75 (0.65) | 1.41 (0.64) | 1.41 (0.50) | 1.00 (0.44) | 15.805, 3, 31.687[c] | P1=P2; P1=P3; P1>P4; P2=P3; P2>P4; P3=P4 |
| - Antagonism ($\omega$ = .68) | 0.79 (0.63) | 0.38 (0.26) | 0.92 (0.62) | 0.30 (0.28) | 8.410, 3, 30.341[c] | P1>P2; P1=P3; P1>P4; P2=P3; P2=P4; P3=P4 |
| - Psychoticism ($\omega$ = .58) | 0.64 (0.67) | 0.31 (0.43) | 0.83 (0.84) | 0.17 (0.29) | 7.040, 3, 29.568[b] | P1=P2; P1=P3; P1>P4; P2=P3; P2>P4; P3=P4 |

*Note.* [a] $p < .05$; [b] $p < .01$; [c] $p < .001$; P1 = profile 1; P2 = profile 2; P3 = profile 3; P4 = profile 4; PDS-ICD-11 = Personality Disorder Severity ICD-11; BPS = Borderline Pattern Scale; E-TRAP = Entrevista Diagnóstica para Transtornos da Personalidade [Diagnostic Interview for Personality Disorders].

# Discussion

The present study sought to identify latent profiles reflecting different configurations of personality impairment expression in the PDS-ICD-11-CRF and to examine how these profiles relate to overall personality disorder severity, maladaptive personality traits, and the borderline pattern specifier. Overall, the findings supported a four-profile solution with profiles sharing common features while differing in the overall level and configuration of impairment. The findings suggest important clinical implications, indicating that latent profiles identified with the PDS-ICD-11-CRF could inform the formulation of more targeted and effective intervention strategies.

## Latent Profiles of Personality Disorder Severity

In contrast to traditional taxonomic approaches in psychopathology research, empirically driven frameworks do not begin with predefined diagnostic categories from which hypotheses are derived. Instead, they start from empirical observations and patterns of covariation, subsequently informing classification systems. Within this perspective, the central research question shifts from validating fixed categories to examining whether psychopathology is best conceptualized as discrete or continuous in nature (Krueger et al., 2018). Consistent with this approach, the present study provides empirical support for the continuous nature of personality pathology. Specifically, the latent profiles were characterized by moderate separation and substantial overlap across indicators, suggesting that they do not reflect discrete diagnostic entities. Rather, the identified profiles represent graded regions along a severity continuum, sharing common features while differing in the overall level and configuration of impairment. This finding aligns with the literature, as indicators of personality pathology, including diagnoses, symptoms, and maladaptive personality traits, are positively

correlated, consequently giving rise to substantial comorbidity when considering categorical taxonomies (Watson & Clark, 2023). This pattern is further supported by research on the general factor of psychopathology (*p* factor), which posits that symptoms across the full spectrum of psychopathology are distinct from one another yet intercorrelated (Caspi et al., 2024). A structurally analogous phenomenon has been identified in personality research, where consistent intercorrelations among personality traits give rise to a General Factor of Personality (GFP), typically accounting for a substantial proportion of shared variance across trait dimensions. Similar to the *p* factor, the GFP reflects a higher-order continuum underlying more specific domains, suggesting that broad dispositional tendencies may organize personality structure at the apex of a hierarchical model (Van Der Linden et al., 2016).

Our findings identified four latent profiles reflecting different levels of personality disorder severity, which showed partial similarities but also meaningful distinctions. With respect to shared features, profiles characterized by higher personality disorder severity (Profiles 1 and 3) exhibited the highest mean levels across most maladaptive personality traits, as assessed by both self-report and clinician-rated measures. This pattern is consistent with research over dimensional models of personality pathology, which posit that increasing personality disorder severity is reflected in broader and more pronounced maladaptive personality trait expressions, such that traits account for a greater proportion of functional impairment at higher levels of personality disturbance (Bach & First, 2018; Sharp et al., 2015). This pattern may also be interpreted in light of the *p* factor, as higher *p* scores have been consistently associated with greater life impairment and more pervasive psychological dysfunction (Caspi et al., 2014). Similarly, the GFP captures shared variance across personality traits (Van Der Linden et al., 2016), indicating that widespread trait elevation may reflect a common dispositional core rather than isolated trait-specific effects.

These two profiles appear to reflect the ICD-11 guidelines for severe personality dysfunction, capturing opposing poles of impairment within the severe range. According to these guidelines (WHO, 2024), high personality disorder severity is characterized by disturbances in identity or sense of self that may be markedly unstable and inconsistent, as observed in Profile 1, or excessively rigid and fixed, as observed in Profile 3. These self-related disturbances are accompanied by pervasive self-contempt, as in Profile 1, or by grandiosity, as in Profile 3. In addition, both profiles exhibited pronounced interpersonal dysfunction, which tends to be extensive, affecting nearly all relationships and substantially limiting the individual's ability or willingness to meet expected social demands (WHO, 2024). However, the profiles differed in the configuration of these impairments: Profile 3 showed more severe deficits in empathy, whereas Profile 1 was characterized by more severe emotional dysregulation, poorer behavioral control, impaired reality testing, and a greater tendency toward behaviors involving harm to others. Thus, although both profiles fall within the severe range of personality pathology, Profile 1 reflects a more globally distributed pattern of impairment across multiple domains of personality functioning, whereas Profile 3 appears to show a more circumscribed yet still severe configuration of dysfunction.

Within Profile 1, Negative Affectivity emerged as the most prominent maladaptive trait, suggesting that intense and pervasive emotional distress constitutes a core feature of this highly severe presentation. This pattern is consistent with previous findings showing that Negative Affectivity is systematically associated with the most severe forms of personality dysfunction (Gamache et al., 2021b) and that impairments in self-functioning, particularly identity (as seen in Profile 1), are the most strongly correlated with this trait (Thimm, 2025).

Similar to Profile 1, Profile 2 exhibited overlapping characteristics, but at moderate levels of dysfunction and with a key distinguishing feature. Whereas Profile 1 was marked by impairments in empathy, including behaviors involving harm to others, patterns that are more

common at higher levels of personality disorder severity (Bach & Anderson, 2020) and tend to occur within a relatively small subgroup of individuals (Banerjee et al., 2009), Profile 2 showed the opposite pattern, characterized by excessive consideration for others and pronounced submissive features. Notably, this profile was defined by the lowest levels of Detachment, indicating a pattern of heightened interpersonal closeness, emotional involvement, and strong orientation toward others, rather than a tendency to maintain social or emotional distance. Consistent with this configuration, Bornstein (2012), in studies of individuals with high levels of trait dependency or dependent personality disorder, found that such patients may lack insight into the impact of their dependency needs and may employ a broad range of destructive strategies to strengthen interpersonal bonds or prevent abandonment. Such individuals also tend to surround themselves with others who inadvertently reinforce and sustain their underlying pathology (Bornstein, 2012). Thus, although Profile 2 exhibits a submissive pattern distinct from Profile 1, it nonetheless reflects significant severity and notable impairments that are amenable to effective clinical intervention.

Overall, the latent profiles identified in our sample demonstrated differentiation in personality disorder severity across both self- and interpersonal domains, in contrast to Thomson et al. (2024), who found more prominent impairments in self-functioning elements, and Gamache et al. (2021a), who identified empathy deficits as the defining feature of the severe profile. Another notable point is that the borderline functioning pattern, as measured by the BPS, did not discriminate among the severity-marked profiles, which aligns with the view that borderline criteria represent core features of severity and higher levels of disturbed behavior (Sharp et al., 2015). Nonetheless, the more severe profiles still exhibited higher mean scores. The PDS-ICD-11-CRF also successfully delineated Profile 4 as reflecting adaptive personality functioning, a profile characterized by the absence of clinically significant

impairments and with low mean levels of maladaptive personality traits, borderline features, and externally assessed personality disorder severity indicators.

**Clinical Implications of Personality Disorder Severity Latent Profiles**

The assessment of personality disorder severity marks a clear advance over categorical models by enabling clinicians to quantify the level of impairment and determine the appropriate intensity of care. Dimensional approaches have demonstrated superior clinical utility, offering greater descriptive precision, improving communication of patients' difficulties, and more effectively informing treatment planning (Hansen et al., 2019). Nevertheless, personality disorder severity alone does not capture the specific organization of psychological functioning. Individuals with comparable levels of impairment may differ substantially in their structural configuration and predominant mechanisms, particularly in light of the ICD-11 guidelines, which conceptualize personality dysfunction along opposite poles of maladaptive functioning (WHO, 2024). Thus, overall scores of personality disorder severity indicate the extent of dysfunction, but not the specific way in which it is expressed in self and interpersonal functioning.

Research highlights the added value of distinguishing latent profiles within comparable personality disorder severity levels. Patterns such as resilient, undercontrolled, and overcontrolled profiles have been associated with distinct emotion regulation styles and intervention needs (Gilmartin et al., 2024; Isaksson et al., 2021; Rossi et al., 2021; So et al., 2023), underscoring the clinical relevance of differentiation. Profile-based approaches extend the applicability of dimensional models by supporting early identification of personality pathology and informing modular or individualized treatment strategies (Thomson et al., 2024). Moreover, severity-informed profiles may assist in allocating patients within stepped-care

frameworks (De la Rosa-Cáceres et al., 2024) and enhance clinician ratings on instruments such as the PDS-ICD-11-CRF by promoting a more integrative interpretation of item-level data.

Building on this rationale, evidence-based treatments such as Schema Therapy and Dialectical Behavior Therapy, both supported by strong empirical foundations (Bach & Bernstein, 2018; Tracy et al., 2023), may particularly benefit from profile-informed case formulations. These approaches explicitly rely on tailoring interventions to patients' predominant emotional, cognitive, and behavioral patterns, making the identification of latent profiles clinically meaningful, as specific impairment types are identified. Integrating personality disorder severity with profile specification therefore may strengthen the clinical value of dimensional models, enhancing their practical utility for individualized intervention planning.

## Limitations

Some limitations warrant consideration. The relatively small sample size may have constrained the robustness and generalizability of the findings. In particular, Profile 3 included only nine individuals, which likely reduced statistical power and limited the detection of statistically significant differences, especially in comparisons involving external validation measures. As a result, some profile-specific associations may have been underestimated or remained undetected. Future studies with larger and more balanced samples are needed to provide more stable profile solutions, enhance the reliability of between-profile comparisons, and allow for a more nuanced examination of how maladaptive personality traits relate to distinct configurations of severity.

