

1 **abstract: 236 words**

2 **manuscript: 2611 words**

3 **references: 319 words**

4 **tables: 2**

5 **supplements: 4**

6

7

8

9

10

11 **DSM-5 Assessments of the Level of Personality Functioning:**

12 **Intrapersonal and Interpersonal Functioning**

13

Author Note

1
2
3
4
5
6
7
8
9
10
11
12
13

Lieve Beheydt, University Psychiatric Center Duffel, Department of Medicine and Health Sciences, University of Antwerp and Faculty of Psychology and Educational Sciences, KU Leuven; Didier Schrijvers, University Psychiatric Center Duffel, Department of Medicine and Health Sciences, University of Antwerp; Bernard Sabbe, University Psychiatric Center Duffel, Department of Medicine and Health Sciences, University of Antwerp; Bart Jansen, University Psychiatric Center Duffel, Carmen Degrave, University Psychiatric Center Duffel, Patrick Luyten, Faculty of Psychology and Educational Sciences, KU Leuven and Research Department of Clinical, Educational and Health Psychology, University College London, UK.

This research was supported by a special fellowship of the FWO research fund Flanders (1901315N).

DSM-5 Assessments of the Level of Personality Functioning:

Intrapersonal and Interpersonal Functioning

Objective. In DSM-5, Section III, the Level of Personality Functioning (LPF) was proposed as a severity index of personality disorders (PDs), but as it reflects both trait-like (availability) and state-like (accessibility) features, of which, moreover, the relationship with the experience of patients is unclear, we critically examined LPF in patients with general psychopathology.

Method. This study compared the validity of the direct Inventory of Personality Organization (IPO), and the indirect Differentiation-Relatedness Scale (DRS) LPF-measure, in relation to measures of intrapersonal and interpersonal functioning. The sample consisted of 70 inpatients with general psychopathology and no primary PDs. Associations of both measures with DSM-PDs were examined, with and without controlling for clinical distress.

Results. The IPO was significantly related to age and clinical distress. When controlling for clinical distress, the IPO was still associated with cluster A (odd) and B (erratic) PD features, high levels of self-criticism, conflict in relationships and low levels of adaptive coping strategies. The DRS was only related to the schizotypal PD.

Conclusions. In patients with general psychopathology, both the IPO and the DRS, appear to have limitations in measuring LPF. The IPO seems to be prone to state effects, although correlations with PDs remained significant when controlling for clinical distress. The DRS seemed to be more independent from clinical distress but was unexpectedly unrelated to features of personality pathology. DRS reflects availability, while IPO also reflects different degrees of accessibility of LPF in PDs.

1 To overcome problems of categorical classification of personality disorders (PDs)
2 such as lack of therapeutic specificity, a dimensional Alternative Model of Personality
3 Disorders (AMPD) has been proposed in DSM-5, Section III (Diagnostic and Statistical
4 Manual of Mental Disorders, 5th edition; APA, 2013). It consists of a hybrid system of the
5 level of personality function (LPF, criterion A), indicating presence and severity of PDs with
6 impairments in mental representations of self and interpersonal functioning, and the style of
7 PDs with maladaptive traits (criterion B). The proposal of the AMPD suggests the
8 independence of criteria A and B, but the debate about the relationship between the two
9 dimensions remains unresolved (Widiger et al., 2018). Evidence is accumulating that
10 impairments in mental representations of the self in relation to that of others as developed in
11 object relations hamper personality integration and thus underlie personality pathology
12 (Lowyck, Luyten, Verhaest, Vandeneede, & Vermote, 2013). However, it is not clear yet
13 whether LPF could be implied by the maladaptive traits, form a separate trait or could be a
14 general factor of psychopathology underlying both traits and symptoms (Widiger et al., 2018).
15 As, however, the state-trait model of Zuroff, Blatt, Sanislow, Bondi, & Pilkonis (1999)
16 suggests that the availability (content and structure) of mental representations is quite stable
17 but that the accessibility may fluctuate in temporary (mood) states and context, we
18 investigated the impact of clinical distress on a direct and indirect LPF measure. Because a
19 range of newer instruments is still being validated, we compared an already extensively
20 investigated self-report measure to a performance-based measure of LPF (Huprich, Auerbach,
21 Porcerelli, & Bupp, 2016), to refine the construct as called for by the HitOP consortium
22 (Widiger et al., 2018). The Inventory of Personality Organization (IPO; Lenzenweger,
23 Clarkin, Kernberg, & Foelsch, 2001) as the direct measure, reveals a conscious representation
24 of LPF, while the Differentiation and Relatedness Scale (DRS; Diamond et al., 2014) as the
25 indirect measure, reveals the object-related representation of LPF.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21

DRS and IPO.

