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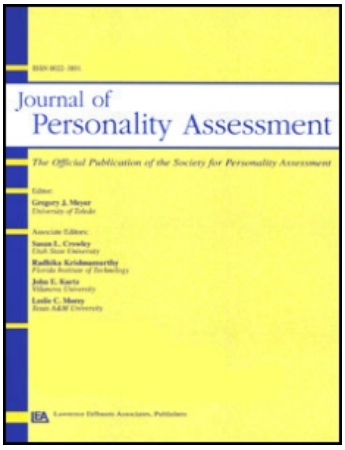

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Personality Traits in the *DSM-5*

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Personality Traits in the *DSM–5*

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Recent advances in personality research coupled with a broad acknowledgment of the limitations of the representation of personality pathology in the third and fourth editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–III* and *DSM–IV*) have positioned personality science to influence the shape of personality assessment in the fifth edition (*DSM–5*). Representing normative personality with well-validated traits that are broad, normally distributed, theoretically integrative, and distinct from personality disorder constructs would take optimal advantage of this opportunity. The assessment of normative traits would also link a large body of personality research with the practice of clinical diagnosis and would encourage clinicians to consider every patient's personality regardless of his or her diagnosis. Furthermore, conceptualizing personality traits and disorders separately would promote more careful clinical consideration of the functional severity and specific symptom constellations among personality disorders. Based on these considerations I argue that Five-factor model personality traits should be assessed separately from personality disorders in the *DSM–5*.

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In a report about progress toward the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. [*DSM–III*]; American Psychiatric Association, 1987), the manual's editor, R. L. Spitzer wrote, "As part of the discussion of the multi-axial approach, the Task Force will consider requiring a personality disorder diagnosis for all patients so that personality disorders, when accompanied by more acute disorders, are not ignored, as is commonly done" (Spitzer, 1976, as quoted in Williams, 1985). It is clear from this statement that Spitzer was motivated to incorporate personality assessment into the *DSM* because of his concerns that clinicians routinely ignore personality. However, by using the term *personality disorder* (PD) rather than *personality,* Spitzer implied that the personality of any person who does not meet criteria for a PD is not clinically important.

Yet most personality assessors view normative personality traits and dynamics as an essential context within which to view psychopathology and behavior. The failure of the *DSM–III* and *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM–IV*]; American Psychiatric Association, 1994) to provide a means for assessing such characteristics, combined with multiple empirical shortcomings of the *DSM–III/DSM–IV* PD model (Clark, 2007; Krueger, Skodol, Livesley, Shrout, & Huang, 2007; Widiger & Trull, 2007) may explain the limited use of personality assessment in clinical practice both before and after *DSM–III.* Because of both the shortcomings of the *DSM–III/DSM–IV* PDs and advances in personality science, personality psychology finds itself in a potent position to influence *Diagnostic and Statistical Manual of Mental Disorder* (5th ed. [*DSM–5*]) personality assessment. However, personality psychology currently risks contributing further to the problematic conflation of personality traits and disorders by replacing disorders with traits.

In this article I describe this risk and argue for the decoupling of normative personality trait assessment and PD diagnosis in the *DSM–5*. I first review research on normative personality and its relation to personality pathology. I next critique the *DSM–5* proposal in the context of this review. I conclude with a proposal that capitalizes on the gains made in personality science toward a more valid and clinically useful conception of personality traits and disorders.

NORMATIVE PERSONALITY

Research on personality traits has progressed exponentially over the past few decades. Many in the field now recognize the Five-factor model (FFM; neuroticism, extraversion, openness, agreeableness, and conscientiousness) or one of its close cousins (e.g., models with two to seven broad dimensions) as reflecting the natural ordering of a higher order level of personality traits (Goldberg, 1993). This structure appears to generalize across cultures (McCrae & Costa, 1997) and to include traits that can be mapped onto brain regions (De Young et al., 2010) and pathways (Depue & Lenzenweger, 2004). The course of FFM traits has been studied extensively and evidence for their absolute and differential stability in adulthood is substantial (Caspi, Roberts, & Shiner, 2005). Research has also documented the heritability of traits (Loehlin, 2001), the influences of genetic factors on personality stability (Bleidorn, Kandler, Riemann, Angleitner, & Spinath, 2009; Hopwood, Donnellan, et al., 2011), and the relations of traits to childhood temperament (Caspi & Silva, 1995; Rothbart, 2007). Finally, evidence supports the predictive validity of personality constructs for a host of important life outcomes (Grucza & Goldberg, 2007; Ozer & Benet-Martinez, 2006).