## Conclusion

The present study provides empirical support for a dimensional and person-centered conceptualization of personality pathology within the ICD-11 framework. The identification of four latent profiles of personality disorder severity underscores that personality dysfunction is best understood as graded configurations of impairment rather than discrete diagnostic categories, with meaningful variation in both overall severity and the organization of self- and interpersonal disturbances. The findings further highlight the clinical utility of the PDS-ICD-11-CRF in capturing heterogeneity across personality dysfunction severity levels, demonstrating convergence with maladaptive personality traits, self-reported personality disorder severity, borderline features, and clinician-rated external measure. By delineating adaptive and impaired profiles and differentiating distinct expressions of severe dysfunction, these results support the value of integrating severity-based, clinician-informed assessments to guide individualized case formulation and treatment planning in line with contemporary dimensional models of psychopathology.

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## General Final Considerations of the Master's Thesis

This master's thesis aimed to examine the psychometric properties of the Brazilian version of the PDS-ICD-11-CRF and to investigate latent profiles of personality disorder severity associated with different configurations of personality dysfunction. Building on the robust evidence of validity and reliability of the original instrument (Sellbom et al., 2024), the study investigated the validity and reliability of the Brazilian version of the measure, as well as identified latent severity profiles in the PDS-ICD-11-CRF and their associations with other dimensional components of personality disorders. Together, the findings have contributed to advancing personality assessment in line with the ICD-11 model, enhancing its clinical and scientific applicability within the national context.

The first study supported a robust unidimensional structure for the PDS-ICD-11-CRF, with high internal consistency ($\omega = .91$; $\alpha = .90$) and adequate item discrimination and difficulty parameters across a broad range of severity levels, with optimal measurement precision from moderate to high dysfunction. Additionally, the evidence indicated strong interrater reliability for the total score (ICC = .86), although agreement at the item level was somewhat more modest. Regarding convergent validity, significant correlations were found with the PDS-ICD-11, the PID5BF+M, the BPS, and the E-TRAP. The findings provide empirical support for the use of the PDS-ICD-11-CRF for assessing personality disorder severity in Brazil.

The second study identified a four-profile solution of latent personality disorder severity profiles. Profile 1 was characterized by severe impairments across multiple domains of personality functioning, with Negative Affectivity as the most prominent trait. Profile 2 exhibited moderate impairment, with a pattern of submissive and dependent behaviors. Profile 3 showed severe impairment, including restricted identity, grandiosity, and deficits in empathy. Finally, Profile 4 reflected a healthy personality, with no elevated levels of maladaptive traits. Overall, these findings support the conceptualization of personality pathology as a continuum

of severity with heterogeneous expressions of dysfunction. They also underscore the clinical utility of clinician-rated, severity-based, person-centered approaches for assessment and treatment planning within the ICD-11 framework, highlighting the PDS-ICD-11-CRF as a reliable and effective instrument for this purpose.

In conclusion, this thesis provides strong psychometric evidence for the Brazilian version of the PDS-ICD-11-CRF. The findings demonstrate robust validity and reliability and highlight the measure's utility in identifying latent personality disorder severity profiles. Keeley et al. (2023), after an extensive overview of diagnostic classification systems (spanning approximately 17,000 words and 190 references), concluded that the process of diagnosis is far from straightforward. Similarly, this research, encompassing over 90 pages of analysis, underscores the complexity of diagnostic determination. Collectively, these studies advance the application of the ICD-11 framework according to the WHO (2020) guideliness in the context of personality pathology and dimensional investigations, providing a foundation for both clinical assessment and future research on personality disorder severity in Brazil.

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## Appendix A – Informed Consent Form for Psychologists

Você está sendo convidado a participar da pesquisa "Avaliação Dimensional dos Transtornos da Personalidade: Estudos de Adaptação de Medidas da CID-11 para o Brasil", de responsabilidade de Lídia Figueiredo dos Santos, mestranda do Departamento de Psicologia Clínica da Universidade de Brasília. O objetivo desta pesquisa é investigar evidências de validade e fidedignidade dos instrumentos *Personality Assessment Questionnaire for ICD-11* (PAQ-11 R) e *Personality Disorder Severity ICD-11 Clinician-Rating Form* (PDS-ICD-11), traduzidos e adaptados para o português brasileiro.

Assim, gostaríamos de consultá-lo/a sobre seu interesse e disponibilidade de cooperar com a pesquisa. Para tanto, leia as informações apresentadas no Registro de Consentimento a seguir. Caso algo não esteja claro ou se você quiser mais informações, você pode entrar em contato conosco por meio do endereço de e-mail indicado a seguir.

Você poderá obter esclarecimentos adicionais em qualquer momento da pesquisa (início, durante e após a finalização) por meio do e-mail: pesquisapersonalidadeunb@gmail.com. É assegurado que as informações serão mantidas em sigilo pelos pesquisadores.

Para participar da pesquisa, você deverá fazer um curso para treinamento teórico-prático em Avaliação dos Transtornos da Personalidade. Após, você deverá atender um ou mais pacientes (em dia e horário diferente do habitual e sem custos para o paciente), o que implicará em informar dados de identificação seus e dos pacientes que você irá avaliar, mediante consentimento deles também. Os dados provenientes de sua participação na pesquisa, a saber, suas respostas aos questionários, ficarão sob a guarda do pesquisador responsável pela pesquisa em local seguro, sendo garantido o sigilo e a confidencialidade das informações. A coleta de dados será realizada por meio de entrevista computadorizada e questionários eletrônicos nessa plataforma online. O primeiro questionário diz respeito a aspectos sociodemográficos, enquanto o segundo questionário possui questões referentes a aspectos da personalidade de seus pacientes. Além disso, você responderá a uma entrevista computadorizada em sessão com o paciente. Gostaríamos que você os respondesse de forma honesta e sincera, com base em seu conhecimento técnico-científico sobre a pessoa a qual atende.

Após dar o seu consentimento, você responderá ao questionário sociodemográfico, ao instrumento e à entrevista computadorizada. É para este procedimento que você está sendo convidado a participar. Sua participação na pesquisa implica em risco mínimo, como ter que dispor de cerca de 15 horas de treinamento e supervisão, de duas a seis horas de atendimento (a depender do número de pacientes participantes da pesquisa) e 1 hora para responder aos questionários (total de tempo para preencher os dados dos pacientes atendidos), além de poder apresentar cansaço ou algum desconforto ao longo dos questionários. Para tanto, lembramos que você pode interromper a participação a qualquer momento, assim como contatar o pesquisador para dúvidas.

Além disso, você precisa estar ciente que, desde que essa pesquisa é online, há sempre o risco de intrusão de agentes externos, como por exemplo hackers, e assim a possibilidade de ser identificado/a. Contudo, nós fazemos de tudo para garantir que isso não acontecerá por meio do uso de um servidor seguro.

Nós garantimos que os dados serão mantidos e guardados seguramente. Espera-se com esta pesquisa oferecer para as comunidades clínica e científica, brasileira e internacional, versões

dos instrumentos adaptados transculturalmente ao contexto brasileiro, que sejam válidos e fidedignos para a avaliação dos domínios da personalidade, conforme modelo dimensional da CID-11. Além disso, você poderá se beneficiar diretamente dessa pesquisa ao poder refletir e avaliar sobre as características da personalidade de seu paciente ao responder os questionários.

Sua participação é voluntária e livre de qualquer remuneração. Você é livre para recusar-se a participar, retirar seu consentimento ou interromper sua participação até o momento de clicar no botão "enviar" ao final do questionário, bastando, para isso, fechar a página do navegador de internet sem clicar em "enviar". Por haver a identificação pelo seu nome e CPF do paciente, caso você decida retirar seu consentimento, os dados poderão ser retirados da pesquisa. Todas as perguntas desta pesquisa são de resposta obrigatória. No entanto, você tem o direito de não responder às questões desta pesquisa, se assim desejar, sem ser necessário você se justificar. Para tanto, basta interromper imediatamente a sua participação fechando a janela do questionário. A recusa em participar, ou interrupção após iniciar as respostas, não irá acarretar qualquer penalidade a você ou perda de benefícios.

Se você tiver qualquer dúvida em relação à pesquisa, você pode nos contatar através do telefone (31) 98860-3350 ou pelo e-mail pesquisapersonalidadeunb@gmail.com. Ao participar da pesquisa, você contribui para a ciência e consente com a publicação dos resultados do estudo na comunidade científica.

Este projeto foi revisado e aprovado pelo Comitê de Ética em Pesquisa em Ciências Humanas e Sociais (CEP/CHS) da Universidade de Brasília e estão de acordo de acordo com as orientações da CONEP, em especial, o OFÍCIO CIRCULAR Nº 2/2021/CONEP/SECNS/MS, "sobre procedimentos em pesquisa com qualquer etapa em ambiente virtual". As informações com relação à assinatura do TCLE ou aos direitos do participante da pesquisa podem ser obtidas por meio do e-mail do CEP/CHS: cep_chs@unb.br ou pelo telefone: (61) 3107-1592.

Enfatizamos a importância de você, como participante de pesquisa, guardar em seus arquivos uma cópia deste consentimento, se assim o desejar, imprimindo ou fazendo um print desta página. O registro de consentimento ocorrerá ao clicar no item abaixo "Aceito participar", caso decida participar dessa pesquisa. Caso você não concorde em participar dessa pesquisa, basta você fechar essa janela.

## Appendix B – Informed Consent Form for Patients

Você está sendo convidado a participar da pesquisa Avaliação Dimensional dos Transtornos da Personalidade: Estudos de Adaptação de Medidas da CID-11 para o Brasil, de responsabilidade de Lídia Figueiredo dos Santos, mestranda do Departamento de Psicologia Clínica da Universidade de Brasília. O objetivo desta pesquisa é investigar evidências de validade e fidedignidade dos instrumentos *Personality Assessment Questionnaire for ICD-11* (PAQ-11 R) e *Personality Disorder Severity ICD-11 Clinician-Rating Form* (PDS-ICD-11), traduzidos e adaptados para o português brasileiro. Assim, gostaríamos de consultá-lo/a sobre seu interesse e disponibilidade de cooperar com a pesquisa.

Para tanto, leia as informações apresentadas no Registro de Consentimento a seguir. Caso algo não esteja claro ou se você quiser mais informações, você pode entrar em contato conosco por meio do endereço de e-mail indicado a seguir. Você poderá obter esclarecimentos adicionais em qualquer momento da pesquisa durante e após a finalização) por meio do e-mail: pesquisapersonalidadeunb@gmail.com. É assegurado que o seu nome não será divulgado, sendo mantido o mais rigoroso sigilo. Os dados provenientes de sua participação na pesquisa, a saber, suas respostas aos questionários, ficarão sob a guarda do pesquisador responsável pela pesquisa em local seguro, sendo garantido o sigilo e a confidencialidade das informações.

A coleta de dados será realizada por meio de uma entrevista com seu psicoterapeuta (em dia e horário diferente do habitual e sem custos para você) e por meio questionários eletrônicos nessa plataforma online. A entrevista e os questionários têm questões sobre aspectos de sua personalidade e saúde e gostaríamos que você os respondesse de forma honesta e sincera. Após dar o seu consentimento, você primeiro responderá um questionário sociodemográfico, e, em seguida, responderá a quatro instrumentos que avaliam aspectos da personalidade. Depois, você participará de uma entrevista que também avalia aspectos da sua personalidade com seu psicoterapeuta. É para este procedimento que você está sendo convidado a participar.

