

INTRODUCTION: PERSONALITY DISORDERS INTO THE 21ST CENTURY

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For those dedicated to studying the personality disorders (PDs), there is, perhaps, no period filled with greater irony in the history of modern clinical psychology and psychiatry than between 2005 and 2014. Indeed, some might find it amusing that those most interested in studying personality disorders experienced some of the most contentious debates in the move toward the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5; American Psychiatric Association, 2013), only for the Board of Trustees of the American Psychiatric Association to retain the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev. [DSM–IV–TR]; American Psychiatric Association, 2000) classification system for personality disorders that almost all agreed was dysfunctional, not empirically supported, and clinically not useful. If one were to invoke a musical metaphor to describe these series of events, one might consider 21st-century personality

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Personality Disorders: Toward Theoretical and Empirical Integration in Diagnosis and Assessment,
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disorder research nonmelodic, polyphonic, and, at times, atonal to the point of sounding rather cacophonous. However, with any serious piece of music, there are ways in which the composer takes the various themes and melodies and seeks to integrate them into something melodious and satisfying. In this case, the composer is the collective wisdom of scientific and scholarly activity. And, as editor of this volume, I could be described as a conductor of this highly talented orchestra of researchers and clinicians, who seek to take many themes and craft them together in a melodic fashion.

This is what this book is intended to do—to tell the story about the “cacophony” of attempts to label and define personality disorders over the past several years and to describe ways in which the future can be more harmonious. Stated within the scope of professional psychology, this book seeks to provide a framework for the diagnosis, assessment, and research on personality disorders that is theoretically and empirically sound, clinically robust, and of assistance to future generations of psychologists and mental health professionals.

Below, I provide a peek into this text by telling the story of how the cacophony swelled and how the themes are modulating. I first review the recent history and current directions for the study of PDs found in the Personality and Personality Disorders Work Group (PPDWG) proposals for DSM–5, the actual DSM–5 personality disorder system, the *International Classification of Diseases* (10th and 11th eds.), and the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006) and its upcoming revision. Then, I provide an overview of how this book is organized. I first describe those opening chapters that focus upon issues involving the use of categories and dimensions to assess and diagnose personality disorders. This is followed by a discussion of those chapters dedicated to enhancing the research and assessment strategies surrounding the personality disorders. I then briefly describe those final chapters that seek to integrate different “melodies” (i.e., theoretical perspectives) into a more harmonious model of personality disorders. For clinicians and researchers alike, the intention of this text is to help readers expand their thinking about the personality disorders, consider ways in which the field has and should evolve over time, and offer new ways to think about the patients we treat and the system we use by which to assess and diagnose them.

THE DSM–IV TO DSM–5 TRANSITION

In 2005, a white paper was published by Tom Widiger and Erik Simonsen in the *Journal of Personality Disorders*. It was the product of a group of personality disorder researchers who came together to offer important ideas about

how the field should evolve in preparation for *DSM-5*. Shortly thereafter, the PPDWG for *DSM-5* was formed, chaired by Andrew Skodol, MD.¹ In August 2009, the PPDWG presented some of its initial ideas about necessary changes for the diagnosis and assessment of personality disorders at the biannual Congress of the International Society for the Study of Personality Disorders (held at the Mt. Sinai School of Medicine). Included in this presentation was a discussion of the need to consider both categorical and dimensional systems of assessing personality disorders, including the use of personality traits in lieu of the extant formal categories. In March 2010, these ideas were formally posted on the *DSM-5* website. Paranoid, Schizoid, Histrionic, Narcissistic, and Dependent PDs were proposed for elimination. The remaining personality disorders were described not as categories with a polythetic composition of symptoms but as prototypes. In this case, clinicians were asked to determine to what extent a patient matched the newly formulated prototype. In this system, a 37-trait, facet system for assessing personality was suggested as an additional model for diagnostic assessment. The Levels of Functioning Scale was proposed as well, in which individuals' self- and other-representations were to be evaluated for their level of adaptation toward social functioning (Skodol et al., 2011).

