Self–Other Agreement on Ratings of Personality Disorder Symptoms and Traits:
Three Meta-Analyses

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Abstract

The present chapter considers the factors important to self–other agreement on personality disorder, reviews the literature on this topic, and presents 3 meta-analyses with a total of 53 studies of self–other agreement on personality disorder (total $N = 11,812$). Meta-analyses were completed on 1) overall self–other agreement on personality disorder symptoms and traits, 2) self–other agreement on DSM personality disorders, and 3) self–other agreement on maladaptive personality traits measured dimensionally by the Personality Inventory for DSM-5 (PID-5). Overall median self-other agreement was $r = .37$. Self–other agreement on DSM PDs ranged from $r = .32$ (dependent PD) to $r = .51$ (antisocial PD). Median self–other agreement was somewhat higher on the PID-5 maladaptive trait domains ($r = .45$), which is in line with prior estimates of the magnitude of self–other agreement on “normal” FFM trait domains.

keywords: self–other agreement; personality disorder; five-factor model; personality assessment; Personality Inventory for DSM-5; informant-report; meta-analysis

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The Five-Factor Model (FFM) of personality is a dimensional model of mostly adaptive levels of personality traits (Goldberg, 1993; John, Naumann, & Soto, 2008). It was originally developed through the study of the English language (Allport, 1937) and consists of five broad personality trait “domains” (neuroticism, extraversion, openness, agreeableness, and conscientiousness) that each contain more specific “facets” of personality. Personality *disorder* is defined as an “enduring pattern of inner experience and behavior” (American Psychiatric Association [APA], 2013, p. 645) that is inconsistent with an individual’s culture, is rigid and stable, begins in adolescence, and is associated with distress (APA, 2013). Personality disorders, as defined by the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition* (DSM-5; APA, 2013), can be thought of as “maladaptive variants” of FFM personality traits (Widiger, Gore, Crego, Rojas, & Oltmanns, 2017). For example, high levels of FFM conscientiousness are associated with adaptive characteristics such as being punctual and hard-working. The maladaptive variant of the FFM conscientiousness domain is compulsivity¹, including the traits of rigidity, perfectionism, and workaholism—characteristic of the DSM obsessive-compulsive personality disorder category—which are maladaptive because they cause impairment in life (Boudreaux, 2016; Livesley, 2007; Samuel, Riddell, Lynam, Miller, & Widiger, 2012). The research supporting the FFM conceptualization of personality disorder is extensive and will be described later in this chapter. The differences between personality “symptoms” and “traits” can be complicated. However, because research indicates that symptoms converge with FFM traits—and symptoms that compose the personality disorders in the DSM personality disorder categories

¹ Compulsivity is analogous to “Anankastia” in the International Classification of Diseases-11 (World Health Organization, 2018).

are defined as being “enduring” and “stable” (APA, 2013, p. 645)—we use the words “trait” and “symptom” interchangeably in this chapter.

Self–other agreement on personality traits has been of interest to psychological researchers for many years, largely because self–other agreement on personality traits provides convergent validation evidence for their existence (Campbell & Fiske, 1959; Costa & McCrae, 1988; Norman, 1963). This line of research simultaneously tests the validity of personality traits and the uniqueness of personality data reported by the self and by others. The magnitude of self–other agreement on personality traits such as those in the more adaptive ranges of the FFM is moderate (e.g., Connelly & Ones, 2010). In contrast, self–other agreement has been shown to be relatively lower on the maladaptive personality traits that constitute personality disorders (e.g., Klonsky, Turkheimer, & Oltmanns, 2002). Findings in this area are nuanced, however, and they rely on numerous factors. Because—to our knowledge—there have not been follow-up reviews or a meta-analysis of this literature, no further conclusions have been drawn since publication of a systematic review on self–other agreement on personality disorder by Klonsky et al. (2002).

Further, a paradigm shift is underway in personality disorder (PD) classification (Clark, 2007; Krueger, Derringer, Markon, Watson, & Skodol, 2012; Widiger & Trull, 2007).

Dimensional measures and models of personality disorder traits are now being used more often to investigate self–other agreement, which may influence conclusions about self–other agreement on personality disorder. Dimensional measures and models of personality disorder view personality disorder as collections of maladaptive personality traits that are measured on scales from low to high, rather than criteria (i.e. symptoms or traits) that are categorically rated as being present or absent.

In this chapter, we will discuss factors related to self–other agreement on personality disorder traits, review research findings, and provide three meta-analyses on this topic in hopes of better understanding the extent of self–other agreement on personality disorder. We provide meta-analyses for 1) overall median self–other agreement correlations on personality disorder traits across multiple conceptualizations of personality disorder, 2) self–other agreement correlations on traits from specific DSM personality disorder categories (i.e., the more traditional way of classifying personality disorder), and 3) self–other agreement correlations on maladaptive personality trait domains from the dimensional Criterion B of the DSM-5 Section-III alternative model of personality disorders (AMPD; APA, 2013)—that can be understood as maladaptive extensions of the FFM trait domains.

Self–other agreement on personality disorder traits has implications for personality assessment and for the construct validity of personality disorder. Self–other agreement is usually measured in two ways: 1) Rank-order stability agreement, which is the correlation between self- and informant reports of the same trait, and indicates an individual’s rank on a personality disorder trait compared to other people in the sample and 2) Mean-level agreement, which is the correspondence of mean-levels of the same personality disorder trait, and indicates how the mean-level of a personality disorder trait self-reported by a sample of targets compares to the mean-level reported for those targets by informants. Agreement indicates convergent validity; that is, when both perspectives provide similar information about the same trait, we develop support for the existence of personality disorder traits. Disagreement on both forms (i.e., rank-order agreement and mean-level agreement) indicates that different information about personality disorder traits is being provided by targets compared to informants. It may raise questions about the validity of inferences regarding the presence of personality pathology.