Sua participação na pesquisa implica em risco mínimo, como ter que dispor de cerca de duas horas para participar de uma sessão de entrevista com seu psicoterapeuta e 45 minutos para responder aos questionários deste formulário, além de poder apresentar cansaço ou algum desconforto ao longo dos procedimentos. Para tanto, lembramos que você pode interromper a participação a qualquer momento, assim como contatar o pesquisador para dúvidas.

Além disso, você precisa estar ciente que, desde que essa pesquisa é online, há sempre o risco de intrusão de agentes externos, como por exemplo hackers, e assim a possibilidade de ser identificado/a. Contudo, nós fazemos de tudo para garantir que isso não acontecerápor meio do uso de um servidor seguro. Nós garantimos que os dados serão mantidos e guardados seguramente.

Espera-se com esta pesquisa oferecer para as comunidades clínica e científica, brasileira e internacional, versões dos instrumentos adaptados transculturalmente ao contexto brasileiro, que sejam válidos e fidedignos para a avaliação dos domínios da personalidade, conforme modelo dimensional da CID-11. Além disso, você poderá se beneficiar diretamente dessa pesquisa ao poder refletir e autoavaliar suas características de personalidade ao responder os questionários.

Sua participação é voluntária e livre de qualquer remuneração. Você é livre para recusar-se a participar, retirar seu consentimento ou interromper sua participação a qualquer momento,

bastando, para isso, fechar a página do navegador de internet sem clicar em “enviar”. Por haver dados que permitem a sua identificação pessoal, caso você decida retirar seu consentimento, os dados poderão ser retirados da pesquisa mesmo após o envio das suas respostas. Todas as perguntas desta pesquisa são de resposta obrigatória. No entanto, você tem o direito de não responder às questões desta pesquisa, se assim desejar, sem ser necessário você se justificar. Para tanto, basta interromper imediatamente a sua participação fechando a janela do questionário. A recusa em participar, ou interrupção após iniciar as respostas, não irá acarretar qualquer penalidade a você ou perda de benefícios.

Se você tiver qualquer dúvida em relação à pesquisa, você pode nos contatar através do telefone (31) 98860-3350 ou pelo e-mail pesquisapersonalidadeunb@gmail.com.

A equipe de pesquisa garante que os resultados de participação individual no estudo serão devolvidos aos participantes por meio do relatório de desempenho ao fim do questionário. Os resultados do estudo serão publicados na comunidade científica.

Este projeto foi revisado e aprovado pelo Comitê de Ética em Pesquisa em Ciências Humanas e Sociais (CEP/CHS) da Universidade de Brasília e estão de acordo de acordo com as orientações da CONEP, em especial, o OFÍCIO CIRCULAR Nº 2/2021/CONEP/SECNS/MS, “sobre procedimentos em pesquisa com qualquer etapa em ambiente virtual”. As informações com relação à assinatura do TCLE ou aos direitos do participante da pesquisa podem ser obtidas por meio do e-mail do CEP/CHS: cep_chs@unb.br ou pelo telefone: (61) 3107-1592.

Enfatizamos a importância de você, como participante de pesquisa, guardar em seus arquivos uma cópia desse consentimento, se assim o desejar, imprimindo ou fazendo um print desta página.

O registro de consentimento ocorrerá ao clicar no botão abaixo, caso decida participar dessa pesquisa e você será direcionado/a para o primeiro questionário. Caso você não concorde em participar dessa pesquisa, basta você fechar essa janela.

## Appendix C – Informed Consent Form for Volunteers

Você está sendo convidado a participar da pesquisa "Avaliação Dimensional dos Transtornos da Personalidade: Estudos de Adaptação de Medidas da CID-11 para o Brasil", de responsabilidade de Lídia Figueiredo dos Santos, mestranda do Departamento de Psicologia Clínica da Universidade de Brasília. O objetivo desta pesquisa é investigar evidências de validade e fidedignidade dos instrumentos *Personality Assessment Questionnaire for ICD-11* (PAQ-11 R) e *Personality Disorder Severity ICD-11 Clinician-Rating Form* (PDS-ICD-11), traduzidos e adaptados para o português brasileiro. Assim, gostaríamos de consultá-lo/a sobre seu interesse e disponibilidade de cooperar com a pesquisa.

Para tanto, leia as informações apresentadas no Registro de Consentimento a seguir. Caso algo não esteja claro ou se você quiser mais informações, você pode entrar em contato conosco por meio do endereço de e-mail indicado a seguir. Você poderá obter esclarecimentos adicionais em qualquer momento da pesquisa (início, durante e após a finalização) por meio do e-mail: pesquisapersonalidadeunb@gmail.com. É assegurado que o seu nome não será divulgado, sendo mantido o mais rigoroso sigilo. Os dados provenientes de sua participação na pesquisa, a saber, suas respostas à entrevista, ficarão sob a guarda do pesquisador responsável pela pesquisa em local seguro, sendo garantido o sigilo e a confidencialidade das informações.

A coleta de dados será realizada por meio de uma entrevista com dois alunos de graduação em Psicologia treinados na aplicação de uma entrevista mediada por computador, sendo um aluno aplicador e outro observador. A entrevista tem questões sobre aspectos de sua personalidade e saúde e gostaríamos que você os respondesse de forma honesta e sincera. Após dar o seu consentimento, você responderá as perguntas de identificação deste formulário e depois você participará da entrevista. É para este procedimento que você está sendo convidado a participar.

Sua participação na pesquisa implica em risco mínimo, como ter que dispor de cerca de duas horas para participar de uma sessão de entrevista, além de poder apresentar cansaço ou algum desconforto ao longo da entrevista. Para tanto, lembramos que você pode interromper a participação a qualquer momento, assim como contatar o pesquisador para dúvidas.

Além disso, você precisa estar ciente que, desde que essa pesquisa contém procedimentos online, há sempre o risco de intrusão de agentes externos, como por exemplo hackers, e assim a possibilidade de ser identificado/a. Contudo, nós fazemos de tudo para garantir que isso não aconteça por meio do uso de um servidor seguro. Nós garantimos que os dados serão mantidos e guardados seguramente.

Espera-se com esta pesquisa oferecer para as comunidades clínica e científica, brasileira e internacional, versões dos instrumentos adaptados transculturalmente ao contexto brasileiro, que sejam válidos e fidedignos para a avaliação dos domínios da personalidade, conforme modelo dimensional da CID-11. Além disso, você poderá se beneficiar diretamente dessa pesquisa ao poder refletir e autoavaliar suas características de personalidade ao responder à entrevista.

Sua participação é voluntária e livre de qualquer remuneração. Você é livre para recusar-se a participar, retirar seu consentimento ou interromper sua participação a qualquer momento, bastando, para isso, fechar a página do navegador de internet sem clicar em "enviar". Por haver dados que permitem a sua identificação pessoal, caso você decida retirar seu consentimento, os dados poderão ser retirados da pesquisa mesmo após o envio das suas respostas.

Todas as perguntas desta pesquisa são de resposta obrigatória. No entanto, você tem o direito de não responder às questões desta pesquisa, se assim desejar, sem ser necessário você se justificar. Para tanto, basta interromper imediatamente a sua participação fechando a janela do questionário. A recusa em participar, ou interrupção após iniciar as respostas, não acarretará qualquer penalidade a você ou perda de benefícios.

Se você tiver qualquer dúvida em relação à pesquisa, você pode nos contatar através do telefone (31) 98860-3350 ou pelo e-mail pesquisapersonalidadeunb@gmail.com.

A equipe de pesquisa garante que os resultados de participação individual no estudo serão devolvidos aos participantes por meio do relatório de desempenho. Os resultados do estudo serão publicados na comunidade científica.

Este projeto foi revisado e aprovado pelo Comitê de Ética em Pesquisa em Ciências Humanas e Sociais (CEP/CHS) da Universidade de Brasília e estão de acordo de acordo com as orientações da CONEP, em especial, o OFÍCIO CIRCULAR No 2/2021/CONEP/SECNS/MS, “sobre procedimentos em pesquisa com qualquer etapa em ambiente virtual”. As informações com relação à assinatura do TCLE ou aos direitos do participante da pesquisa podem ser obtidas por meio do e-mail do CEP/CHS: cep_chs@unb.br ou pelo telefone: (61) 3107-1592.

Enfatizamos a importância de você, como participante de pesquisa, guardar em seus arquivos uma cópia desse consentimento, se assim o desejar, imprimindo ou fazendo um print desta página.

O registro de consentimento ocorrerá ao clicar na resposta “Sim.” no formulário, caso decida participar dessa pesquisa e você será direcionado para o primeiro questionário. Caso você não concorde em participar dessa pesquisa, basta você fechar essa janela.

## Appendix D – Informed Consent Form for Undergraduate Psychology Students

Você está sendo convidado a participar da pesquisa "Avaliação Dimensional dos Transtornos da Personalidade: Estudos de Adaptação de Medidas da CID-11 para o Brasil", de responsabilidade de Lídia Figueiredo dos Santos, mestranda do Departamento de Psicologia Clínica da Universidade de Brasília. O objetivo desta pesquisa é investigar evidências de validade e fidedignidade dos instrumentos Personality Assessment Questionnaire for ICD-11 (PAQ-11 R) e Personality Disorder Severity ICD-11 Clinician-Rating Form (PDS-ICD-11), traduzidos e adaptados para o português brasileiro.

Assim, gostaríamos de consultá-lo/a sobre seu interesse e disponibilidade de cooperar com a pesquisa. Para tanto, leia as informações apresentadas no Registro de Consentimento a seguir. Caso algo não esteja claro ou se você quiser mais informações, você pode entrar em contato conosco por meio do endereço de e-mail indicado a seguir.

Você poderá obter esclarecimentos adicionais em qualquer momento da pesquisa (início, durante e após a finalização) por meio do e-mail: pesquisapersonalidadeunb@gmail.com. É assegurado que as informações serão mantidas em sigilo pelos pesquisadores. Para participar da pesquisa, você deverá fazer um curso para treinamento teórico-prático em avaliação de trasntorno da personalidade conforme o modelo dimensional da CID-11, após, você deverá fazer duas avaliações de outros participantes, o que implicará em informar dados de identificação seus e das pessoas que você irá avaliar, mediante consentimento delas também. Os dados provenientes de sua participação na pesquisa, a saber, suas respostas aos questionários, ficarão sob a guarda do pesquisador responsável pela pesquisa em local seguro, sendo garantido o sigilo e a confidencialidade das informações.