The ORI-Differentiation and Relatedness Scale as an indirect measure of LPF.

Diamond and Blatt's DRS (Diamond et al., 2014) is a 10-level ordinal subscale of the ORI (inter-rater reliability of ORI is .70, $p=0.0005$, Vermote, 2005). It assesses the LPF as representational levels for mother, father, (therapist), peer, and self, resulting from dialectics between relatedness and self-definition. Blatt's theory and assessment have influenced the proposed two-dimensional LPF-Scale in DSM-5, Section III. The DRS measures the transition from impairments in basic differentiation between self and others, with lack (level 1) or confusion (level 2) of boundaries (e.g. *flood of details with a sense of confusion*), over attempts to establish and maintain object and self-constancy by the use of mirroring (level 3) idealization and denigration (level 4) or oscillation between both (level 5) (e.g. *extreme one-sided description*), to differentiated and integrated concepts of self and others (level 6), with increasing tolerance for ambiguities (level 7), (e.g. *integration of disparate aspects*), and the capacity for empathic (level 8), reciprocal (level 9) relationships with a mutual reflective construction of meaning (level 10) (e.g. *understanding the perspective of the other*) (Diamond et al., 2014). Reliability of the DRS is good, DRS ICC = .83 (Shrout & Fleish) (Diamond et al., 2014), and concurrent and discriminant validity is solid (Calamaras, Reviere, Gallagher, & Kaslow, 2016). Because Blatt's theory is rooted in object-relational thinking and attachment theory, it is assumed that the levels of representation of significant others might differ, depending on differing dyads with the self.

The Inventory of Personality Organization as a direct measure of LPF.

The IPO is a self-report measure of LPF, assessing features seen as typical key dimensions in LPF (Widiger et al., 2018, p.3). The IPO derives from the theory of Kernberg, stating that the quality of object relations results in a continuum of ego functioning from normal to severe,

22
23
24
25

1 with three organization levels. Combinations of impairments in three key subscales of IPO
2 determine the levels. These scales measure 1) identity confusion (ID, 21 items) as poor
3 understanding of self and others (e.g. 'I pick up hobbies and interests and then drop them'), 2)
4 the use of primitive defenses (PD, 16 items) as splitting and projection (e.g. 'I feel I don't get
5 what I want'), and 3) problems with reality testing (RT, 20 items) as maintaining empathy
6 with ordinary social criteria of reality (e.g. 'I feel that my wishes or thoughts will come true as
7 if by magic'). While the neurotic level may show avoiding defenses against inner conflicts,
8 the borderline level shows impairments in ID and PD, and the psychotic level shows problems
9 in RT moreover. Studies have revealed excellent internal consistency and test-retest reliability
10 ($r = .72-.83$, Lenzenweger et al., 2001) and supported convergent, concurrent and discriminant
11 validity (e.g., Lenzenweger et al., 2001; Lowyck et al., 2013; Smits, Vermote, Claes, &
12 Vertommen, 2009).

13 While existing research has provided evidence for the reliability and validity of both the DRS
14 and the IPO, the only study that directly compared the relationship between both instruments
15 and features of clinical functioning (Lowyck et al., 2013) found that correlations between IPO
16 and DRS were only small to medium and therefore initiated the measurement of
17 complementary personality aspects. DRS predicted depression severity, clinical symptoms,
18 and self-harm, IPO predicted clinical symptoms, interpersonal problems, and self-harm. As,
19 however, this study included a sample of disordered personality patients, it remains unclear to
20 what extent these findings generalize to patients with general psychopathology and only
21 secondary personality pathology and to what extent these associations reflect clinical distress,
22 PD traits or/and impaired personality functioning.