Substantial disagreement leads to important questions: 1) are the reports valid? and 2) which source is more accurate in their description of targets' levels of the respective trait? Importantly, levels of self–other agreement on personality disorder traits are not necessarily proxy measures of accuracy. For example, it is possible that one source may be more accurate than the other, which would decrease self–other agreement, but not the accuracy of the more accurate source (it is also possible that both reports are inaccurate—and either agree or disagree with each other).

Self–other agreement on personality disorder traits may depend on any of several important factors such as type of informant (e.g., spouses, close others, clinicians, or classmates), length and quality of the relationship, target age, target gender, sample type, assessment method, specific instrument, reliability of ratings from each source, and differential item functioning on measurement instruments across perspectives (see Section II on moderators of accuracy in this handbook). Theories on the judgment of more adaptive personality traits have posited that the type of relationship between a target and an informant can affect the shared observable information that there is available to agree upon (Funder, 1995). For example, spouses and clinicians may have more information about less observable characteristics such as the target's tendency to experience negative emotion, while classmates and friends may have more accessible information about more observable characteristics such as talkativeness and gregariousness (Funder, 1995; Vazire, 2010). Spouses may also be less apprehensive than friends, classmates, or other family members to report on evaluative traits such as conscientiousness and agreeableness because of their closeness to the target. Target age may influence self–other agreement as a result of personality maturation; that is, as personality matures—and becomes more stable—self–other agreement may increase (Rohrer, Egloff, Kosinski, Stillwell, & Schmukle, 2018).

Adaptive dimensional models of personality, such as the FFM, have been shown to capture personality disorder traits (e.g., Samuel & Widiger, 2008). Haigler and Widiger (2001) showed that simply by altering the NEO-Personality Inventory-Revised (Costa & McCrae, 1992) items, correlations between the NEO-PI-R openness, agreeableness, and conscientiousness scales and personality disorder increased. For example, the correlations between the NEO-PI-R conscientiousness domain and three measures of obsessive-compulsive personality disorder were small, but the correlations between NEO-PI-R conscientiousness items that were experimentally altered to include maladaptivity (e.g., changing the item “I keep my belongings neat and clean” to “I keep my belongings excessively neat and clean”) and three measures of obsessive-compulsive personality disorder were large (Haigler & Widiger, 2001). Miller (2012) has demonstrated that simply adding together the facets of the NEO-PI-R deemed characteristic of certain personality disorders—by expert researchers and clinicians (Lynam & Widiger, 2001; Samuel & Widiger, 2004)—creates personality disorder scores that correlate as highly with personality disorder measures as personality disorder measures correlate with each other (Trull, Widiger, Lynam, & Costa, 2003). Indeed, FFM personality disorder (FFMPD) measures have been developed for most of the DSM PDs (e.g., Widiger et al., 2017; Widiger, Lynam, Miller, & Oltmanns, 2012). It should be noted, however, that FFMPD scales can and should be used in any combination across FFMPD measures (e.g., for clinical assessment or research on maladaptive low agreeableness, maladaptive low agreeableness scales from FFMPD borderline, narcissistic, and/or antisocial personality disorders can be used in combination).

It is likely that theories of accuracy from adaptive personality models would extend to the judgment of maladaptive personality traits. Agreement studies on maladaptive traits often find that disinhibition (i.e., maladaptive low conscientiousness), detachment (i.e., maladaptive low

extraversion), and exhibitionism (e.g., maladaptive high extraversion traits) have the highest self–other agreement (Jopp & South, 2015; Keulen et al., 2011; Markon et al., 2013; Oltmanns, Crego, & Widiger, 2018; Ready & Clark, 2002; Samuel, Suzuki, Bucher, & Griffin, 2018). This finding is consistent with studies on adaptive trait models showing higher self–other agreement on conscientiousness and extraversion (Connelly & Ones, 2010). There are exceptions, however, in which relatively higher agreement has been found on antagonistic traits (i.e., maladaptive low agreeableness), compared to other maladaptive trait domains—a pattern that would not be expected based on accuracy theories of normal range traits (Kelley et al., 2018; Sleep, Lamkin, Lynam, Campbell, & Miller, in press). These mixed findings indicate that a meta-analysis of the growing literature would be useful.

Self–other agreement is undoubtedly affected by measurement considerations. For example, 1) The assessment method (e.g., interview or questionnaire) should be considered in self–other agreement on personality disorder traits. Clinical interviews are often used to collect information on personality disorder traits from patients and informants (Klonsky et al., 2002). Method effects unique to certain instruments may influence self–other agreement. Further, different specific instruments using the same method may even have different levels of agreement (e.g., one self-report questionnaire may demonstrate higher self–other agreement than another self-report questionnaire). 2) Reliability can also affect self–other agreement. For example, low internal consistency of the items on a test scale limits the maximum correlation that would be possible between two scores (i.e., attenuation; Furr & Bacharach, 2008). Interestingly, informant-ratings often demonstrate higher internal consistency than self-ratings (Balsis, Cooper, & Oltmanns, 2015). 3) Differential item functioning across perspectives in the assessment of personality disorder traits may also be important (Balsis, Loehle-Conger, Busch,

Ungredda, & Oltmanns, 2017; Cooper, Balsis, & Oltmanns, 2012). Informant-reports of personality disorder traits have demonstrated differential item functioning, in that informants may indicate the presence of pathological traits at lower levels than self-reports (i.e., to “agree” on a maladaptive personality trait question might reflect the presence of more significant pathology in a target when it is reported by an informant than when it is reported by the target; Balsis et al., 2017). If this finding is replicated, it could have ramifications for understanding mean-level self–other agreement on personality disorder traits—because mean-levels on the same scales would have different meanings between self- and informant-reports.