A coleta de dados será realizada por meio de entrevista computadorizada e questionários eletrônicos nessa plataforma online, sendo que o trabalho será realizado em duplas de participantes. O primeiro questionário diz respeito a aspectos sociodemográficos, enquanto o segundo questionário possui questões referentes a aspectos da personalidade da pessoa que você está avaliando. Gostaríamos que você os respondesse de forma honesta e sincera, com base em seu conhecimento técnico-científico sobre a pessoa a qual atende. Após dar o seu consentimento, você primeiro responderá ao questionário sociodemográfico, e, em seguida, responderá ao instrumento. É para este procedimento que você está sendo convidado a participar.

Sua participação na pesquisa implica em risco mínimo, como ter que dispor de cerca de 15 horas de treinamento, quatro horas de avaliação (total de duas pessoas avaliadas, sendo duas horas por pessoa) e 40 minutos para responder aos questionários, além de poder apresentar cansaço ou algum desconforto ao longo dos questionários. Para tanto, lembramos que você pode interromper a participação a qualquer momento, assim como contatar o pesquisador para dúvidas. Além disso, você precisa estar ciente que, desde que essa pesquisa é online, há sempre o risco de intrusão de agentes externos, como por exemplo hackers, e assim a possibilidade de ser identificado/a. Contudo, nós fazemos de tudo para garantir que isso não acontecerá por meio do uso de um servidor seguro. Nós garantimos que os dados serão mantidos e guardados seguramente.

Espera-se com esta pesquisa oferecer para as comunidades clínica e científica, brasileira e internacional, versões dos instrumentos adaptados transculturalmente ao contexto brasileiro, que sejam válidos e fidedignos para a avaliação dos domínios da personalidade, conforme modelo dimensional da CID-11. Além disso, você poderá se beneficiar diretamente dessa pesquisa ao poder refletir e avaliar sobre as características da personalidade de seu paciente ao responder os questionários.

Sua participação é voluntária e livre de qualquer remuneração. Você é livre para recusar-se a participar, retirar seu consentimento ou interromper sua participação a qualquer momento, bastando, para isso, fechar a página do navegador de internet sem clicar em "enviar". Por haver dados que permitem a sua identificação pessoal, caso você decida retirar seu consentimento, os dados poderão ser retirados da pesquisa mesmo após o envio das suas respostas.

Todas as perguntas desta pesquisa são de resposta obrigatória. No entanto, você tem o direito de não responder às questões desta pesquisa, se assim desejar, sem ser necessário você se justificar. Para tanto, basta interromper imediatamente a sua participação fechando a janela do questionário. A recusa em participar, ou interrupção após iniciar as respostas, não irá acarretar qualquer penalidade a você ou perda de benefícios.

Se você tiver qualquer dúvida em relação à pesquisa, você pode nos contatar através do telefone (31) 98860-3350 ou pelo e-mail pesquisapersonalidadeunb@gmail.com.

Ao participar da pesquisa, você contribui para a ciência e consente com a publicação dos resultados do estudo na comunidade científica.

Este projeto foi revisado e aprovado pelo Comitê de Ética em Pesquisa em Ciências Humanas e Sociais (CEP/CHS) da Universidade de Brasília e estão de acordo de acordo com as orientações da CONEP, em especial, o OFÍCIO CIRCULAR Nº 2/2021/CONEP/SECNS/MS, "sobre procedimentos em pesquisa com qualquer etapa em ambiente virtual". As informações com relação à assinatura do TCLE ou aos direitos do participante da pesquisa podem ser obtidas por meio do e-mail do CEP/CHS: cep_chs@unb.br ou pelo telefone: (61) 3107-1592.

Enfatizamos a importância de você, como participante de pesquisa, guardar em seus arquivos uma cópia deste consentimento, se assim o desejar, imprimindo ou fazendo um print desta página.

O registro de consentimento ocorrerá ao clicar no botão abaixo "Aceito participar", caso decida participar dessa pesquisa e você será direcionado para o primeiro questionário. Caso você não concorde em participar dessa pesquisa, basta você fechar essa janela.

## Appendix E – Sociodemographic Questionnaire for Psychologists

1. Nome completo:

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2. CPF:

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3. CRP:

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4. Estado em que atua:

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5. E-mail:

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6. Formação:

- Graduação Completa
- Especialização
- Mestrado
- Doutorado
- Pós-Doutorado

7. Área de atuação:

- Avaliação Psicológica
- Psicoterapia
- Avaliação e Psicoterapia
- Perícia
- Outra: _____

8. Tempo de atuação na área:

- Menos de 1 ano
- Entre 1 a 2 anos
- Entre 2 a 5 anos
- Entre 5 a 10 anos
- Entre 10 a 15 anos
- Mais de 15 anos

## Appendix F – Sociodemographic Questionnaire for Patients

1. Qual o nome do(a) seu(a) psicólogo(a)?

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2. Qual seu CPF?

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3. Qual seu e-mail?

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4. Qual a sua idade?

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5. Como você foi designado(a) ao nascimento, nos seus registros civis?

- Feminino
- Masculino
- Prefiro não responder

6. Qual das seguintes alternativas descreve melhor a forma como você se identifica hoje?

- Mulher
- Homem
- Mulher trans, mulher transexual ou mulher transgênero
- Homem trans, homem transexual ou homem transgênero
- Travesti
- Queer, não-binário ou gênero flúido
- Outro: _____

7. Qual a sua cor/raça/etinia?

- Branca
- Preta
- Parda
- Amarela (asiática)
- Indígena
- Outro: _____
- Prefiro não declarar

8. Qual o seu estado civil?

- Solteiro(a)
- União estável
- Casado(a)

- Separado(a)
- Divorciado(a)
- Viúvo(a)
- Prefiro não declarar

9. Qual sua ocupação?

- Trabalho/estudo
- Do lar
- Desempregado(a)
- Aposentado(a)
- Licença saúde
- Licença materinidade
- Outro: _____

10. Qual a renda familiar mensal? (somatório dos recebimentos de todas as pessoas que moram com você)

- Até R$ 847.69
- Até R$ 1,839.95
- Até R$ 3,086.88
- Até R$ 5,524.29
- Até R$ 10,450.96
- Até R$ 22,435.43
- Mais que R$ 22,435.43

11. Qual a sua escolaridade?

- Ensino fundamental incompleto
- Ensino fundamental completo
- Ensino médio incompleto
- Ensino médio completo
- Graduação incompleta
- Graduação completa
- Pós-Graduação incompleta (especialização, mestrado ou doutorado)
- Pós-Graduação completa (especialização, mestrado ou doutorado)

12. Em qual Estado você reside?

- Acre - AC
- Alagoas - AL
- Amapá - AP
- Amazonas - AM
- Bahia - BA
- Ceará - CE
- Distrito Federal - DF
- Espírito Santo - ES
- Goiás - GO
- Maranhão - MA
- Mato Grosso - MT

- Mato Grosso do Sul - MS
- Minas Gerais - MG
- Pará - PA
- Paraíba - PB
- Paraná - PR
- Pernambuco - PE
- Piauí - PI
- Rio de Janeiro - RJ
- Rio Grande do Norte - RN
- Rio Grande do Sul - RS
- Rondônia - RO
- Roraima - RR
- Santa Catarina - SC
- São Paulo - SP
- Sergipe - SE
- Tocantins - TO

13. Você está fazendo algum tratamento psicológico no momento?

- Sim / Não

14. Você está fazendo algum tratamento psiquiátrico no momento?

- Sim / Não

15. Você toma algum medicamento psiquiátrico?

- Sim / Não

16. Você tem algum diagnóstico relacionado à saúde mental?

- Sim / Não

17. Quais?

---

## Appendix G – Sociodemographic Questionnaire for Volunteers

1. Qual seu nome?

---

2. Qual seu e-mail?

---

3. Qual seu número de telefone?

---

4. Qual seu CPF?

---

5. Quais são os melhores dias e horários para uma sessão presencial na Universidade de Brasília?

---

6. Qual a sua idade?

---

7. Como você foi designado(a) ao nascimento, nos seus registros civis?

- Feminino
- Masculino
- Prefiro não responder

8. Qual das seguintes alternativas descreve melhor a forma como você se identifica hoje?

- Mulher
- Homem
- Mulher trans, mulher transexual ou mulher transgênero
- Homem trans, homem transexual ou homem transgênero
- Travesti
- Queer, não-binário ou gênero flúido
- Outro: _____

9. Qual a sua cor/raça/etinia?

- Branca
- Preta
- Parda
- Amarela (asiática)

- Indígena
- Outro: _____
- Prefiro não declarar

10. Qual o seu estado civil?

- Solteiro(a)
- União estável
- Casado(a)
- Separado(a)
- Divorciado(a)
- Viúvo(a)
- Prefiro não declarar

11. Qual sua ocupação?

- Trabalho/estudo
- Do lar
- Desempregado(a)
- Aposentado(a)
- Licença saúde
- Licença materinidade
- Outro: _____

12. Qual a renda familiar mensal? (somatório dos recebimentos de todas as pessoas que moram com você)

- Até R$ 847.69
- Até R$ 1,839.95
- Até R$ 3,086.88
- Até R$ 5,524.29
- Até R$ 10,450.96
- Até R$ 22,435.43
- Mais que R$ 22,435.43

13. Qual a sua escolaridade?

- Ensino fundamental incompleto
- Ensino fundamental completo
- Ensino médio incompleto
- Ensino médio completo
- Graduação incompleta
- Graduação completa
- Pós-Graduação incompleta (especialização, mestrado ou doutorado)
- Pós-Graduação completa (especialização, mestrado ou doutorado)

14. Em qual Estado você reside?

- Acre - AC
- Alagoas - AL

- Amapá - AP
- Amazonas - AM
- Bahia - BA
- Ceará - CE
- Distrito Federal - DF
- Espírito Santo - ES
- Goiás - GO
- Maranhão - MA
- Mato Grosso - MT
- Mato Grosso do Sul - MS
- Minas Gerais - MG
- Pará - PA
- Paraíba - PB
- Paraná - PR
- Pernambuco - PE
- Piauí - PI
- Rio de Janeiro - RJ
- Rio Grande do Norte - RN
- Rio Grande do Sul - RS
- Rondônia - RO
- Roraima - RR
- Santa Catarina - SC
- São Paulo - SP
- Sergipe - SE
- Tocantins - TO

15. Você está fazendo algum tratamento psicológico no momento?

- Sim / Não

16. Você está fazendo algum tratamento psiquiátrico no momento?

- Sim / Não

17. Você toma algum medicamento psiquiátrico?

- Sim / Não

18. Você tem algum diagnóstico relacionado à saúde mental?

- Sim / Não

19. Quais?

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## Appendix H – Brazilian version of the PDS-ICD-11-CRF

**Por favor, para cada área listada abaixo, selecione a afirmação que melhor descreve, em geral, como a pessoa tem sido nos últimos dois anos.**