Reaction to this was substantial, and little was positive. Three journals (*Personality Disorders: Theory, Research, and Treatment*; *Journal of Personality Disorders*; and *Journal of Personality Assessment*) took up these issues in a series of fairly critical papers. Shedler et al. (2010) published an editorial in the *American Journal of Psychiatry* denouncing the deletion of PD categories. Widiger (2011), a longtime supporter of trait assessment for the personality disorders, criticized the PPDWG for its dismissal of the five-factor model of personality as a viable system upon which to build the *DSM-5* diagnostic system. And Bornstein (2011a) and Ronningstam (2011) offered strong criticisms of the idea of deleting Dependent and Narcissistic PDs, respectively. A year later, Huprich (2012) offered a critical commentary about the PPDWG's failure to follow its own rules when deciding to eliminate Depressive PD from the diagnostic manual.

In response to some of these criticisms, the PPDWG proposed retaining Narcissistic PD. In further evaluation of the pathological personality trait structure, the PPDWG also concluded that five broad trait domains with 25 corresponding facets would best assess personality structure in its pathological expression. It thus published the Personality Inventory for *DSM-5*

¹Other members included Renato Alarcon, Carl Bell, Donna Bender, Lee Anna Clark, Robert Krueger, John Livesley, Les Morey, John Oldham, Larry Siever, and Roel Verhul. For an interesting discussion of the membership of this work group, see Blashfield and Reynolds (2012).

(PID-5) in both a patient self-report version and a clinician-assessed version. It also decided against the use of a prototype system and opted for the retention of six personality disorder categories. In doing so, the PPDWG noted that each category also could be described by a constellation of some number of the 25 pathological traits. Furthermore, it reiterated that personality disorders eliminated from the *DSM* could be subsumed within the trait structure, as could any patient with a pathological manifestation of personality who did not adequately fit the *DSM* criteria for the six remaining PDs. Despite these changes, controversy remained. In my preparation for a roundtable discussion on the topic of *DSM*-5 PDs at the 2011 annual meeting of the Society for Personality Assessment, I contacted Dr. Steven Hyman, chair of the *DSM*-5 Diagnostic Spectra Committee, about some of the changes then being discussed. He wrote (personal communication, February 8, 2011),

I am well aware of the controversy surrounding the proposed PD chapter in *DSM*-5. . . . I do not think that there was ever a serious notion of doing without a PD chapter in *DSM*-5, although there was a serious discussion of both distributing some PDs to other chapters and a serious discussion of cross-listing some disorders. There was a strong argument from diverse scientific sources to place schizotypal PD in a schizophrenia spectrum based on family, twin, cognitive, and imaging studies, and in accord with *ICD*-10 practice. . . . The second serious debate was about placing antisocial PD in a chapter with a group of externalizing disorders including CD [conduct disorder] based on comorbidity, family, and twin data. The metastructure discussion concluded with two alternatives, either moving ASPD [antisocial personality disorder] to externalizing (favored) or cross-listing in externalizing and PDs. I do not know how that will ultimately be resolved.

In May 2012, a series of critical talks about the *DSM*-5 Personality and Personality Disorders Work Group proposal were offered by myself and Drs. Robert Bornstein, Joel Paris, Mark Zimmerman, and John Livesley in a symposium at the American Psychiatric Association annual meeting. Dr. Andrew Skodol, chair of the work group, responded graciously to these concerns, reiterating the value of categorical and dimensional assessment, not to mention the utility of the Levels of Functioning Scale. However, on December 1, 2012, the Board of Trustees of the American Psychiatric Association opted not to adopt the PPDWG's proposal. Instead, it retained the current *DSM*-IV-TR (American Psychiatric Association, 2000) model (though the multiaxial approach of assigning personality disorders on Axis II was eliminated). The work group's proposal for a hybrid category and trait system was published in Section III of *DSM*-5 (American Psychiatric Association, 2013). And so, after nearly five years of work and preparation

for a change in the *DSM-5*, nothing fundamental had changed, leaving many disappointed by this series of events.