23 Therefore, in this study, we investigated associations of IPO and DRS with features of
24 possible cognitive, intrapersonal and interpersonal dysfunction in a sample of patients with
25 general psychopathology, with and without controlling for clinical distress. In this sample,

1 PDs were less severe, and chronic psychosis was excluded, but functional impairment and
2 subjective distress, two prerequisites for diagnosis of PD in DSM-5, were present.
3 We expected more severe personality pathology traits and PDs, more self-criticism and
4 dependency, and more maladaptive interpersonal functioning and coping with higher IPO
5 scores and lower DRS scores. Indeed, impairments of LPF can be understood as impaired
6 object relations, manifested in impaired identity, self-directedness, interpersonal empathy, and
7 intimacy (see AMPD). Following previous findings with IPO and DRS, we did not expect
8 relationships with age, gender, or educational level. In keeping with the nature of PD, we
9 hypothesized no influence of clinical distress in the relationship between PDs and DRS and
10 IPO.

11 **Method**

12 **Participants**

13 Seventy inpatients (Caucasian, 35 males) aged 18 to 60 ($\bar{x} = 36.6$, SD 11.9) were
14 included, consecutively admitted for specialized diagnosis and brief psychotherapy. The only
15 inclusion criterion was general psychopathology (Supplement S1), but patients with manifest
16 psychosis, cognitive deterioration, were selected out before admission to the ward. The mean
17 level of education was higher secondary education (level 3, from 1= primary education to 6 =
18 university).

19 **Measurements**

20 *Clinical Distress*

21 The *Symptom Checklist-90* (SCL-90; Arindell & Ettema, 1986) is a 90 items self-
22 descriptive scale with eight subscales and a total scale. Patients rate each item on a 5-point
23 Likert scale. The subscales are summed up.

24 *Psychiatric Symptoms*

1 *Beck Depression Inventory* (BDI; Van der Does, 2002) is a 21-item self-descriptive 4-point
 2 (0-3) scale multiple-choice inventory with three subscales. Total severity score is the sum
 3 (max. 63) and can be minimal (0-13), light (14-19), moderate (20-28) or severe (29-63).

4 *Dissociation Questionnaire* (DIS-Q; Vanderlinden, Van Dyck, Vertommen, Vandereycken, &
 5 Verkes, 1993) is a 63-item self-descriptive questionnaire with a 5-point Likert scale for
 6 degrees of dissociative experiences with four subscales. The total score is summed up.

7 ***Personality pathology***

8 Descriptive DSM IV-TR

9 *ADP-IV* (Schotte & De Doncker, 1996) consists of 94 trait-distress items, each criterion of
 10 DSM-IV-TR scoring the typicality of the trait on a 7-point Likert scale. If score ≥ 5 , then
 11 distress is scored on a 3-point Likert scale. Trait and distress scores are summed up for every
 12 dimension, and a categorical score is calculated following a DSM-IV-TR algorithm with
 13 combinations of cut-offs for traits and distress. After that, the diagnosis of clusters A, B, and
 14 C is calculated.

15 Criterion A DSM 5, Section III

16 *The Depressive Experience Questionnaire* (DEQ; Luyten, Corveleyn, & Blatt, 1997) is a 66-
 17 item self-descriptive questionnaire, with a 7-point Likert scale with three factors, self-
 18 criticism and dependency were used as dimensions of LPF. Scores were calculated using
 19 factor scores and loadings of the original DEQ (same psychometric characteristics).

20 *The Differentiation and Relatedness Scale* (DRS-ORI; Blatt, Wein, Chevron, & Quinlan,
 21 1979) is a 10-point ordinal clinician rating scale of LPF. It is indirect because the aim is
 22 obscure for the subject. The performance-based LPF is scored on the *Object Relations*
 23 *Inventory*, a semi-structured interview in which subjects are asked to describe important
 24 others (i.e., mother (DR-M), father (DR-F), peers (DR-P) and self (DR-S)) as detailed as
 25 possible. Then, DRS is used to assess the ability to understand both oneself and one's

1 interpersonal matrix. For a full description of the use of DRS and ORI, see Diamond et al.
2 (2014). The same levels can be clinically rated (after training for reliability) for different
3 significant others like the mother (DR-M), the father (DR-F), the self (DR-S), a peer (DR-P)
4 or a therapist (DR-T).

5 *The Inventory of Personality Organization* is a self-report instrument and hence a direct
6 measure of LPF with 136 items on a 5-point Likert scale and 9 subscales of which Identity
7 Diffusion (ID), Primitive Defense (PD) and Reality Testing (RT) are keys to determine the
8 organization level by different combinations (see introduction).

9 ***Functional outcome***

10 *Progressive Matrices* (PM; Raven, 2006) estimates IQ by 60 multiple-choice items in 5 sets
11 of visual pattern detection with increasing difficulty. The rough score is converted into a
12 percentile according to a set of criteria such as age.