### 1. Identidade

| | |
|---|---|
| **2** | Frequentemente não tem noção de si mesmo(a) ou de sua identidade, especialmente quando está com outras pessoas (ex.: tem limites muito fracos entre si e os outros; baseia a própria identidade em fatores externos). |
| **1** | Às vezes fica confuso(a) sobre si mesmo(a) ou sua identidade, especialmente quando está com outras pessoas (ex.: identifica-se exageradamente com os outros; espelha os comportamentos ou interesses dos outros). |
| **0** | Tem uma noção estável de si mesmo(a) ou de sua identidade. |
| **1** | Tem uma noção de si mesmo(a) ou de sua identidade que geralmente é muito fixa e restrita (ex.: foca rigidamente em um papel pessoal ou ocupacional específico). |
| **2** | Tem uma noção de si mesmo(a) ou de sua identidade excessivamente restrita e imutável, não importando as circunstâncias (ex.: foco extremo em um papel pessoal ou ocupacional específico a qualquer custo). |

### 2. Valor pessoal

| | |
|---|---|
| **2** | Sente-se sem valor na maior parte do tempo, o que causa sofrimento significativo ou afeta os relacionamentos com outras pessoas. |
| **1** | Frequentemente experimenta baixa autoestima, o que causa angústia ou às vezes afeta os relacionamentos com outras pessoas. |
| **0** | Geralmente não experimenta problemas com a autoestima. |
| **1** | Geralmente se sente melhor do que os outros, o que afeta os relacionamentos com outras pessoas. |
| **2** | Sente-se superior aos outros, o que afeta a forma como se relaciona com outras pessoas. |

### 3. Autopercepção

| | |
|---|---|
| **2** | Acredita que não tem pontos fortes ou qualidades (isto é, falta de características positivas). |

| | |
|---|---|
| **1** | Acredita que tem poucos pontos fortes ou qualidades (isto é, poucas características positivas). |
| **0** | Tem uma boa percepção de seus próprios pontos fortes e limitações. |
| **1** | Acredita que tem poucas limitações ou fraquezas (isto é, poucas características negativas). |
| **2** | Acredita que não tem limitações ou fraquezas (isto é, ausência de características negativas). |

**4. Metas**

| | |
|---|---|
| **2** | Raramente é capaz de estabelecer e seguir metas realistas (ex.: apresenta comportamento impulsivo ou precipitado que causa problemas para buscar ou alcançar suas metas; dificuldade para buscar ou alcançar metas devido à insegurança ou vergonha). |
| **1** | Às vezes tem dificuldade em estabelecer e seguir metas realistas (ex.: devido à insegurança, dependência, impulsividade ou falta de planejamento). |
| **0** | Consegue estabelecer e seguir metas realistas. |
| **1** | Às vezes se torna obstinado(a) em alcançar suas metas, com dificuldade em flexibilizá-las (ex.: tem padrões rígidos, expectativas excessivamente obstinadas ou irrealistas; persiste injustificadamente em busca de metas que têm poucas chances de sucesso). |
| **2** | Regularmente se torna obstinado(a) em alcançar suas metas e acha quase impossível flexibilizá-las (ex.: é completamente rígido(a) ou extremamente teimoso(a)). |

**5. Interesse em relacionamentos**

| | |
|---|---|
| **2** | Esforça-se para evitar contato com outras pessoas a ponto de causar problemas significativos (ex.: tende a se isolar por completo ou se sente extremamente angustiado(a) ao interagir com outras pessoas). |
| **1** | Às vezes, evita outras pessoas a ponto de causar problemas (ex.: busca isolamento social ou se sente angustiado(a) ao interagir com outras pessoas). |
| **0** | Tem um bom equilíbrio entre se sentir confortável em estar sozinho(a) e em estar com outras pessoas. |
| **1** | Às vezes fica angustiado(a) ou chateado(a) quando não está perto de outras pessoas (ex.: sente-se solitário(a) ou carente de atenção). |
| **2** | Frequentemente fica angustiado(a), chateado(a) ou desesperado(a) quando não está perto de outras pessoas (ex.: sente solidão extrema, abandono ou forte carência de atenção). |

### 6. Tomada de perspectiva

| | |
|---|---|
| **2** | Nunca considera ou entende os pensamentos e sentimentos das outras pessoas, o que causa problemas sérios nos relacionamentos. |
| **1** | Frequentemente desconsidera ou não entende os pensamentos e sentimentos das outras pessoas, o que causa problemas nos relacionamentos. |
| **0** | Considera e consegue compreender facilmente os pensamentos e sentimentos das outras pessoas. |
| **1** | Frequentemente considera intensamente ou passa muito tempo preocupado(a) com o que os outros pensam ou sentem, o que causa angústia. |
| **2** | Sempre considera muito intensamente o que os outros pensam ou sentem, passando longo período de tempo preocupado(a) com isso, o que causa sério sofrimento. |

### 7. Reciprocidade nos relacionamentos

| | |
|---|---|
| **2** | É sempre muito egoísta, o que causa problemas nos relacionamentos (ex.: comportamento abusivo, manipulador ou altamente controlador que envolve danos ou sofrimento grave a outras pessoas). |
| **1** | Às vezes é muito egoísta, o que causa problemas nos relacionamentos (ex.: comportamento rude, indiferente, insubordinado ou dominador que envolve conflitos ou sofrimento a outras pessoas). |
| **0** | É capaz de estabelecer e manter relacionamentos próximos e mutuamente satisfatórios (ex.: prioriza adequadamente as necessidades próprias e dos outros). |
| **1** | Às vezes é incapaz de priorizar a si mesmo(a) nos relacionamentos, mesmo quando é prejudicado(a) pelos outros (ex.: coloca as necessidades dos outros acima de suas próprias, o que causa sofrimento; permanece em um relacionamento disfuncional). |
| **2** | Raramente é capaz de priorizar a si mesmo(a) nos relacionamentos, mesmo quando é prejudicado(a) pelos outros (ex.: é excessivamente submisso(a) a ponto de se sentir incapaz de terminar o relacionamento, mesmo sofrendo abuso, sendo controlado(a) ou também vitimizado(a) por outros). |

### 8. Gestão de desentendimentos

| | |
|---|---|
| **2** | Frequentemente discute ou tem conflitos com os outros, o que causa sérios problemas de relacionamento (ex.: resulta na ausência de amizades confiáveis ou relacionamentos românticos). |
| **1** | Às vezes entra em discussões ou conflitos com os outros, o que causa problemas de relacionamento (ex.: resulta em poucas amizades ou dificuldade em manter relacionamentos românticos). |
| **0** | É capaz de administrar desentendimentos ou conflitos nos relacionamentos de forma cooperativa. |
| **1** | Geralmente evita desentendimentos e conflitos com outros, o que lhe causa problemas (ex.: tem dificuldades em expressar assertivamente suas necessidades resultando em uma baixa satisfação). |
| **2** | Evita desentendimentos e conflitos com os outros a qualquer custo, o que lhe causa sérios problemas (ex.: é incapaz de expressar assertivamente suas necessidades, resultando em falta de satisfação). |

### 9. Controle e expressão emocionais

| | |
|---|---|
| **2** | Frequentemente não consegue regular suas emoções, o que causa sérios problemas para si ou para os outros. |
| **1** | Às vezes tem dificuldade em regular suas emoções, o que causa sérios problemas para si ou para os outros. |
| **0** | Geralmente é capaz de regular e expressar suas emoções de forma apropriada. |
| **1** | Às vezes suprime ou não expressa suas emoções, incluindo alexitimia (dificuldade de reconhecer emoções), o que causa alguns problemas para si ou para os outros. |
| **2** | Quase sempre suprime ou nunca expressa suas emoções, incluindo alexitimia severa (dificuldade de reconhecer emoções), que causa problemas sérios para si ou para os outros. |

### 10. Controle comportamental

| | |
|---|---|
| **2** | Frequentemente age de forma tão precipitada ou impulsiva que causa sérios problemas para si mesmo(a). |
| **1** | Às vezes age por impulso sem considerar as consequências, o que causa problemas para si. |

| | |
|---|---|
| **0** | Geralmente é capaz de manter a espontaneidade enquanto mantém um controle apropriado de suas próprias ações. |
| **1** | Às vezes é tão controlado(a) em suas ações que não aproveita a vida da mesma forma que os outros (ex.: deixa de desfrutar oportunidades não planejadas). |
| **2** | Frequentemente é tão controlado(a) em suas ações que quase nunca aproveita a vida (ex.: é tão controlado que prefere perder momentos importantes se esses não foram planejados com antecedência). |

**11. Percepção da realidade durante estresse**

| | |
|---|---|
| **0** | Mesmo quando muito estressado(a), é geralmente capaz de perceber a realidade situacional ou interpessoal de forma precisa. |
| **1** | Quando muito estressado(a), a percepção da realidade situacional ou interpessoal é, em alguma medida, distorcida (ex.: espera que o pior aconteça; sensação de rejeição quando criticado(a) pelos outros). |
| **2** | Quando muito estressado(a), a percepção da realidade situacional ou interpessoal é significativamente distorcida (ex.: desconfia excessivamente dos outros; experimenta estados semelhantes a sonhos). |
| **3** | Quando muito estressado(a), a percepção da realidade situacional ou interpessoal é geralmente perdida (ex.: apresenta alucinações transitórias ou outras experiências bizarras; apresenta despersonalização; demonstra desconfiança extrema). |

**12. Fazer mal a si próprio(a)** (intencional ou não intencional)

| | |
|---|---|
| **0** | Nunca faz mal a si mesmo(a). |
| **1** | Raramente faz mal a si mesmo(a) (ex.: uma ou duas pequenas ações prejudiciais contra si; sem gestos suicidas). |
| **2** | Às vezes faz mal a si mesmo(a) (ex.: poucas ações prejudiciais contra si; pelo menos um gesto suicida). |
| **3** | Frequentemente faz mal a si mesmo(a) (ex.: muitas ações prejudiciais contra si; gestos suicidas significativos). |

**13. Fazer mal aos outros** (intencional ou não intencional)

| | |
|---|---|
| **0** | Nunca faz mal aos outros. |
| **1** | Raramente faz mal aos outros (ex.: uma agressão física; um incidente colocando os outros em risco). |

| | |
|---|---|
| **2** | Às vezes faz mal aos outros (ex.: múltiplas agressões físicas ou incidentes colocando os outros em risco). |
| **3** | Frequentemente faz mal aos outros (ex.: recorrentes agressões físicas ou incidentes colocando os outros em risco). |

**14. Ao considerar todas as respostas (isto é, nos itens de 1 a 13), até que ponto elas causam prejuízo em áreas importantes da vida da pessoa (por exemplo, pessoal, familiar, social, escolar, profissional)?**

| | |
|---|---|
| **0** | *Nenhuma ou alguma dificuldade* (ex.: nenhuma alteração notável nos relacionamentos sociais, ocupacionais e interpessoais; os problemas são limitados a relacionamentos ou situações específicos). |
| **1** | *Prejuízo leve* (ex.: limitado a áreas circunscritas, como relacionamentos românticos e emprego; presente em mais áreas, mas de gravidade mais leve; geralmente, é capaz de sustentar o emprego e manter alguns relacionamentos, mas pode ter problemas com supervisores, colegas de trabalho e amigos). |
| **2** | *Prejuízo moderado* (ex.: prejuízo acentuado em algumas áreas do funcionamento enquanto outras podem estar preservadas; os relacionamentos são provavelmente caracterizados por conflitos, evitações, isolamentos ou extrema dependência). |
| **3** | *Prejuízo grave* (ex.: comprometimento grave em todas ou quase todas as áreas da vida; afetando gravemente praticamente todos os relacionamentos; capacidade e disposição ausentes ou gravemente comprometidas para realizar papéis sociais e ocupacionais esperados). |

# Appendix I – Administration and Interpetration Manual of the Brazilian version of the PDS-ICD-11-CRF

## Manual de Aplicação e Interpretação

O PDS-ICD-11 *Clinician-Rating Form* foi desenvolvido de acordo com as descrições clínicas e requisitos diagnósticos da 11ª edição da Classificação Internacional de Doenças (CID-11) da Organização Mundial de Saúde (OMS) para determinar a presença e a severidade do transtorno da personalidade.