THE TRANSITION FROM *ICD-10* TO *ICD-11*

Planning for the next edition of the *International Classification of Diseases* is under way as this text is being published. Tyrer et al. (2011) described changes being proposed for the diagnosis and assessment of personality disorders in the *ICD-11*. These include classifying personality disorders mainly on the basis of the level of severity, providing a classification system that is based on five broad trait domains, and providing a rating procedure that allows a diagnosis to be made more easily than does the existing procedure. Like the PPDWG, the *ICD-11* work group has argued that the current labels for personality disorders are unsatisfactory, given the paucity of empirical support for some and their extensive overlap. It also has noted that wide varieties of disturbance in personality pathology and an artificial dichotomy between normality and abnormality are present in the current system. Finally, it has noted that the stigma associated with a personality disorder diagnosis often precludes use of the diagnosis in many clinical settings, which necessitates a change in the way personality disorders are assessed and diagnosed.

By way of describing their ideas more completely, Tyrer et al. (2011) proposed five levels of severity for personality disorders in the *ICD-11*: (a) None; (b) Personality difficulty—some problems in certain situations; (c) Personality disorder—well-demarcated problems in a range of situations; (d) Complex personality disorder—definite personality problems usually across several domains and across all situations; and (e) Severe personality disorder—complex disorders that lead to risk to self or others. Additionally, Tyrer et al. described five trait domains that reflect qualities seen from the time of Hippocrates (450 BC) to the present. They described these domains as Asocial/Schizoid, Dyssocial/Antisocial, Obsessional/Anakastic, Anxious/Dependent, and Emotionally Unstable.

As was the case for the *DSM-5*, reaction to the *ICD-11* proposal was mixed. For instance, Bateman (2011) questioned whether a radical change should be employed without any evidence that it will do better than the extant system. He also questioned what would happen to clinically useful categories, such as Borderline PD, if a trait system defined by severity were adopted. Davidson (2011) questioned the exclusion of assessing self and relational functioning, as well as the idea that the new system would decrease stigmatization. Finally, Silk (2011) noted that clinician subjectivity still is the ultimate criterion by which diagnosis is assigned. This has been a criticism across past editions of the diagnostic manuals and will not be solved with the current proposal.

THE DEVELOPMENT AND EVOLUTION OF THE PSYCHODYNAMIC DIAGNOSTIC MANUAL

Though not as widely known as the *DSM* or *ICD*, the *Psychodynamic Diagnostic Manual (PDM)* was published in 2006 by the Alliance of Psychoanalytic Organizations. This group was composed of members from five different psychoanalytic and psychodynamic groups and was chaired by Nancy McWilliams and the late Stanley Greenspan.² It was the intent of these authors to create a manual informed by psychoanalytic and psychodynamic perspectives; more important, the *PDM* was meant to be clinician friendly and to describe the inner, subjective experience of patients—something that clinicians hear constantly and that most work with as part of their treatment for patients with personality disorder. The *PDM* was not intended to replace the *DSM* or *ICD* but to supplement them in a way that made it more clinically useful. As in the *DSM* system, several axes were described. The P Axis lists 15 types of personality disorders, seven of which have subtypes.³ These categories were based on the extant psychodynamic literature and informed by a vast body of research, which included 300 text pages of empirical summaries listed in the last part of the *PDM*. Reviews of the *PDM* have been favorable (e.g., Clemens, 2007; Weiner, 2006), including one by Widiger (2006), who has been a strong advocate of the trait system. At present, the *PDM*–2 revision is under way, being chaired by Vittorio Lingiardi and Nancy McWilliams (Huprich et al., in press).

The P Axis will be reformulated in several ways in the *PDM*–2. First, a psychotic level of personality organization or “psychotic ways of functioning” may be added in the “Low Level of Borderline Personality Organization” subtype. Second, the types of personality disorders listed on the P Axis will be integrated and revised. Classification of these disorders will be guided by recent developments in the assessment research literature and could incorporate the findings of measures such as the Shedler–Westen Assessment Procedure (SWAP-200) and its new versions and applications (SWAP-II: Westen, Shedler, Bradley, & DeFife, 2012; SWAP-200-Adolescents: Westen, Shedler, Durrett, Glass, & Martens, 2003), the Psychodynamic Diagnostic Prototypes (Gazzillo, Lingiardi,

²The American Psychoanalytic Association, the International Psychoanalytical Association, Division 39 (Psychoanalysis) of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the National Membership Committee on Psychoanalysis in Clinical Social Work (subsequently renamed the American Association for Psychoanalysis in Clinical Social Work).