A practical implication of low self–other agreement is that one source may be more valid for the prediction of important criteria. Self-reports of personality disorder traits have been shown to predict behavior and consequential life outcomes (Dixon-Gordon, Whalen, Layden, & Chapman, 2015; Powers & Oltmanns, 2012). Likewise, informant-reports of personality disorder traits have been shown to predict behavior and important outcomes (Kaurin et al., 2018; Klein, 2003; Fiedler, Oltmanns, & Turkheimer, 2004). Neither source is necessarily more valid than the other. Incremental validity analyses have even demonstrated that—for some purposes and under certain conditions—informant-reports of personality disorder traits predict behavior and consequential outcomes over and above self-reports (Cruitt & Oltmanns, 2018; Galione & Oltmanns, 2013; Ready, Watson, & Clark, 2002). For example, informant-reports of personality disorder traits are predictive of targets’ dismissal from the military (Fiedler et al., 2004), neutral-observer behavioral ratings (Kaurin et al., 2018), and social adjustment (Klein, 2003) over and above self-reports. These findings are important because they may have implications for clinical assessment, treatment, and the ultimate prevention of health problems. For example, if a clinician

is interested in the risk of a certain life outcome given a certain personality trait, the clinician may defer to an informant-report of that trait rather than a self-report.

Self–other agreement on personality disorder also depends on the way that personality disorder is classified. Personality disorders are currently defined in the DSM-5 Section II as categorical types. Many people in the lay public have heard of borderline, paranoid, and narcissistic personality disorders. This traditional conceptualization, however, is plagued with problems—the largest being that personalities do not fall into personality types (or categories). Personality disorders can be understood similarly to normal personality—as dimensions, or constellations of traits.

21st Century Shift in the Conceptualization and Classification of Personality Disorder

The release of explicit criteria sets for categorical personality disorders in the DSM-III (APA, 1980) was a significant development in the clinical and empirical classification of personality disorders. For example, instead of short descriptions for different types of personality disorder, personality disorders now contained detailed lists of specific criteria, or symptom sets. If a person were to present with a certain number of the criteria (e.g., at least five of nine symptoms listed for borderline personality disorder), they could be diagnosed with the personality disorder. This system represented a huge improvement because clinicians across the United States could now refer to the same criteria while diagnosing personality disorders. Unfortunately, the criteria for each personality disorder were still largely developed on the basis of clinical experience and anecdotal evidence (Widiger & Clark, 2000). This unscientific method that was used for the development of the criteria sets has proven problematic because of 1) the arbitrary cutoff thresholds (e.g., people with four symptoms likely have impairment levels similar to those with five symptoms, but may not meet the threshold for a personality disorder

diagnosis), 2) high rates of co-occurrence across the categorical personality disorder types (e.g., borderline and dependent, and many other combinations are often present within the same person), and 3) heterogeneity within disorders (e.g., people with the same personality disorder diagnosis may have almost entirely different symptoms; Clark, 2007; Widiger & Trull, 2007).

Research over the past few decades has demonstrated that the facets and domains of the FFM can be extended to capture DSM personality disorders (Lynam & Widiger, 2001; Samuel & Widiger, 2008). Further, new measures that assess maladaptive variants of the FFM facets can be used to better capture personality disorder traits (Widiger et al., 2017). This evidence suggests that personality disorders can be conceptualized as “constellations” of maladaptive variants of personality traits from the FFM (Lynam & Widiger, 2001). Subsequent research has demonstrated that the FFM can address problems related to the traditional DSM categorical approach to the diagnosis of personality disorders. For example, there are no arbitrary diagnostic cutoffs, no “types” of personality disorder, and fewer co-occurrences and heterogeneity within types. There are only constellations of maladaptive traits. The FFM was developed based on the “lexical hypothesis,” which postulates that the importance of personality trait terms is based on their level of representation in the language: More important traits presumably have more synonym terms (Allport, 1937; Goldberg, 1993). Thus, the FFM not only helps resolve problems of heterogeneity and unreliable categories/types—it rests on a firm scientific base².

Section-III of the DSM-5 includes an alternative dimensional model of personality disorder (the AMPD). It was designed to be a replacement for the traditional DSM categorical model, and it resembles closely many of the features of an FFM approach to PD. The AMPD

² Assessment of maladaptive personality traits at the facet level will be important for future classification, as assessment of only broad maladaptive trait *domains* may lead to similar heterogeneity problems as in broad DSM personality disorder types.

model includes Criterion A, which describes problematic self and interpersonal functioning, and Criterion B, which includes a five-domain maladaptive trait model. The AMPD states, “these five broad domains are maladaptive variants of the five domains of the extensively validated and replicated personality model known as the ‘Big Five’ or Five Factor Model of personality (FFM)” (APA, 2013, p. 773). Underneath the five broad domains are listed 25 more specific facets of maladaptive personality that can be understood as maladaptive variants of FFM traits (see Krueger et al., 2012 for a review; and Crego, Oltmanns, & Widiger, 2018). This model is a promising leap for personality disorder classification, but its official adoption was rejected by the APA Board of Trustees (Widiger, 2013). Although it currently appears in the DSM-5 Section III entitled “Emerging Measures and Models,” it is generating considerable interest among researchers and clinicians (Al-Dajani, Gralnick, & Bagby, 2016). The upcoming release of the World Health Organization’s (WHO) *International Classification of Diseases, 11th edition* (ICD-11; WHO, 2018) has proposed a similar dimensional trait model of personality disorder—including 1) a general level of personality disorder severity and 2) five maladaptive trait domains (Tyrer, Mulder, Kim, & Crawford, in press). The DSM-5 AMPD was an important step towards the official adoption of a dimensional model of personality disorder. The adoption of an official dimensional personality disorder trait model in the ICD-11 is an even more important step because the ICD is the authoritative mental disorder diagnostic system for 194 WHO member countries around the world (Oltmanns & Widiger, 2018)—the DSM is the system for mental disorder diagnosis only in the United States. The adoption of a dimensional personality disorder model in ICD-11 would indicate that, moving forward, personality disorder will be classified dimensionally using maladaptive trait domains in the DSM and in the ICD.