### Desenvolvimento

O formulário original foi desenvolvido por Bo Bach, Tiffany Brown & Martin Sellbom por meio da colaboração de dois centros de pesquisa:

*Department of Psychology*
*Personality, Psychopathology, and Measurement (PPM) Lab*
*University of Otago*
*Dunedin 9016, New Zealand*

*Psychiatric Research Unit*
*Center for Personality Disorder Research (CPDR)*
*Mental Health Services, Region Zealand*
*Slagelse 4200, Denmark*

### Adaptação brasileira

A adaptação foi realizada por Lídia Figueiredo dos Santos & Sérgio Eduardo Silva de Oliveira do Núcleo de Estudos em Avaliação Psicológica Clínica (NEAPSIC) do Instituto de Psicologia da Universidade de Brasília.

## Citação do PDS-ICD-11 *Clinician-Rating Form*

Sellbom, M., Brown, T. A., & Bach, B. (2023). Development and psychometric evaluation of the Personality Disorder Severity ICD-11 (PDS-ICD-11) Clinician-Rating Form. *Personality and Mental Health*, *18*(1), 60-68. https://doi.org/10.1002/pmh.1596

# Transtornos da Personalidade

## Descrição

Transtorno de personalidade é caracterizado por problemas no funcionamento de aspectos do "self" (p. ex., identidade, autoestima, precisão do autoconceito, autodirecionamento) e/ou disfunção interpessoal (p. ex., capacidade de desenvolver e manter relacionamentos próximos e mutuamente satisfatórios, capacidade de compreender os pontos de vista de outras pessoas e de lidar com conflito em relacionamentos) que persistem durante um longo período de tempo (p. ex., 2 anos ou mais). A perturbação é evidenciada por padrões de cognição, experiência emocional, expressão emocional e comportamento que são maladaptativos (p. ex., inflexíveis ou mal regulados) e é evidenciada em uma série de situações pessoais e sociais (i. e., não está limitada a relacionamentos ou papéis sociais específicos). Os padrões de comportamento que caracterizam o distúrbio não são adequadas ao estágio de desenvolvimento e não podem ser explicados primariamente por fatores sociais ou culturais, incluindo conflito sócio-político. O distúrbio está associado a sofrimento substancial ou prejuízo significativo no funcionamento pessoal, familiar, social, educacional, ocupacional ou de outras áreas importantes (OMS, 2024).

### Classificações

- 6D10.0 Transtorno de personalidade leve
- 6D10.1 Transtorno de personalidade moderado
- 6D10.2 Transtorno de personalidade grave
- 6D10.Z Transtorno de personalidade, gravidade não especificada
- QEHO.7 Personalidade difícil

## 6D11 Traços ou padrões de personalidade proeminentes

Qualificadores de domínios de traços podem ser aplicados a Transtornos de Personalidade ou Dificuldade de Personalidade para descrever as características da personalidade do indivíduo que são mais proeminentes e que contribuem para a perturbação da personalidade. Domínios de traços são contínuos com características normais de personalidade em indivíduos que não têm Transtorno de Personalidade ou Dificuldade de Personalidade. Domínios de traço não são categorias diagnósticas, mas sim representam um conjunto de dimensões que corresponde à estrutura subjacente da personalidade. Podem ser aplicados tantos qualificadores de domínios de traço quanto forem necessários para descrever o funcionamento da personalidade. Indivíduos com perturbação mais grave da personalidade tendem a ter maior número de domínios de traço proeminentes (OMS, 2024).

**Traços:** Afetividade Negativa, Distanciamento, Desinibição, Antissocialidade e Anancastia.

# Aplicação

## Instruções para aplicação

O PDS-ICD-11 *Clinician-Rating Form* é um instrumento de heterorrelato, no qual o clínico avalia a pessoa a quem presta atendimento. O formulário deve ser preenchido com base em características clínicas observadas ao longo dos últimos dois anos da vida do indivíduo. Ressalta-se que o preenchimento deve ser realizado fora do horário das sessões, com base no conhecimento clínico acumulado pelo profissional ao longo do acompanhamento do avaliado.

## Número de itens

- 14 itens.
- Os 10 primeiros itens consistem na indicação, entre 5 afirmativas em uma escala bipolar, de qual afirmativa melhor reflete o funcionamento do paciente. Nesse sentido, uma resposta intermediária (“0”) reflete o funcionamento normal da personalidade, enquanto prejuízos são abordados nas extremidades de cada pólo do espectro (“2”: prejuízos mais graves, e “1”: prejuízos leves ou moderados).
- Os 4 últimos itens foram classificados em uma escala de 4 pontos que varia de “0” a “3”.
- O último item refere-se à avaliação global da severidade, variando entre “nenhuma ou alguma dificuldade”, “prejuízo leve”, “prejuízo moderado” e “prejuízo grave”.
- A partir das respostas, a pontuação total indica a severidade global do transtorno.
- Nos casos em que o indivíduo pode ser classificado com mais de uma resposta para um item, deve-se considerar a resposta com maior pontuação.

## Instrução para pontuação

- Itens 1-10 são pontuados: 2 – 1 – 0 – 1 – 2.

- Itens 11-14 são pontuados: 0 – 1 – 2 – 3.
- O PDS-ICD-11 *Clinician-Rating Form* é pontuado pela soma dos escores para todos os 14 itens (somatório dos escores varia de 0 a 32).

## Itens

1. Identidade
2. Valor pessoal
3. Autopercepção
4. Metas
5. Interesse em relacionamentos
6. Tomada de perspectiva
7. Reciprocidade nos relacionamentos
8. Gestão de desentendimentos
9. Controle e expressão emocionais
10. Controle comportamental
11. Percepção da realidade durante estresse
12. Fazer mal a si próprio(a) (intencional ou não intencional)
13. Fazer mal aos outros (intencional ou não intencional)
14. Avaliação global da severidade

## Interpretação dos itens

PDS-CID-11: Itens Bipolares com Definições e Caracterizações dos Polos Disfuncionais e dos Pontos Médios Funcionais

| Dimensão (Definição) | Polo Esquerdo (Disfuncional) | Ponto Médio (Funcionamento Saudável) | Polo Direito (Disfuncional) |
|---|---|---|---|
| **Identidade** (Capacidade de manter um senso coerente, estável e contínuo de self) | **Difusa, instável** (Não sabe quem é; não consegue se diferenciar das pessoas; apresenta uma imagem de si instável – muda com frequência a forma como se vê) | **Sentido de self claro, estável e integrado** (Sabe quem é; integra os múltiplos papéis em um self integrado) | **Rígida, excessivamente fixa** (Se define exclusivamente por meio de um papel – trabalho, social, família, religião; tem uma ideia muito fixa de si mesmo sem considerar nuances) |
| **Autoestima** (Avaliação emocional geral de si próprio, incluindo valor próprio e autoconfiança) | **Autoestima baixa, autodesvalorização** (Não gosta de si mesmo; bastante crítico e rígido em relação a si mesmo; autoestima frágil às críticas e opiniões das pessoas) | **Autoestima realista e estável** (Tem uma estima pessoal adequada; valoriza o self em adequada proporção; tem segurança emocional em relação ao self) | **Autoestima inflada, arrogância** (Tem uma estima pessoal irrealista; valoriza excessivamente o self; sente uma autoconfiança desproporcional, acreditando ser capaz ou bom em coisas que não tem habilidades) |
| **Autopercepção** (Imagem que a pessoa tem de si mesma, incluindo características, habilidades e limitações) | **Autodepreciativa, excessivamente negativa** (Foca nos próprios defeitos; hipervaloriza os erros que comete; acredita ser inadequado; subestima as próprias capacidades) | **Autoimagem equilibrada e precisa** (Tem uma percepção realista de suas capacidades e limitações; reconhece seus defeitos e qualidades de forma adequada; conhece bem o que consegue e não consegue fazer) | **Grandiosa, visão exagerada de si** (Se vê mais habilidoso do que realmente é; não reconhece os erros que comete, minimizando os próprios defeitos e usando fatores externos para explicar os próprios erros; superestima as próprias capacidades) |
| **Metas** | **Sem rumo, falta de direção** (Não sabe quem quer ser na vida; não consegue estabelecer metas de | **Busca de metas com adequada flexibilidade e com propósito** | **Metas rígidas, irreais** (Estabelece metas de vida exageradas, irrealistas; obcecado na busca de seus |