³The personality disorders listed in the *PDM* include schizoid, paranoid, psychopathic/antisocial (passive and aggressive subtypes), narcissistic (arrogant and depressed subtypes), sadistic and sadomasochistic, masochistic/self-defeating (moral and relational subtypes), depressive (introjective, anaclitic, and mixed subtypes), somatizing, dependent (passive-aggressive and counterdependent subtypes), phobic/avoidant, anxious, obsessive-compulsive (obsessive and compulsive subtypes), hysterical/histrionic (inhibited and demonstrative subtypes), dissociative identity, and mixed.

& Del Corno, 2012), the Inventory of Personality Organization (Kernberg & Clarkin, 1995), the Structured Interview of Personality Organization (Clarkin, Caligor, Stern, & Kernberg, 2004), and the Karolinska Psychodynamic Profile (Weinryb, Rössel, & Åsberg, 1991a, 1991b). Moreover, an Emotionally Dysregulated Personality Disorder, which roughly corresponds to the *DSM* description of Borderline Personality Disorder, may be added.⁴ Given that the *PDM* does not have such a construct, such an addition may be empirically and clinically warranted.

Third, Blatt's (2008) conceptualization of two key configurations of psychopathology, anaclitic and introjective, is examined in greater depth in terms of the relationship of these concepts to the personality disorders. Introjective issues, centered on problems about the definition of one's identity, seem to predominate within Schizoid, Schizotypal, Paranoid, Narcissistic, Antisocial (Psychopathic), and Obsessive–Compulsive PDs. Anaclitic issues, related to the need to develop more stable and mutual object relations, seem more predominant in Borderline, Histrionic, and Dependent PDs.

Summary

As noted above, the creators of the *DSM*, *ICD*, and *PDM* frameworks all want to change the classification and diagnosis of personality disorders. *DSM* and *ICD* advocates have clear interests in incorporating a dimensional model by which to classify and describe personality pathology, and *PDM* advocates have more interests in retaining a typological system that is based upon the degree of fit between a patient and a particular prototype. In that sense, all three frameworks are moving toward recognizing a dimensional nature to the personality disorders. Likewise, the creators of all three manuals are interested in assessing an individual's level of functioning, though in slightly different formats—such as severity level (*ICD*), quality of relationships and interpersonal functioning (*DSM*), and level of personality organization, which de facto translates into an overall level of functioning across multiple domains.

Given what I have described above regarding the recent and upcoming changes in the diagnostic manuals, it should be clear that the field is set for a paradigm shift. How this shift should occur, however, has been the focus of much debate and, at times, sharp criticism. Nevertheless, there is a line of convergence among theories and research findings that can and should be

⁴Axis P does not consider some traditional *DSM* personality disorders, such as Schizotypal and Borderline. This arose out of early work with the SWAP in which many patients diagnosed with Schizotypal PD actually were best classified on the Schizoid prototype, and those diagnosed with Borderline PD were on the Histrionic, Emotionally Dysregulated, Dependent, and Masochistic factors.

integrated so that the field of personality disorders can move forward into the 21st century with greater clarity and unity of perspective. This is the intention of creating this book at this time.

In the paragraphs to follow, I provide a brief overview of what the contributors have offered in their discussion of assessment, research, and diagnosis of personality pathology. It is my intention that readers will find these chapters helpful not only as an overview but also as a way to think about how to integrate theory, practice, and research in ways that provide patients the best of what our science and practice have to offer.