Self–Other Agreement on Personality Disorder: A Brief Literature Review

More than 50 studies have been published regarding self–other agreement on the presence of personality disorder traits and symptoms. There are important distinctions in methodology among these studies, and their results vary in important ways (as discussed previously). We will review influential findings in the following sections.

Rank-order agreement.

Our compilation of over 50 studies of self–other agreement on personality disorder reported a range of rank-order correlation sizes from $r = .12$ to $r = .90$, with a median of $r = .35$ (see Table 1). There are college, clinical, and community samples presenting a range of effect sizes from small (e.g., Tackett et al., 2013; Yalch & Hopwood, 2016; Zimmerman et al., 1988) to large (e.g., Coolidge et al., 1995; Few et al., 2013; Kelley et al., 2018; Miller et al., 2011). Likewise, there are studies with clinicians, classmates, partners, close others, and parents serving as informants that present both small (Ferro & Klein, 1995; Hill et al., 2000; McKeeman & Erickson, 1997; Tackett et al., 2013; Samuel et al., 2014) and large effect sizes (Coolidge et al., 1995; Few et al., 2013; Kelley et al., 2018; Peselow, Sanfilipo, Fieve, & Gulbenkian, 1994; Tromp & Koot, 2010). A similar pattern is found when considering differences in effect sizes for studies with similar target age and gender, length of acquaintance, method of assessment, and assessment instrument. Sample size does not appear to influence the magnitude of the correlation. The variability in these findings and in the methodologies used might reflect the lack of controlled systematic research on this topic. The findings indicate the need for more careful studies controlling for several of these variables while examining the effects more specifically. The only firm conclusion that can be drawn to date is that, based on a number of factors, agreement appears variable. Interestingly, the presence of personality disorder in target persons

has been shown to reduce agreement on FFM personality traits (Furr, Dougherty, Marsh, & Mathias, 2007).

Mean-level agreement.

Mean-level agreement is also important in the consideration of self–other agreement, but it has been studied less frequently than rank-order agreement. Studies that have compared mean self-reported levels of personality disorder traits to mean informant-reported levels of personality disorder traits have produced inconsistent findings. In terms of the DSM PDs, many studies with clinical samples have reported similar diagnostic rates between self and informant-reports—indicating self–other agreement on diagnosis (Bernstein et al., 1997; Case et al., 2007; Dreessen et al., 1998; Walters et al., 2004). However, several studies have found significant mean-level differences where informants report significantly more narcissistic and borderline personality pathology than is found in the self-reports (Keulen et al., 2011; Miller et al., 2005; Modestin & Puhon, 2000; Riso et al., 1994; Schuppert et al., 2012). Several studies have found mean-level self-reports of avoidant and obsessive-compulsive personality pathology to be significantly higher than informant-reports (Clifton et al., 2005; Miller et al., 2005; Modestin & Putin, 2000; South, Oltmanns, Johnson, & Turkheimer, 2011).

Regarding maladaptive traits, Samuel et al. (2018) found that clients generally rated themselves higher on maladaptive personality traits than their therapists rated them, particularly with regard to traits in the domain of psychoticism, which largely composes traits of schizotypal personality disorder. The effect was so large that it might reflect a misunderstanding of the psychoticism items on the part of the clients. Indeed, the PID-5 psychoticism items include delusions that are characteristic of schizophrenia—not schizotypal personality traits (see Crego & Widiger, 2017 for an in-depth discussion of this issue). Other studies have failed to find mean-

level differences between self- and informant-reported levels of maladaptive personality traits (Fowler & Lilienfeld, 2007). South and colleagues (Jopp & South, 2015; South et al., 2011) have found that, within romantic couples, partners tend to attribute more pathological traits to themselves than to their partners. Overall, studies using dimensional maladaptive trait perspectives have found that self-reports show higher mean-levels than informant-reports, with discrepancies between studies. Several single studies have found higher mean-levels of maladaptive traits from the informant-perspective, but, to our knowledge, these specific findings have not yet been replicated: In single studies, informant-reports have been significantly higher on negative temperament and disinhibition (Keulen et al., 2011), psychopathy (on one out of three measures; Miller et al., 2011), and rejection (Tromp & Koot, 2010).

Future research studies should include mean-level comparisons, which can be useful for identifying which source reports more personality pathology and for identifying the variables that may be responsible for mean-level differences. However, as mentioned previously, mean self- and informant-report ratings on maladaptive traits may not be equivalent. For example, on a scale from 1-5 (with “5” being the most maladaptive response), a “3” rating from the informant-report might be just as maladaptive as a “4” rating from the self-report. This would be evidence that informants report maladaptive personality at lower levels (Balsis and colleagues have demonstrated this; Balsis et al., 2017). This may directly reduce mean-level agreement between self- and informant-reports. In this case, mean-level comparisons between self- and informant-reports may not be particularly useful—because the self and informants complete items differently. Alternative methods may have to be used in order to meaningfully compare mean-level self–other agreement.