13 *Quality of Relationships Inventory* (QRI; Pierce, Sarason, & Sarason, 1991) is a self-report
14 scale with 25 items scored on a 4-point Likert scale with three calculated subscales: support,
15 conflict, and depth.

16 *Utrechtse Coping Lijst* (UCL; Schreurs & van de Willige, 1988) is a self-report scale with 47
17 items scoring on a 5-point scale the frequency of using a specific coping (seven subscales).

18 **Procedures**

19 The ethics committee of NPO Emmaus, Mechelen, and the University of Antwerp,
20 Belgium, approved this study. The assessment was part of the routine treatment, except for the
21 ORI. Patients were informed about the study, filled in coordinates and demographical data,
22 and provided written informed consent. Then, in the first two weeks of admission, they got a
23 psychiatric diagnosis (S1), an interview with the ORI, and they digitally filled in the clinical
24 questionnaires.

25 **Statistical analysis**

1 Statistical analyses were performed using SPSS 22.00 (IBM corp., 2013). Pearson's
 2 correlations between DRS levels rated on ORI descriptions of self, mother, father and peer
 3 and IPO-ID, IPO-PD and IPO-RT were calculated (* $p < .05$, ** $p < .01$). Next, correlations were
 4 calculated for DR-S, DR-M, DR-F, DR-P and IPO- ID, PD and RT as aspects of LPF
 5 measures and clinical distress and symptoms (SCL-90, BDI, DIS-Q), differentiated criterion
 6 A dimensions of AMPD (DEQ), DSM-IV-TR PDs (ADP-IV) and functional relational (QRI)
 7 and coping (UCL) measures. Partial correlations were calculated to control for clinical
 8 distress covarying for SCL-90. Comparison of correlations was tested with Fisher z or
 9 Hoerger Z-scores for dependent correlations. Comparison of categorical groups (gender) was
 10 calculated for IPO-ID, IPO-PD, and IPO-RT with ANOVA and Bonferroni correction for
 11 multiple comparisons.

12 Results

13 Convergent validity of DRS and IPO

14 Results indicated that DRS and IPO do not correlate (DR-S: r IPO-ID = .11, r IPO-PD = .12, r
 15 IPO-RT = .09, $p > .05$) (S2). But, while subscales of IPO correlated comparably high (r IPO-
 16 ID/RT = .54**, r IPO-PD/RT = .58**, r IPO-ID/PD = .66**), correlations between DRS
 17 representations diverged in very small correlations with DR-P (r DR-F = .27*), moderate
 18 correlations with DR-S (all = .34**) and a high correlation between DR-M and DR-F (r =
 19 .54**).

20 Associations of DRS and IPO with stable and fluctuating variables

21 Neither DRS nor IPO correlated with gender, level of education, or IQ (S3), stable factors in
 22 personality development. Temporary and dynamic measures such as age (r = .28-.31*) (S3),
 23 clinical distress (r SCL-90 = .57-.61**), symptoms of depression (r BDI = .436-.558**) and
 24 especially the more fluctuating symptoms of dissociation (r DISQ = .717-.786**) all
 25 correlated with IPO (S4).

1 **Controlling for clinical distress in associations of DRS and IPO with functional** 2 **measures**

3 Therefore, we re-ran correlations with traits of PD, coping, and relational functioning,
4 controlling for clinical distress (see table 1). While DRS was not related to coping measures
5 and relational functioning (table 2), all IPO measures were related to self-criticism and
6 dependency (table 1), to most coping measures, and conflict in relationships (table 2).
7 Although there was a significant impact of clinical distress for self-criticism and dependency,
8 only correlations between IPO and self-criticism remained after controlling for clinical
9 distress (r IPO-ID = .528**, r IPO-PD = .452**, r IPO-RT = .215*). Hence, self-criticism
10 appeared to be a structural deficit in impaired IPO (LPF), while dependency seemed to be
11 explainable by contextual, interpersonal, and distress features.