| | | | |
|---|---|---|---|
| (Capacidade de definir e perseguir objetivos de forma eficaz e realista) | vida; falha em perseguir seus objetivos, os abandonando; muda frequentemente suas metas) | (Sabe quem quer ser na vida; estabelece metas de vida que são realistas e que podem ser flexibilizadas diante das contingências da vida; persiste na busca por alcançar seus objetivos, mesmo diante de dificuldades) | objetivos, a ponto de prejudicar outras áreas de sua vida; problemas para mudar metas que não são atingíveis, persistindo em propósitos excessivos; rígido na ideia de conquistar as próprias metas) |
| **Interesse por relacionamentos** (Engajamento social e desejo de manter vínculos significativos) | **Isolamento social, desinteresse** (Evita ativamente interações com as pessoas; demonstra acentuado desconforto em situações sociais; não tem interesse em se relacionar com as pessoas) | **Engajamento, valoriza e mantém relacionamentos recíprocos** (Tem apreço pelas relações que possui; mesmo se tímido gosta de estar com as pessoas com quem tem afinidade e valoriza momentos interpessoais; mostra interesse pelas pessoas e desejo de manter relações significativas com os outros) | **Dependente em excesso, pegajoso** (Não consegue ficar só; tem necessidade excessiva do asseguramento das outras pessoas para a tomada de decisões; depende das pessoas para o bem-estar pessoal; acredita ser mais íntimo do que realmente é das pessoas; excessivamente dependente e demandante das pessoas; usa das relações para segurança pessoal) |
| **Tomada de perspectiva** (Capacidade de compreender e considerar os sentimentos e pontos de vista dos outros) | **Egocêntrica, sem perspectiva** (Problema para considerar as perspectivas das pessoas; não se importa com os sentimentos alheios; se alguém discorda do seu ponto de vista, reage agressivamente e interpreta a discordância como uma ameaça; autocentrado, importando exclusivamente com suas próprias necessidades) | **Considera pontos de vista alheios mantendo distinção entre si e o outro** (Consegue considerar e respeitar múltiplas perspectivas; consegue equilibrar a satisfação das próprias necessidades e das dos outros; sabe ceder e sabe assegurar os próprios desejos; consegue diferenciar as próprias necessidades das dos outros) | **Superidentificação, fronteiras confusas** (Apresenta submissão aos outros; tem uma excessiva preocupação com o bem-estar dos outros a ponto de se autoanular; tem preocupação excessiva com o que os outros pensam ou sentem em relação a si; foco excessivo nos outros; faz coisas que não gostaria para agradar os outros) |
| **Reciprocidade nos relacionamentos** | **Distante, emocionalmente frio** (Usa das relações para satisfação e ganhos pessoais; recebe mais do que | **Intimidade e autonomia equilibradas** | **Mesclado, envolvimento excessivo** (As relações são simbióticas; a pessoa dá muito mais do que recebe nas |

| | | | |
|---|---|---|---|
| (Capacidade de manter relacionamentos íntimos e equilibrados em termos de reciprocidade) | dá nas relações; manipula os outros para conseguir o que quer; as relações não são genuínas, mas utilitárias, para se obter vantagens) | (Estabelece relações de reciprocidade; os relacionamentos são fonte de apoio mútuo e satisfatória para si e para os outros; há um equilíbrio entre dar e receber nas relações) | relações; sente-se insatisfeita nas relações, mas não consegue se afirmar para uma relação mais equilibrada; se submete aos outros sem capacidade para colocar limites) |
| **Gestão de desentendimentos** (Capacidade de reconhecer, enfrentar e resolver tensões ou desentendimentos com os outros de maneira construtiva e equilibrada) | **Confrontador, argumentativo** (Em situações interpessoais tensas tende a ser hostil e confrontador; perde a cabeça e agrava o conflito; teima e não cede, querendo ter a última palavra) | **Assertivo e respeitoso ao comunicar desentendimentos** (Apresenta uma postura diplomática, sendo capaz de gerir conflitos com respeito e assertividade; consegue estabelecer limites claros, se autoafirmando ao mesmo tempo que mantém o respeito e o cuidado à situação de desentendimento) | **Evita conflitos, submisso** (Em contextos interpessoais de conflito, evita ou foge da situação; se submete aos outros para evitar desentendimentos; não sabe se autoafirmar assertivamente em situações de conflitos; em conflitos pode apresentar comportamentos pouco adaptativos, como paralisar de medo, chorar por não conseguir gerir as próprias emoções) |
| **Controle e expressão emocionais** (Capacidade de expressar emoções de forma adequada e regulá-las quando necessário) | **Suprimida, distante** (Falha na capacidade de identificar suas próprias emoções adequadamente; apresenta uma pobre experiência e expressão emocionais; apresenta uma faixa limitada de emoções, geralmente caracterizada por poucas reações emocionais positivas e negativas; tende a sentir desprazer na vida; tem frieza emocional) | **Consciência emocional, expressa e regula emoções adequadamente** (Consegue reconhecer de forma adequada as próprias emoções, sendo capaz de descrevê-las e expressá-las de forma apropriada; experimenta emoções positivas e negativas de forma proporcional às situações; expressa as emoções positivas e negativas de forma controlada) | **Desregulada, intensa em excesso** (Experimenta de forma desproporcional as emoções positivas e negativas; é hiper-reativo emocionalmente; tem dificuldade para controlar a expressão emocional, tanto em relação a afetos positivos como a afetos negativos; é supersensível, pois mesmo coisas pequenas e cotidianas da vida o impactam significativamente) |
| **Controle comportamental** (Capacidade de gerenciar os impulsos e | **Impulsivo, imprudente** (Falha na capacidade de autorregulação comportamental; age impulsivamente; tem | **Regulação comportamental adaptativa e flexível** (Consegue balancear de forma flexível e adequada o modo como | **Excessivamente controlado, rígido** (É extremamente controlado, cuidando de forma meticulosa o modo como se comporta e se expressa; |

| | | | |
|---|---|---|---|
| comportamentos de forma apropriada ao contexto) | comportamentos imprudentes, falhando na capacidade de considerar riscos; é irresponsável e facilmente se distrai, não cumprindo suas obrigações) | se comporta, equilibrando o autocontrole e a espontaneidade; consegue flexibilizar o nível de autocontrole com relação ao contexto – por exemplo, aumentando o controle em contextos formais e afrouxando o controle em contextos de lazer) | gosta e busca ter o controle de tudo, sendo rígido na forma como conversa e interage com as pessoas; falta espontaneidade nas suas atitudes; tende a não ser genuíno em suas ações, mas sempre calculando suas falas e seus gestos e expressões) |

PDS-CID-11: Itens Unipolares com Definições e Caracterizações dos Contínuos que Variam da Funcionalidade à Disfuncionalidade

| **Dimensão (Definição)** | **Polo Esquerdo (Funcionamento Saudável)** | **Polo Direito (Disfuncional)** |
|---|---|---|
| **Percepção da realidade durante estresse** (Precisão nas avaliações e capacidade de tomar decisões em situações de incerteza) | **Percepção acurada, realista** (Consegue avaliar com acurácia situações tensas; não apresenta estado de confusão mental em situações estressantes, mantendo-se hábil para considerar de forma ampla e lúcida o que está acontecendo) | **Perda de contato com a realidade, ideias distorcidas** (Em situações estressantes apresenta ideias enviesadas de desconfiança ou de expectativa de que o pior vai acontecer; perde o contato com a realidade apresentando confusão mental, não sabendo pensar claramente as situações; pode apresentar ideias paranoides ou mesmo experiências de desconexão coma realidade) |
| **Fazer mal a si próprio(a)** (Tendência à autoagressão e a tomar decisões prejudiciais ao próprio bem-estar) | **Autocuidado e zelo para consigo** (Cuida de si mesmo; zela pelo próprio bem-estar; não se machuca física e emocionalmente de forma intencional ou não intencional a si mesmo; toma decisões que respeitam a própria integridade psicológica e física) | **Autossabotagem, suicidabilidade** (Tem ideias e condutas suicidas; machuca-se física e emocionalmente de forma intencional ou não intencional; pratica autossabotagem tomando decisões que fazem mal a si próprio) |
| **Fazer mal ao outro** (Comportamentos ou atitudes que causam sofrimento, prejuízo ou desconforto a outras pessoas) | **Cuidado e zelo para com o outro** (Tem cuidado para com as pessoas; preza pelo bem-estar psicológico e físico dos outros; toma decisões que garantem a integridade psicológica e física das pessoas) | **Hostil e agressivo com as pessoas** (Apresenta comportamentos hostis, antagonistas e pouco amistosos para com os outros; negligencia o bem-estar psicológico e físico das pessoas; toma decisões, intencional ou não intencionalmente, que prejudicam ou geram sofrimento aos outros) |

| | | |
|---|---|---|
| **Prejuízo psicossocial** (Sofrimento ou prejuízos em diferentes áreas da vida devido às características da personalidade) | **Funcionamento psicossocial saudável** (As próprias características da personalidade não interferem negativamente a sua vida; o funcionamento da personalidade gera satisfação pessoal e possibilita a condução de uma vida psicologicamente saudável) | **Prejuízos psicossociais ou sofrimento significativo** (Suas características de personalidade geram importantes sentimentos de insatisfação pessoal; sente vontade de ser diferente, pois sofre muito por ser quem é; tem importantes prejuízos familiares, sociais, românticos, laborais ou em outras áreas da vida por causa de suas características de personalidade) |

## Appendix J – PDS-ICD-11

Por favor, selecione a afirmação de cada uma das 14 áreas que melhor descreve você no geral.

### 1. Identidade

☐ Frequentemente não tenho ideia de quem eu sou, principalmente quando estou com outras pessoas.

☐ Às vezes me confundo sobre quem eu sou, principalmente quando estou com outras pessoas.

☐ A ideia que tenho sobre quem eu sou é estável.

☐ A ideia que tenho de quem eu sou é, geralmente, muito fixa e se limita a somente um aspecto da minha vida (ex.: me defino somente pelo meu trabalho ou pela relação que tenho com uma pessoa - pai/mãe, filho/a, cônjuge, etc.).

☐ A ideia que tenho sobre quem eu sou é excessivamente limitada a um aspecto da minha vida e imutável, independente das circunstâncias (ex.: eu não mudo quem eu sou mesmo que isso afete negativamente meus relacionamentos ou trabalho).

### 2. Valor pessoal

☐ Na maioria das vezes eu me sinto sem valor, e isso afeta a forma como me relaciono com as pessoas.

☐ Frequentemente tenho dificuldade em me sentir bem comigo mesmo(a) e isso às vezes afeta a forma como me relaciono com as pessoas.

☐ Normalmente me sinto bem comigo mesmo(a).

☐ Frequentemente sinto que sou melhor do que os outros e isso afeta a forma como me relaciono com as pessoas.

☐ Sempre me sinto superior aos outros, e isso afeta a forma como me relaciono com as pessoas.

### 3. Autopercepção

☐ Não tenho pontos fortes.

☐ Tenho poucos pontos fortes.

☐ Tenho um bom conhecimento sobre meus pontos fortes e fracos.

☐ Tenho poucos pontos fracos ou limitações.

☐ Não tenho pontos fracos ou limitações.

**4. Metas**

☐ Raramente eu consigo estabelecer e seguir metas.

☐ Às vezes acho difícil estabelecer e seguir metas.

☐ Não tenho nenhum problema em estabelecer e seguir metas realistas (isto é, que podem ser alcançadas).

☐ Às vezes acho difícil mudar minhas metas mesmo quando elas são muito difíceis de alcançar.

☐ Normalmente acho difícil mudar minhas metas mesmo quando elas são quase impossíveis de alcançar.

**5. Interesse em relacionamentos**

☐ Não tenho interesse em estar com outras pessoas e faço qualquer coisa para evitá-las.