Meta-Analyses

The surge of studies on self–other agreement for personality disorder traits and the inconsistencies in the literature indicate that new meta-analyses would be useful. Klonsky et al. (2002) reviewed 17 studies and concluded that agreement was “modest at best” (p. 300). Klonsky and colleagues examined agreement on categorical personality disorder diagnoses using the kappa statistic and found unequivocally low self–other agreement. The low kappa statistics might reflect problems associated with the categorical personality disorder classification (i.e., it is harder for self and informant to agree when an arbitrary threshold must be met to contribute to the agreement statistic). In the present analyses, we focused on rank-order correlations between continuous measures of either DSM-type personality disorder symptoms or maladaptive personality traits, which are probably more accurate measures of self–other agreement because they are not categorical. Since Klonsky’s systematic review, more than 30 studies have been conducted on self–other agreement for personality disorders. Studies were selected for the present meta-analysis if they presented original empirical data in which self–other agreement was quantified by comparing scores on self- and informant-report personality disorder instruments using correlations of ordinal test scores. An additional literature search on PsychINFO was conducted using all combinations of the search terms from each of the three following groups with all terms from the other groups: 1) “personality disorder,” “maladaptive personality,” and “personality pathology,” 2) “agreement,” “correspondence,” “convergence,” and “correlation,” and 3) “informant,” “observer,” “other,” and “spouse.” The search was conducted on studies published through August 2018.

Meta-analyses were conducted on 53 studies of self–other agreement on personality disorder symptoms and traits (including several qualifying studies that were included in the Klonsky review; see Table 1). We present three meta-analyses: 1) A meta-analysis of overall

self–other agreement on personality disorder as measured by DSM symptoms and dimensional maladaptive traits, 2) A meta-analysis of self–other agreement on traditional DSM personality disorder symptoms, and 3) A meta-analysis of self–other agreement on maladaptive personality disorder traits from the perspective of emerging dimensional models of personality disorder (i.e., the PID-5). The analyses were conducted in R statistical software (R Core Team, 2013) using the *robumeta* (Fisher & Tipton, 2015) and *metafor* (Viechtbauer, 2010) packages. Random-effects models were fit using a restricted maximum-likelihood estimator. The data file compiled from the studies and R syntax are available online at: <https://osf.io/gd6tc/>.

1. Overall meta-analysis of self–other agreement on PD. All 53 studies were used in the first meta-analysis examining the overall median correlation of self–other agreement on PD features (symptoms/traits). The degree of heterogeneity was significant ($\tau^2 = .0320$, $SE = 0.0084$, 95% *CI* [.0202, .0605]), indicating that there were significant differences in the study effect sizes. I^2 was 86.87%, (95% *CI* [80.64, 92.58]) indicating that 86.87% of the variation in effect sizes was reflective of actual differences in the population mean. The Q statistic ($Q = 298.3725$) had 52 degrees of freedom and was statistically significant ($p < .0001$), indicating that the studies did not share a common effect size. The estimated model coefficient (i.e., summary effect size) was $r = .37$, 95% *CI* [.32, .42]). A forest plot of all studies is presented in Figure 1.

A set of diagnostic tests derived from standard regression that is used to identify outliers (studies with large effects on overall study heterogeneity) is included in the *metafor* package (Viechtbauer & Cheung, 2010). One study (Peselow et al., 1994; pre-treatment group, median $r = .90$) fulfilled criteria as an influential study ($Q = 221.6024$; See Figure 2). These tests indicate that Peselow et al.’s study showed a significantly higher level of self–other agreement than the other studies. A funnel plot was created (see Figure 3) and Egger’s regression and rank

correlation tests were completed to check for publication bias (Quintana, 2015). The regression test for funnel plot asymmetry was statistically significant at $z = 2.4491$, $p = .0143$, but the rank correlation test was not significant (Kendall's $\tau = .144$, $p = .1286$), suggesting some presence of publication bias. However, heterogeneity can occur for several reasons, including heterogeneity in the methodology of the studies included in the meta-analysis (Sterne et al., 2011), which was indeed present in this case. Further, studies on self–other agreement on personality disorder traits often include tests of many traits at the same time, some of which may be significant and others not. As a result, the evidence for publication bias is unclear.

Moderator analyses were completed to check for the influence of several variables that were presented in all studies on the heterogeneity of findings across studies. Target age and target gender did not moderate the overall effect size ($QM[1] = 2.52$, $p = .1123$ and $QM[1] = 0.00$, $p = .9706$, respectively), nor did dummy-coded sample type variables (community ($QM[1] = 0.12$, $p = .7289$), clinical ($QM[1] = 2.14$, $p = .1433$), college ($QM[1] = 0.72$, $p = .3961$), or informant relationship variables (parent ($QM[1] = 0.05$, $p = .8262$), partner ($QM[1] = 0.11$, $p = .7342$), or clinician ($QM[1] = 1.45$, $p = .2283$)). There is some evidence that use of assessment interviews ($QM[1] = 4.04$, $p = .0445$) moderated the relationship—the use of questionnaires did not ($QM[1] = 1.81$, $p = .1787$).