12 **Correlations of DRS and IPO with PDs controlling for clinical distress: three types**

13 Correlations of DRS (DR-S and DR-P) with PDs were surprisingly limited to cluster A, the
14 schizoid, schizotypal, borderline and histrionic PD and, after controlling for clinical distress,
15 only DR-S was related with exclusively the schizotypal PD. This particular PD has been
16 questioned as a PD and would rather suggest a genetic vulnerability like schizophrenia
17 (Lenzenweger, 2015). IPO correlated with all PDs, but after controlling for clinical distress,
18 three types appeared. First, correlations of the IPO with cluster C seemed to be merely state-
19 dependent, while, second, correlations with cluster A or B remained strong, even if they too
20 showed important impact of clinical distress. Third, PDs typically associated with extreme
21 internalizing (schizoid and avoidant) and externalizing (antisocial, histrionic, passive-
22 aggressive, and narcissistic) traits, seemed to be independent of clinical distress. Thus,
23 descriptive PDs showed three types, according to susceptibility to distress.

24 **Discussion**

25 **Availability and accessibility of LPF**

1 In summary, in this sample, the DRS appeared to be associated with psychotic vulnerability
2 and was not associated with clinical measures of PD-severity (distress, symptoms, traits, or
3 functioning in relationships or coping). DRS measured the *availability* of personality
4 functioning, the structural vulnerability that gives rise to disturbances in the self (Zuroff,
5 Sadikaj, Kelly, & Leybman, 2015). IPO, in turn, was state dependent and was associated with
6 interpersonal functioning, clinical distress, coping, functioning of self, and with all PDs.
7 However, comparisons of correlations between descriptive PDs and IPO (LPF) before and
8 after controlling for clinical distress differentiated three types of PDs by the impact of clinical
9 distress. This difference in impact could be understood as a measure of the *accessibility* of
10 personality functioning, the fluctuation of mental structures by mood, social context, or
11 biological factors.

12 **DRS and IPO complement in differentiating identity integration from clinical distress**

13 In all, the present research reveals an impact of clinical distress on PDs. But, the impact
14 differs depending on the type of PD. The three types revealed in the comparison of the results
15 for IPO and DRS in the present sample indicate that DRS is only useful to detect psychotic
16 PDs (*availability*), IPO is complementary (*availability and accessibility*). IPO shows in high
17 LPF (cluster C) a relationship with PDs determined by clinical distress, in medium LPF (with
18 extreme internalizing or externalizing traits), the presence of clinical distress shows no
19 impact, but in low LPF (cluster A and B), there is a clear impact of both hampered identity
20 integration and clinical distress. Even if the present study is limited in scope due to the
21 specificity of the sample, which is limited to general psychopathology patients, it opens a
22 perspective for reliable measurement of PDs, independent of clinical distress.

23

References

- 1
2 Blatt, S.J., Wein, S.J., Chevron, E.S., & Quinlan, D.M. (1979). Parental representations and
3 depression in normal young adults. *Journal of abnormal psychology*, 88, 388-397.
- 4 Calamaras, M. R., Reviere, S. L., Gallagher, K. E., & Kaslow, N. J. (2016). Changes in
5 differentiation-relatedness during psychoanalysis. *Journal of Personality Assessment*,
6 98(1), 44–50. doi:10.1080/00223891.2015.1064439
- 7 Diamond, D., Blatt, S. J., Stayner, D. A., Kaslow, N. J., Auerbach, J. S., Luyten, P., &
8 Lowyck, B. (2014). *Manual for the Differentiation-Relatedness Scale*. New Haven,
9 CT: Yale University
- 10 Huprich, S. K., Auerbach, J. S., Porcerelli, J. H., & Bupp, L. L. (2016). Sidney Blatt's Object
11 Relations Inventory: Contributions and Future Directions. *Journal of Personality*
12 *Assessment*, 98(1), 30–43. doi:10.1080/00223891.2015.1099539
- 13 IBM Corp. Released 2013. *IBM SPSS Statistics for Windows, Version 22.0*. Armonk, NY:
14 IBM Corp.
- 15 Lenzenweger, M. F., Clarkin, J. F., Kernberg, O. F., & Foelsch, P. A. (2001). The Inventory
16 of Personality Organization: Psychometric properties, factorial composition, and
17 criterion relations with affect, aggressive dyscontrol, psychoses proneness, and self-
18 domains in a nonclinical sample. *Psychological Assessment*, 13, 577-589. doi:
19 10.1037/1040-3590.13.4.577
- 20 Lenzenweger, M. F. (2015). Thinking clearly about schizotypy: Hewing to the schizophrenia
21 liability core, considering interesting tangents, and avoiding conceptual quicksand.
22 *Schizophrenia Bulletin*, 41(2), S483–S491. doi:10.1093/schbul/sbu184
- 23 Lowyck, B., Luyten, P., Verhaest, Y., Vandeneede, B., & Vermote, R. (2013). Levels of
24 personality functioning and their association with clinical features and interpersonal