PART I: CURRENT ISSUES IN THE DIAGNOSIS AND ASSESSMENT OF PERSONALITY DISORDERS

As noted, there has been considerable debate about the utility and validity of the current *DSM-IV-TR/DSM-5* personality disorder categories (e.g., Clark, 2007; Clarkin & Huprich, 2011; Huprich & Bornstein, 2007; Krueger, Skodol, Livesley, Shrout, & Huang, 2007; Widiger & Samuel, 2005). Research on clinicians' preferences for diagnosing personality pathology indicates that clinicians prefer a type-based system and can more accurately assign a diagnosis when assessing the degree of match between a given type and their patient (Rhadigan & Huprich, 2012; Rottman, Ahn, Sanislow, & Kim, 2009; Spitzer, First, Shedler, Westen, & Skodol, 2008; Westen, 1997). As Kenneth Silk (Chapter 1) discusses, diagnosis is an essential component of providing health care in that it recognizes that some set of problems or symptoms that have a unifying set of causes exists and that these problems or symptoms can be understood and treated. Diagnostic categories or types also allow for a more consistent way in which clinicians can talk with each other (Clarkin & Huprich, 2011). These points are elaborated upon by Kevin Meehan and John Clarkin in Chapter 4. They raise important questions about how the identification of personality traits (pathological or not) can inform what it is that is done in the clinical setting. (And, as chapters in Part III demonstrate, most contemporary models of personality disorders focus upon issues of how the individual thinks about and relates to him/herself and others and less upon traits.)

Yet, the problems with the current categorical systems—and clinicians' reliance upon their internalized representations of such categories and types—are well documented. These include (a) a failure to “carve nature at its joints,” (b) lack of a meaningful or well-validated boundary between normal and disordered personality, (c) excessive heterogeneity within diagnostic categories, (d) excessive diagnostic co-occurrence across categories, (e) inadequate coverage of the full range of personality difficulties seen in clinical practice,

(f) questionable temporal stability of the diagnoses, (g) dissatisfaction among the clinicians with the current types, (h) questionable psychometric properties, and (i) problems in relying upon extant inner models and a failure to attend to all the data in front of the clinician. These issues are taken up directly by Douglas Samuel and Sarah Griffin (Chapter 2) and Kristian Markon and Katherine Jonas (Chapter 3). The authors of both chapters discuss the psychometric superiority and universality of dimensional models of personality and personality pathology. Markon and Jonas in particular describe benefits of a system of measurement that is based on unidimensional scales and traits and explain how the explanatory power of such measurement may exceed that of more heterogeneous, current diagnostic constructs.

Fortunately for the reader, the authors of these first four chapters offer ideas about how to integrate the disparate findings from their own points of view. They all recognize the necessity or implicit utility of categories and dimensions and view each framework as having strengths and weaknesses. Such ideas are not new;⁵ however, it would seem the time has come for newer diagnostic systems to incorporate the strengths of both categories and dimensions.

PART II: RESEARCH AND ASSESSMENT STRATEGIES

How personality disorders are assessed and studied has a big influence on what can be learned about the individual being assessed, because each method of assessment has its own strengths and shortcomings (Huprich & Bornstein, 2007). Given this context, Part II of the book offers important information about recent developments in assessment and research methodologies and how they have and can inform our understanding of personality pathology. It begins with Aidan Wright and Johannes Zimmermann's (Chapter 5) comprehensive summary of a plethora of data analytic techniques that have been developed and refined over the past two decades, which will be interesting to both researchers and clinicians. In their discussion of these techniques—which includes a primer on the methods themselves—Wright and Zimmerman offer ideas about why current personality disorder assessment methods contribute to the problems of comorbidity and fail to provide adequate differentiation of patients in meaningful ways. They also discuss how more recent developments in statistical modeling (e.g., factor mixture models, latent class analysis) allow for the identification of both categories and dimensions, something that is sure to be more frequently utilized in years to come.

⁵See Widiger, Trull, Clarkin, Sanderson, and Costa (2005); Strack and Millon (2007); and Shedler and Westen (2004).

Chapter 6 is provided by Alex Keuroghlian and Mary Zanarini, who discuss the lessons learned from recent longitudinal studies of personality disorders. Two important longitudinal studies are the focus of their attention: the McLean Study of Adult Development and the Collaborative Longitudinal Study of Personality Disorders. The authors highlight how traits and symptoms tend to remain stable over time (some more than others) but that DSM-based PD diagnoses often remit, contrary to the idea that personality disorders are stable and untreatable.