2. Meta-analysis of self–other agreement on symptoms from specific DSM PD types.

The number of studies used in meta-analyses for median self–other correlations on each of the ten specific DSM PDs ranged from 20 (schizoid) to 27 (borderline), with a median of 23.5. The degrees of heterogeneity were significant, ranging from $\tau^2 = .0569$ ($SE = 0.0216$; schizoid) to $\tau^2 = .136$ ($SE = 0.0466$; narcissistic), with a median of $\tau^2 = .0817$. I^2 ranged from 94.14% (borderline) to 97.72% (narcissistic), with a median of 96.10%, indicating the percentages of

variation in effect sizes was reflective of actual differences in the population means. The Q statistic ranged from $Q = 223.1648$ (schizotypal) to $Q = 332.5484$ (obsessive-compulsive), with a median of $Q = 267.7654$. The Q statistics were all significant ($p < .0001$), indicating that the studies displayed a significant amount of heterogeneity (i.e., did not share a common effect size).

To account for multiple effect sizes that were compiled from individual studies using the same sample (i.e., dependency in the data), robust variance estimation (RVE; Hedges, Tipton, & Johnson, 2010) was used to calculate meta-analytic summary effect size coefficients. Meta-analytic summary effect size estimates are presented in Table 2. They ranged from .32 (dependent) to .51 (antisocial), with a median of .38, indicating that the average effect size of self–other agreement on personality disorders measured continuously was moderate.

Funnel plots, Egger’s regression test, and rank correlation tests were completed for each of the 10 DSM PDs to check for publication bias (Quintana, 2015). The regression and rank correlation tests for funnel plot asymmetry were statistically significant for borderline, histrionic, dependent, and obsessive-compulsive personality disorders. For schizotypal, the rank correlation test was significant but not the regression test, and the opposite was true for avoidant. These results similarly indicated publication bias in the literature. Similar to the overall funnel plot (Figure 3), the results for specific DSM PD studies showed imbalance where studies appeared to be missing from the right side of the plot. This would indicate that the effect size estimates for four of the PDs (borderline, histrionic, dependent, obsessive-compulsive) and possibly two more (schizotypal and avoidant), are perhaps larger than the coefficients that are presented here. However, again the heterogeneity may be due to other methodological reasons besides publication bias (Sterne et al., 2011).

3. Meta-analysis of self–other agreement on DSM-5 maladaptive trait domains (from the AMPD). Eight studies were used in meta-analyses for median self–other correlations on each of the five the DSM-5 maladaptive trait domains. The degrees of heterogeneity were significant, ranging from $\tau^2 = .0027$ ($SE = 0.0070$; antagonism) to $\tau^2 = .0254$ ($SE = 0.0207$; detachment), with a median of $\tau^2 = .0134$. I^2 statistics were 19.56% (antagonism), 47.12% (psychoticism), 54.61% (disinhibition), 67.89% (negative affect), and 69.56% (detachment), indicating the percentages of variation in effect sizes were reflective of actual differences in the population means for the domains besides antagonism. The Q statistic ranged from $Q = 7.6585$ (antagonism) to $Q = 25.3377$ (detachment), with a median of $Q = 14.9629$. The Q statistics were significant for negative affectivity ($p = .0016$), detachment ($p = .0007$), and disinhibition ($p = .0365$), indicating that these domains displayed a significant amount of heterogeneity (i.e., did not share a common effect size).

To account for multiple effect sizes as well as small sample sizes, robust variance estimation RVE was again used to calculate meta-analytic summary effect size coefficients adjusted for small samples (Tipton, 2015). Meta-analytic summary effect size estimates are presented in Table 2. They ranged from .33 (psychoticism) to .50 (detachment), with a median of .45, indicating that the average effect size of self–other agreement on maladaptive personality traits was moderate.

Diagnostic tests indicated that one study (Few et al., 2013; median $r = .63$, $N = 109$) fulfilled criteria as an influential study in the meta-analyses in each PID-5 trait domain, and that Markon et al. (2013) Study 2 fulfilled criteria as an influential study specifically in the antagonism meta-analysis ($r = .31$, $N = 221$). Egger’s regression test and rank correlation tests were completed for each of the five maladaptive trait domains to check for publication bias

(Quintana, 2015). None of the tests were significant, indicating no publication bias in the literature.

Discussion.

Results from the present meta-analysis indicate that, overall, self–other agreement on personality disorder symptoms and traits is $r = .37$. Agreement on the maladaptive trait domains of the DSM-5 AMPD displayed relatively better agreement than the symptoms of the DSM-5 Section II PD categories. The assessment of personality disorder traits on continua as opposed to dichotomous categories appears to improve agreement. The Klonsky et al. (2002) review’s conclusions were perhaps influenced by the consistently very low kappa statistics that measure diagnostic agreement on dichotomous personality disorder categories. Only 13 studies of self–other agreement on PD were reviewed at that point, and only 11 included correlation coefficients. In contrast, the present meta-analysis used 53 studies meeting our criteria for inclusion. Further, in the years since the Klonsky et al. review was published, dimensional models and measures have been further developed and validated that may contribute to enhanced self–other agreement on personality disorder traits.

Moderation analyses suggested that neither target age nor gender, sample type, nor target/informant relationship type moderated levels of self–other agreement. There was slight evidence that agreement was better when both target and informant were assessed by interview. The lack of significant moderator findings in general may have to do with imbalance of study methodologies—because there is such variety, for each potential moderating variable only a small number of studies have been reported. Sufficient evidence is not yet available to conclude that these variables truly do not moderate self–other agreement. We suggest that more research is needed considering each of these potential moderating variables. Self–other agreement may also

depend on the number of items used to assess a specific construct. Agreement has been lower in DSM-related studies, which often rely only on one item per DSM criterion, whereas agreement on maladaptive traits from a dimensional perspective is typically based on several items per facet scale. Yalch and Hopwood (2016) found lower agreement on dimensional maladaptive traits when they were measured from both self- and informant-perspectives using only one item per trait. This is yet another area that would benefit from further research.