☐ Tenho pouco interesse em estar com outras pessoas e, portanto, as evito.

☐ Tenho um bom equilíbrio entre estar sozinho e com outras pessoas.

☐ Às vezes me sinto chateado(a) quando não estou perto de outras pessoas.

☐ Frequentemente me sinto chateado(a) quando não estou perto de outras pessoas.

**6. Tomada de perspectiva**

☐ Eu nunca me importo com os pensamentos e sentimentos das outras pessoas.

☐ Frequentemente não me importo com os pensamentos e sentimentos das outras pessoas.

☐ Posso facilmente compreender e simpatizar com os pensamentos e sentimentos de outras pessoas.

☐ Frequentemente me preocupo muito com o que os outros pensam e sentem.

☐ Sempre me preocupo muito com o que os outros pensam e sentem.

**7. Reciprocidade nos relacionamentos**

☐ As pessoas sempre reclamam que sou muito egoísta nos relacionamentos.

☐ Às vezes as pessoas reclamam que sou muito egoísta nos relacionamentos.

☐ Sou capaz de estabelecer e manter relações próximas, que são satisfatórias tanto para mim como para o outro.

☐ Às vezes sou incapaz de terminar relacionamentos, mesmo quando são prejudiciais para mim.

☐ Raramente sou capaz de terminar relacionamentos, mesmo quando eles são prejudiciais para mim.

**8. Gestão de desentendimentos**

☐ Frequentemente tenho desentendimentos com as pessoas e isso me causa sérios problemas de relacionamento.

☐ Às vezes tenho desentendimentos com as pessoas e isso me causa problemas de relacionamento.

☐ Sou capaz de lidar com desentendimentos em relacionamentos de forma cooperativa.

☐ Frequentemente evito desentendimentos me submetendo aos outros, mesmo que isso me deixe na pior.

☐ Eu evito desentendimentos e conflitos com as pessoas a qualquer custo.

**9. Controle e expressão emocional**

☐ Frequentemente não consigo controlar minhas emoções e isso me causa sérios problemas com os outros.

☐ Às vezes tenho problemas em controlar minhas emoções e isso me causa alguns problemas com os outros.

☐ Geralmente sou capaz de controlar e expressar minhas emoções de maneira apropriada.

☐ Às vezes as pessoas reclamam que eu não expresso emoções.

☐ Frequentemente as pessoas reclamam que eu não expresso emoções.

**10. Controle comportamental**

☐ Frequentemente ajo de forma tão precipitada ou impulsiva que isso me causa sérios problemas.

☐ Às vezes ajo por impulso sem considerar as consequências e isso me causa problemas.

☐ Geralmente sou capaz de ser espontâneo enquanto mantenho controle apropriado de meus comportamentos.

☐ Às vezes sou tão controlado em minhas ações que não aproveito a vida como os outros.

☐ Frequentemente sou tão exagerado no controle de minhas ações que fica difícil aproveitar a vida.

**11. Percepção da realidade durante estresse**

☐ Quando estou muito estressado(a), eu consigo pensar claramente sobre as situações.

☐ Minha percepção das situações é, em alguma medida, distorcida quando me sinto muito estressado(a) (ex.: espero que o pior aconteça, sensação de rejeição quando recebo críticas).

☐ Às vezes perco a noção da realidade quando me sinto muito estressado(a) (ex.: fico desconfiado(a), sentindo-me desconectado(a) da realidade ou sentindo como se estivesse em um sonho).

☐ Frequentemente perco a noção da realidade quando me sinto muito estressado(a) (ex.: fico extremamente desconfiado(a), vejo ou ouço coisas que outras pessoas não conseguem, tenho experiências de sair do meu corpo).

**12. Fazer mal a si próprio(a)**

☐ Nunca faço mal a mim mesmo(a).

☐ Raramente faço mal a mim mesmo(a).

☐ Às vezes faço mal a mim mesmo(a).

☐ Frequentemente faço mal a mim mesmo(a).

**13. Fazer mal aos outros** (intencional ou não intencional)

☐ Nunca faço mal aos outros.

☐ Raramente faço mal aos outros.

☐ Às vezes faço mal aos outros.

☐ Frequentemente faço mal aos outros.

**14.** Pensando nas suas respostas acima, o quanto elas causam problemas em áreas importantes da sua vida (ex: pessoal, familiar, social, educacional, ocupacional/trabalho)?

☐ Nada.

- ☐ Um pouco.
- ☐ Moderadamente.
- ☐ Muito.

## Appendix K – PID5BF+M

A seguir há uma lista de frases que as pessoas usam para se descrever. Gostaríamos de saber como você se descreve. Não há respostas certas ou erradas. Tente ser o mais honesto possível ao responder. Suas respostas são confidenciais. Não há tempo limite. Leia atentamente as frases e atribua pontos de 0 a 3, conforme o quanto elas são verdadeiras para você, de acordo com a seguinte escala:

0 – Nada (não tem nada a ver comigo, falso)

1 – Pouco (tem um pouco a ver comigo, algumas vezes falso)

2 – Moderadamente (tem a ver comigo, algumas vezes verdadeiro)

3 – Muito (tem muito a ver comigo, totalmente verdadeiro)

| | | |
|---|---|---|
| 1 | Tenho reações emocionais muito mais fortes do que a maioria das pessoas. | 0 1 2 3 |
| 2 | Eu sou bom em enganar as pessoas. | 0 1 2 3 |
| 3 | Geralmente sou bastante descuidado com minhas coisas e com as dos outros. | 0 1 2 3 |
| 4 | Eu mantenho distância das pessoas. | 0 1 2 3 |
| 5 | Eu geralmente percebo relações incomuns entre coisas que a maioria das pessoas não percebe. | 0 1 2 3 |
| 6 | Insisto em fazer tudo com total perfeição, mesmo deixando as pessoas loucas com isso. | 0 1 2 3 |
| 7 | Estou sempre me preocupando com alguma coisa. | 0 1 2 3 |
| 8 | Às vezes é preciso cometer exageros para chegar à frente dos outros. | 0 1 2 3 |
| 9 | Sinto que ajo totalmente por impulso. | 0 1 2 3 |
| 10 | Nada parece me interessar muito. | 0 1 2 3 |
| 11 | Pessoas já me disseram que eu penso sobre as coisas de um modo realmente estranho. | 0 1 2 3 |

| | | |
|---|---|---|
| 12 | É importante para mim que as coisas sejam feitas de uma determinada maneira. | 0 1 2 3 |
| 13 | Eu me preocupo muito em ficar sozinho. | 0 1 2 3 |
| 14 | Eu mereço tratamento especial. | 0 1 2 3 |
| 15 | Perco o fio da meada das conversas porque outras coisas chamam a minha atenção. | 0 1 2 3 |
| 16 | Prefiro manter relacionamentos amorosos longe de mim. | 0 1 2 3 |
| 17 | É estranho, mas algumas vezes objetos comuns parecem ter uma forma diferente do que a usual. | 0 1 2 3 |
| 18 | Continuo tentando melhorar as coisas que faço, mesmo quando elas já estão perfeitas. | 0 1 2 3 |
| 19 | Eu me emociono com facilidade, muitas vezes por uma razão muito pequena. | 0 1 2 3 |
| 20 | É fácil, para mim, tirar vantagem dos outros. | 0 1 2 3 |
| 21 | Mostre que você está respondendo com atenção marcando o número um. | 0 1 2 3 |
| 22 | Muitas vezes esqueço de pagar minhas contas. | 0 1 2 3 |
| 23 | Não gosto de passar meu tempo com os outros. | 0 1 2 3 |
| 24 | Eu já tive algumas experiências realmente esquisitas que são difíceis de se explicar. | 0 1 2 3 |
| 25 | Eu tenho um modo rigoroso de fazer as coisas. | 0 1 2 3 |
| 26 | Eu me preocupo com quase tudo. | 0 1 2 3 |
| 27 | Eu exagero a verdade se isso me trouxer vantagens. | 0 1 2 3 |
| 28 | Não consigo parar de tomar decisões precipitadas, mesmo sabendo que sou assim. | 0 1 2 3 |
| 29 | Raramente fico entusiasmado com alguma coisa. | 0 1 2 3 |
| 30 | Eu tenho vários hábitos que os outros acham que são excêntricos ou estranhos. | 0 1 2 3 |
| 31 | Já me disseram que perco muito tempo me assegurando que as coisas estão no seu devido lugar. | 0 1 2 3 |

| | | |
|---|---|---|
| 32 | Não suporto ser deixado sozinho, mesmo que por algumas horas. | 0 1 2 3 |
| 33 | Eu frequentemente preciso lidar com pessoas que são menos importantes que eu. | 0 1 2 3 |
| 34 | Eu facilmente me distraio. | 0 1 2 3 |
| 35 | Eu termino meus relacionamentos se eles começarem a ficar muito íntimos. | 0 1 2 3 |
| 36 | Às vezes eu olho para um objeto familiar e é como se eu o estivesse vendo pela primeira vez. | 0 1 2 3 |
| 37 | As pessoas reclamam sobre minha necessidade de ter tudo planejado. | 0 1 2 3 |

## Appendix L – BPS

### Borderline Pattern Scale - BPS-Br

**Instruções:**

Abaixo estão listadas várias afirmações sobre como você pode se sentir ou se comportar. Por favor, marque para cada afirmação a resposta que melhor descreve você em uma escala de 1 a 5 pontos, em que 1 = discordo totalmente da afirmação, 2 = discordo, 3 = neutro, 4 = concordo e 5 = concordo totalmente com a afirmação. Por favor, leia cada item com atenção e marque a resposta que melhor corresponde com o seu nível de concordância e discordância. Não há respostas certas ou erradas. Descreva se de forma honesta e exponha suas opiniões o mais fielmente possível.

| | |
|---|---|
| 1. Eu sou emocionalmente instável. | 1 2 3 4 5 |
| 2. Frequentemente me sinto muito envergonhado(a). | 1 2 3 4 5 |
| 3. Tenho problemas para entender a perspectiva dos outros. | 1 2 3 4 5 |
| 4. Eu faço ferimentos em mim mesmo quando estou chateado(a). | 1 2 3 4 5 |
| 5. Meus sentimentos mudam drasticamente. | 1 2 3 4 5 |
| 6. A forma como me vejo muda muito. | 1 2 3 4 5 |
| 7. Meus relacionamentos tendem a ser muito instáveis. | 1 2 3 4 5 |
| 8. Eu não tenho muito autocontrole sobre o que faço. | 1 2 3 4 5 |
| 9. Eu fico com raiva muitas vezes. | 1 2 3 4 5 |
| 10. Eu gostaria de ser outra pessoa. | 1 2 3 4 5 |
| 11. Um dos meus maiores medos é ser abandonado(a). | 1 2 3 4 5 |
| 12. As pessoas dizem que eu lido mal com meus sentimentos. | 1 2 3 4 5 |