The development of brain imaging techniques and genetic markers or substrates associated with personality traits has been an exciting area of research in the past decade or so. In Chapter 7, Susan South presents a comprehensive overview of the biological assessment of personality disorders. Like Wright and Zimmerman, South provides a primer of current methodologies used to study genetic influences on personality. She describes how twin and family studies can be statistically modeled to assess the unique effects of genes and environment on self-reported personality traits and how newer methodologies can account for the interaction of genetics and environment. Many believe that the latter area is most important for understanding how certain traits come to be expressed in those who go on to develop a PD or personality pathology (South & DeYoung, 2013). For those not particularly inclined toward biological models of personality and its pathology, South's chapter will be a pleasant surprise for its readability and how it sheds light on processes and qualities once believed too difficult to assess.

Shifting gears, the next chapter discusses something many clinicians know well—the problems patients with personality disorder have in regard to interpersonal relatedness and the defenses these individuals use to help manage their often difficult lives. In Chapter 8, Caleb Siefert and John Porcerelli provide a valuable overview of the theoretical and empirical literature on assessing interpersonal relatedness and defenses, showing that a key component of just about all personality pathology is the problematic ways in which the self and others are experienced and how individuals use specific patterns of defense to manage these concerns. Given the PPDWG's interest in assessing self- and other-representations in order to quantify an individual's level of functioning (Bender, Morey, & Skodol, 2011), this chapter highlights the need to address these issues more carefully in the descriptive nosology of personality disorders. Issues related to the self and other are almost always a pervasive topic in the consultation room. Even more interesting, Siefert and Porcerelli suggest that many of the personality disorder symptoms can be viewed as a constellation of defenses. They highlight the value of psychodynamically informed assessment of many personality disorders within this framework.

Following up on these ideas is Chapter 9 by Jonathan Shedler, who reviews the work he and Drew Westen have done for over 15 years on the utility of assessing clinicians and developing a diagnostic assessment procedure based upon their expertise. While discussing the value of clinician expertise in the development of an assessment and diagnostic system, Shedler describes the Shedler–Westen Assessment Procedure, which is a clinician-informed, empirically derived system of diagnostic personality prototypes that are seen in daily practice by clinicians. Unlike a number of researchers, Shedler suggests that prototypes offer considerable advantages over dimensionalized trait systems, the most significant of which is their clinical utility.

In Chapter 10, Irving Weiner provides a basic review of the differences in explicit and implicit assessment strategies. He reminds the reader that self-report methods have their place, while also highlighting some significant limitations that are often not given due attention when considering how to assess personality pathology. This section ends with Chapter 11 by Robert Bornstein. In his chapter, Bornstein highlights an experimental methodology known as process-focused assessment (Bornstein, 2011b) and explains how it can be used to understand the implicit and dynamic elements of personality and personality pathology. He provides a description of the principles of process-focused assessment, followed by representative exemplars of studies that have utilized such methodologies. In doing so, he highlights how intrapersonal and interpersonal processes can be detected in individuals with known personality styles or types that are often not well detected in self-reports.

PART III: MOVING TOWARD INTEGRATED AND UNIFIED MODELS OF PERSONALITY DISORDERS AND PATHOLOGY

The final section of this book advances the process of integrating the most common theories of personality disorders that have been utilized for assessment and treatment. For each chapter, the authors were asked not only to consider the major premises behind their respective theories but also to integrate more contemporary empirical findings (reviewed in this text) into the model. Though this latter request might have appeared difficult to accomplish, the authors of these chapters have done a thorough job of tying together ideas prominent in theories besides the ones for which they wrote. What is perhaps most interesting is that all chapters recognize the need to assess self- and other-representations, interpersonal relatedness, the ways in which individuals characteristically manage their psychological problems, the dynamic elements of all personality disorders, and the historical context in which such problems arise. The chapters explore psychodynamic

(Chapter 12 by Patrick Luyten and Sidney Blatt), attachment (Chapter 13 by Kenneth Levy, Wesley Scala, Christina Temes, and Tracy Clouthier), interpersonal (Chapter 14 by Nicole Cain and Emily Ansell), evolutionary (Chapter 15 by Theodore Millon and Stephen Strack), and cognitive/cognitive-affective processing (Chapter 16 by Steven Huprich and Sharon Nelson) models.