Agreement was higher for the antisocial, histrionic, and borderline personality disorders compared to the other DSM PDs. These PDs have historically been part of the “Cluster B” group of personality disorders that is characterized by outgoing and externalizing symptoms. According to adaptive personality models of self–other agreement, outgoing and externalizing features may be more observable to the self and others, more noticeable, and therefore more easily reportable (Funder, 1995; Vazire, 2010; see also Ch. 8 by Krzyzaniak & Letzring in this handbook). Narcissistic personality disorder is also traditionally part of Cluster B, but it has displayed relatively lower agreement across a variety of relationship types (Klonsky et al., 2002; Lukowitsky & Pincus, 2013; Oltmanns, Crego, & Widiger, 2018). This could be the result of vulnerable features characterizing narcissism—such as shame, anger, and insecurity (Miller et al., 2018)—that are associated with lower self–other agreement (Oltmanns et al., 2018). On the other hand, borderline PD also has internalizing features with relatively higher agreement. Perhaps the different distinctive features of borderline PD, such as recklessness and rashness, are more observable and easier to rate for both the self and others compared to the vulnerable and internalizing presentation that can accompany narcissism (Pincus & Lukowitsky, 2010). The remaining DSM PDs displayed relatively lower agreement, with the exception of schizoid. The relatively higher agreement on schizoid features may result from the core of detachment (low

extraversion) that is characteristic of schizoid PD (Krueger et al., 2012; Samuel & Widiger, 2008). Maladaptive low-extraversion behavior might be more noticeable to the self and others.

In the meta-analysis of maladaptive traits, agreement was highest for detachment and disinhibition—the maladaptive low poles of extraversion and conscientiousness, respectively. This finding supports the hypothesis that agreement should be higher on traits related to extraversion and conscientiousness because they are more observable and therefore more reportable by informants (c.f. Vazire, 2010). Agreement was relatively lower on negative affectivity (the high pole of neuroticism) and antagonism (the low pole of agreeableness). This finding also aligns with the hypothesis that neuroticism and agreeableness traits are more internal, less observable, more evaluative, and therefore less agreed upon by the self and others. These meta-analytic findings indicate that studies demonstrating relatively higher self–other agreement on antagonistic or negative affective traits may be the exception, rather than the rule. Psychoticism displayed the lowest self–other agreement. Samuel and colleagues (2018) have noted conspicuously lower agreement on psychoticism traits between patients and their therapists, and the results of our meta-analysis corroborate this finding.

Conclusions and Future Directions

The current meta-analysis indicates that the average level of self–other agreement on personality disorder traits is $r = .37$ and may be described as moderate (Cohen, 1992). Dimensional trait models of personality disorder appear to have better self–other agreement, perhaps in part because they typically include more assessment items per trait domain. There is significant variability across studies, and more careful research is obviously needed. In particular, more research is needed to identify moderators that explain the variability. Valuable information could be gained by more systematic studies including multiple age groups and

multiple assessments (in addition to sources of information)—perhaps in the same studies—to examine potential moderating variables. We recommend that researchers always report, at least, the following self and informant characteristics: age, sex/gender identity, race/ethnicity, the number of informants per target, relationship type, length of acquaintance, closeness, a rating of liking, and several methodological variables: measurement type (i.e., interview, questionnaire), the specific assessment instrument (for both the target and informant), reliability information, and target and informant variable means with tests for significant mean-level differences and effect sizes. It must be noted that small changes in study design might lead to dramatic changes in self–other agreement. For example, the relationship type between the target and the informant or the specific instrument used to measure personality disorder traits might significantly influence the level of agreement. Additional research on mean-level differences in self–other agreement on personality disorder traits is also warranted. Further, research considering sensitivity (i.e., from an item response theory perspective; c.f. Balsis et al., 2017) of self- versus informant-measures of personality disorder traits would be particularly important for understanding these differences. This work will continue to shed light on factors that influence levels of self–other agreement on personality disorder traits. The results could have important implications for assessment, diagnosis, treatment, and prediction.

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Table 1

Studies included in meta-analysis

Author(s)	Year	Median r	N	Sample Type	Target Age (M)	Target Percent Female	Informant Type	Assessment Method
Bernstein et al.	1997	0.47	62	clinical	40.6	10	close others	interview
Bottesi et al.	2018	0.40	80	community	31.5	80	close others	questionnaire
Bradley et al.	2007	0.33	54	clinical	30.0	57	clinician	questionnaire
Caspi et al.	2001	0.49	67	community	33.0	0	partners	interview
Clifton et al.	2004	0.15	2013	military	20.0	38	training groups	questionnaire
Coolidge et al. 1	1995	0.51	52	college	35.9	50	spouses	questionnaire
Coolidge et al. 2	1995	0.36	52	college	35.9	50	friends	questionnaire
Decuyper et al. 1	2014	0.36	197	community	18.2	72	mothers	questionnaire
Decuyper et al. 2	2014	0.35	197	community	18.2	72	mothers	questionnaire
Dowson	1992	0.38	60	clinical	34.1	77	close others	questionnaire
Dreessen et al.	1998	0.31	42	clinical	33.4	46	close others	interview
Ferro & Klein	1997	0.18	224	mixed	32.2	74	close others	interview
Few et al.	2013	0.63	109	clinical	35.9	71	clinicians	questionnaire
Fowler & Lilienfeld	2007	0.32	60	college	18.9	75	close others	questionnaire
Hill et al.	2000	0.18	56	clinical	41.0	52	couples	interview
Jopp & South	2015	0.34	48	couples	25.7	100	couples	questionnaire
Jopp & South	2015	0.45	48	couples	26.6	0	couples	questionnaire
Kaurin et al. 1	2018	0.43	256	college	19.8	51	close others	questionnaire
Kaurin et al. 2	2018	0.23	256	college	19.8	51	close others	questionnaire
Kelley et al.	2018	0.52	87	college	18.9	64	roommates	questionnaire
Keulen et al. 1	2011	0.27	24	forensic	37.6	0	clinicians	questionnaire
Keulen et al. 2	2011	0.20	24	forensic	37.6	0	clinicians	questionnaire