- 1 functioning in patients with personality disorders. *Journal of Personality Disorders*,
2 27(3), 320-336.
- 3 Smits, D. J. M., Vermote, R., Claes, L., & Vertommen, H. (2009). The inventory of
4 personality organization-revised: Construction of an abridged version. *European*
5 *Journal of Psychological Assessment*, 25(4), 223–230. [doi: 10.1027/1015-](https://doi.org/10.1027/1015-5759.25.4.223)
6 [5759.25.4.223](https://doi.org/10.1027/1015-5759.25.4.223)
- 7 Vermote, R. (2005). Touching inner change; psychoanalytically informed hospitalization-
8 based treatment of personality disorders. A process-outcome study (Doctoral
9 dissertation). Retrieved from <https://limo.libis.be>. (LIRIAS1768987)
- 10 Zuroff, D.C., Sadikaj, G., Kelly, A.C., & Leybman, M.J. (2016). Conceptualizing and
11 Measuring Self-Criticism as Both a Personality Trait and a Personality State. *Journal*
12 *of Personality Assessment*, 98(1), 14-21, doi: 10.1080/00223891.2015.1044604

Appendices

Because of reference limitations, we chose to add here the bibliography of the list of assessment instruments. References of conventional standardized assessment instruments were not included in the selective reference list. However, it is possible to consult them in this supplement.

References for assessment instruments

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Arindell, W. A. & Ettema, H. (1986). *SCL-90 handleiding bij een multidimensionele psychopathologie-indicator* [manual for a multidimensional psychopathology indicator]. Lisse: Swets test-services.
- Blatt, S.J., D’Afflitti, J.P., & Quinlan, D.M. (1976). Experiences of depression in normal young adults. *Journal of abnormal psychology*, 85, 383-389.
- Diamond, D., Blatt, S. J., Stayner, D. A., Kaslow, N. J., Auerbach, J. S., Luyten, P., & Lowyck, B. (2014). *Manual for the Differentiation-Relatedness Scale*. New Haven, CT: Yale University
- Does, A.J.W. van der (2002). *BDI-II-NL. Handleiding. De Nederlandse versie van de Beck Depression Inventory-2nd edition*. Lisse: Harcourt Test Publishers.
- Lenzenweger, M. F., Clarkin, J. F., Kernberg, O. F., & Foelsch, P. A. (2001). The Inventory of Personality Organization: Psychometric properties, factorial composition, and criterion relations with affect, aggressive dyscontrol, psychoses proneness, and self-domains in a nonclinical sample. *Psychological Assessment*, 13, 577-589.

- Luyten, P., Corveleyn, J., Blatt, S.J. (1997). *Depressieve Ervaringen Vragenlijst (DEV): Nederlandstalige versie van de Depressive Experiences Questionnaire [DEQ]*. Leuven: KU Leuven.
- Pierce, G. R., Sarason, I. G., & Sarason, B. R. (1991). General and relationship-based perceptions of social support: Are two constructs better than one? *Journal of Personality and Social Psychology*, 61(6), 1028-1039. <http://dx.doi.org/10.1037/0022-3514.61.6.1028>
- Schotte, C., De Doncker, D. (1996). *ADP-IV Questionnaire: Manual and norms*. Antwerp, Belgium: University Hospital Antwerp.
- Schreurs, P.J.G., & van de Willige, G. (1988). *Omgaan met problemen en gebeurtenissen: De Utrechtse Copinglijst (UCL)* [Dealing with problems and events: The Utrecht Coping List (UCL)]. Lisse: Swets & Zeitlinger.
- Vanderlinden, J., Van Dyck, R., Vertommen, H., Vandereycken, W., Verkes, (1993). De Dissociation Questionnaire: Ontwikkeling en karakteristieken van een dissociatievragenlijst [The Dissociation Questionnaire: Development and characteristics of a dissociation questionnaire]. *Nederlands Tijdschrift voor Psychologie*, 47, 134-147.
- Weertman, A., Arntz, A., & Kerkhofs, M.L.M. (2000). *Gestructureerd klinisch interview voor DSM-IV As-II persoonlijkheidsstoornissen (SCID-II)* [Structured clinical interview for DSM-IV Axis-II personality disorders (SCID-II)]. Lisse: Swets Test Publishers.