Chapter 17, by John Clarkin, Nicole Cain, and John Livesley, describes ways in which multiple theories of personality converge on particular ideas related to treatment. The authors suggest that while theoretical integration is not yet possible, an integrated treatment model for personality disorders—something they describe as integrated modular treatment—can and does exist. Although this text is not about treatment per se, I invited the authors to include this chapter because it is guided by the empirical literature on the assessment and diagnosis of personality pathology.

The curious reader may wonder why a five-factor model of personality disorder is not included in this section. This was intentional, mainly because a five-factor model and various trait models of PDs have been described for their capacity to assess and organize personality pathology, but there is very little in the literature that discusses how trait models can be used to inform and affect treatment. This remains a curious aspect of the personality disorder literature, in that there have been no formalized treatments described from a five-factor model. Although some have described five-factor profiles of patients and noted how the assessment can describe the qualities of the person being treated (Stone, 2005; Widiger & Lowe, 2007), the applicability of the model within the consulting room is notably absent. To be fair, however, theoretical paradigm shifts sometimes precede clinical applications; thus, it is possible that a five-factor or dimensionalized model of personality disorder treatment will be articulated more fully in the years to come. Fortunately, most of the authors in this section make some reference to trait theories, and Huprich and Nelson, in particular, describe how trait theory may be integrated into the cognitive-affective processing model.

CLOSING THOUGHTS

It is my intention that this book be of use to researchers and clinicians alike. I have organized this text around the recent and ongoing debates about how to assess and diagnose personality disorders. What I hope has been created is a text that paves the way for a new era of personality disorder conceptualization and research. Many past theories and ideas had the unintended effect of polarizing the field, which today seems inappropriate. Rather,

today's task seems to be to discover how to integrate these various levels (e.g., molecular/genetic, trait, intra- and interpersonal, overt behavioral) and systems (e.g., self-report, behaviorally observed, clinician-guided, biologically organized) of analysis into a diagnostic system that makes the most sense clinically and is also well supported empirically.

As one example of how this integration might occur, consider as an analogy the treatment of bone fractures by orthopedists. Fractures are classified by those that are observed through physical or radiographic examination and their disruption on the mobility and motility processes. They are treated at a rather manifest level via open or closed reduction followed by immobilization and rehabilitation, supplemented by pain management and, for some, antibiotic medications. Yet, the pathophysiology of fractures is relatively well understood, and the biological mechanisms behind bone healing continue to be empirically investigated. Virtually no orthopedists would argue that classification of fractures should be organized around a cellular or molecular framework, nor would they suggest that the only course of treatment for most fractures would be pharmacological. However, research into the pathophysiology of fracture healing will continue, as it elucidates those mechanisms that differentiate who may benefit from enhancements to treatment (e.g., some form of pharmacotherapy; additional or reduced time immobilized; additional attention to other systems that might be adversely affected, such as vascular functioning in the injured limb). Orthopedists recognize that classification and treatment are managed through a particular framework, while understanding and equally valuing that the cellular dynamics of healing offers a different, though important, orientation to the fracture healing process. Knowing both domains is likely to make one a highly competent physician.

Thus, by way of comparison and example, just as the biological and trait researcher should value the subjective, psychodynamic, and interpersonal frameworks, so should dynamic and relational therapists recognize that genetic and neurobiological mechanisms underlie some of the "hard to operationalize" aspects of personality dynamics. For instance, it may be that more observable features of personality (e.g., self- and other-representations, adaptive and maladaptive mechanisms of managing distress) may make the most sense for a classification system, though having a system that is well described for its trait architecture and underlying biogenetic mechanisms will only serve to enhance ways in which the system is better understood for its strengths and limits. Of course, this may turn out not be the best way to organize the classification and diagnostic system. Nevertheless, attending to all the various frameworks by which personality disorders are studied will allow the cacophony to modulate into a new and richer melody.

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