Lawton et al.	2011	0.46	760	community	59.5	55	close others	questionnaire
Lukowitsky & Pincus	2013	0.15	437	college	21.2	41	classmates	questionnaire
Markon et al. 1	2013	0.48	40	community	N/A	48	close others	questionnaire
Markon et al. 2	2013	0.30	221	community	41.7	45	close others	questionnaire
McKeeman & Erickson	1997	0.27	75	college	21.2	100	roommates	questionnaire
Miller et al. 1	2004	0.47	69	clinical	36.1	58	close others	questionnaire
Miller et al. 2	2005	0.51	69	clinical	36.1	58	close others	interview
Miller et al. 3	2011	0.67	32	community	38.8	53	close others	questionnaire
Oltmanns & Turkheimer	2006	0.23	1686	college	18.5	67	hallmates	questionnaire
Oltmanns et al. 1	2014	0.23	1437	community	59.6	55	close others	questionnaire
Oltmanns et al. 2	2018	0.35	137	college	19.0	65	close others	questionnaire
Ouimette et al.	1995	0.35	63	college	19.4	60	close others	questionnaire
Peselow et al. 1	1994	0.90	58	clinical	42.4	52	close others	interview
Peselow et al. 2	1994	0.73	58	clinical	42.4	52	close others	interview
Ready & Clark	2002	0.37	90	clinical	35.0	81	close others	questionnaire
Ready et al.	2000	0.44	189	college	19.7	64	friends	questionnaire
Riso et al.	1994	0.36	105	clinical	31.9	74	close others	interview
Samuel et al. 1	2013	0.35	320	clinical	32.9	62	clinicians	mixed
Samuel et al. 2	2013	0.22	320	clinical	32.9	62	clinicians	questionnaire
Samuel et al. 3	2014	0.12	130	clinical	37.4	31	clinicians	questionnaire
Samuel et al. 4	2014	0.15	130	clinical	37.4	31	clinicians	mixed
Samuel et al. 5	2018	0.41	54	clinical	39.8	52	clinicians	questionnaire
Schuppert et al.	2012	0.35	122	clinical	15.9	95	parents	questionnaire
Sleep et al.	2018	0.37	197	community	26.9	60	close others	questionnaire
South et al.	2011	0.36	82	community	32.0	100	partners	questionnaire
South et al.	2011	0.39	82	community	34.0	0	partners	questionnaire
Tackett et al.	2013	0.25	489	community	14.3	54	parents	questionnaire
Tromp & Koot	2010	0.47	110	clinical	15.6	65	parents	questionnaire
Tyrer et al.	1979	0.12	15	clinical	N/A	N/A	clinicians	interview

Yalch & Hopwood	2016	0.22	101	college	20.0	76	close others	questionnaire
Zimmerman et al.	1988	0.28	66	clinical	37.0	65	close others	interview

Note. Numbered studies have more than one effect size based on different sample or informant types.

Table 2

Meta-Analytic Self–Other Agreement Correlation Effect Sizes

	<i>r</i>	<i>SE</i>	<i>t</i>	<i>df</i>	<i>p</i>	95% CI	RVE τ	<i>k</i>
<i>DSM PDs</i>								
Paranoid	.38	.08	4.53	17	<.001	.20, .56	.0389	23
Schizoid	.42	.07	6.20	14	<.001	.27, .56	.0358	20
Schizotypal	.37	.06	6.01	19	<.001	.24, .50	.0274	26
Antisocial	.51	.07	7.19	18	<.001	.36, .66	.0411	25
Borderline	.44	.06	7.11	20	<.001	.31, .56	.0300	27
Histrionic	.43	.10	4.48	15	<.001	.22, .63	.0357	21
Narcissistic	.37	.10	3.52	15	0.003	.15, .59	.0444	21
Avoidant	.38	.07	5.38	17	<.001	.23, .53	.0432	24
Dependent	.32	.08	4.02	15	0.001	.15, .49	.0390	21
Obsessive	.37	.08	4.80	18	<.001	.21, .54	.0426	26
<i>PID-5 Domains</i>							RVE ω^2	
Negative Affect	.45	.06	6.98	5.57	<.001	.29, .62	.0832	8
Detachment	.50	.06	8.08	5.56	<.001	.35, .66	.0910	8
Psychoticism	.33	.05	6.85	5.61	<.001	.21, .45	.0487	8
Antagonism	.43	.04	11.4	5.62	<.001	.34, .53	.0241	8
Disinhibition	.53	.06	9.06	5.61	<.001	.38, .67	.0214	8

Note. RVE = robust variance estimation, DSM PDs = personality disorders from the *Diagnostic and Statistical Manual of Mental*

Disorders, PID = Personality Inventory for DSM-5, k = number of outcomes.

Figure 1. Forest plot of overall median effect size correlations for studies of self–other agreement on personality disorder. Triangles indicate ranges less than -.40 or greater than .60.

Figure 2. *Diagnostic Tests for Influential Studies.* The one significant outlier is Peselow et al.'s (1994) reported pre-treatment median rank-order agreement coefficient.

Figure 3. *Funnel plot of all studies.*