Moreover, there is substantial evidence regarding the importance of normative traits for clinical assessment. FFM traits relate to most psychiatric disorders including the PDs (Samuel & Widiger, 2008) and many Axis I disorders (e.g., substance abuse: Ruiz, Pincus, & Schinka, 2008; Attention Deficit Hyperactivity Disorder: Nigg et al., 2002; mood disorders: Bagby et al., 1996; see also Kotov, Gamez, Schmidt, & Watson, 2010). Traits also increment Axis I and II diagnoses in predicting clinical dysfunction (Morey et al., 2007; Trull, Widiger, Lynam, & Costa, 2003). Personality traits, and particularly those related

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to affective functioning (i.e., internalizing) and behavioral constraint (i.e., externalizing), can help explain comorbidity between disorders (Krueger, 1999). Thus assessing these personality traits has the potential to refine searches for the etiology of psychopathology. Conversely, pathoplastic personality traits such as those related to interpersonal behavior can capture heterogeneity among people with similar psychopathology (Pincus, Lukowitsky, & Wright, in press). These elements of personality have the potential to depict diagnostic subtypes and thereby guide differential treatment strategy selection for individuals with the same diagnosis but varying personality characteristics.

Personality Traits and Disorders

Emboldened by the large body of evidence on the validity and clinical utility of normative personality traits, some personality psychologists appear to view *DSM–5* as an opportunity to replace the PDs of *DSM*s past with a personality assessment system based exclusively on normative traits (e.g., Widiger & Trull, 2007). The risk in this movement is the same one that faced the authors of the *DSM–III* and *DSM–IV:* the conflation of normative and pathological personality. One argument for replacing PDs with normative traits is that doing so would integrate various trait models (Widiger & Simonsen, 2005) as well as psychological and psychiatric perspectives on personality assessment (Clark, 2007). Indeed it is well documented that personality traits and disorders systematically relate to one another (Samuel & Widiger, 2008). If traits and disorders can be integrated without losing information, why not simply eliminate PDs in the *DSM–5* and replace them with traits?

However, if personality traits and disorders are meaningfully different, efforts should be made to understand and exploit those differences. Indeed, regardless of one's theoretical orientation, personality is an incredibly complex concept that houses a variety of features and elements that can be distinguished in numerous ways. To the extent that normative personality traits and pathological personality symptoms are conceptually and empirically distinct and mutually informative in clinical assessment, it would be more clinically useful to assess routinely both traits and disorders than to limit assessment to one domain or the other. Here I offer four reasons why personality traits and disorders are distinct and why it would be important to assess normative traits and PD constructs separately in the *DSM–5.*

Normative Traits Relate to Most Forms of Psychopathology

Normative personality traits correlate with nearly every individual difference variable in psychology, including most forms of psychopathology (Kotov et al., 2010). Often these correlations are stronger for disorders other than PDs. For instance, Ruiz et al. (2008) conducted a meta-analysis of the relations between FFM traits and antisocial PD and substance abuse. Both of these diagnoses were systematically related to traits, but the magnitude was stronger for substance abuse than antisocial PD (in clinical samples, the average absolute correlation between neuroticism, extraversion, agreeableness, and conscientiousness with antisocial PD was .17, whereas the same correlation for substance use disorders was .32; their Table 5). As such, there is nothing necessarily unique about the relations between FFM traits and PDs. Demonstrating these relations is not sufficient for arguing that personality traits and disorders overlap completely.

Furthermore, some evidence suggests that FFM traits are mostly related to overall severity and are more limited in depicting stylistic differences in pathological expression. Specifically, most PDs involve relatively high neuroticism and low agreeableness, extraversion, and conscientiousness (Morey et al., 2002; Saulsman & Page, 2004). In Samuel and Widiger's (2008) meta-analysis of PD–FFM relations, all PDs had positive correlations with neuroticism; all had negative correlations with extraversion except antisocial, histrionic, and narcissistic; all had negative correlations with agreeableness except dependent; and all had negative correlations with conscientiousness except obsessive–compulsive. In a recent study (Hopwood, Malone, et al., in press), the four FFM traits just listed related strongly to the sum of all PD symptoms but showed limited relations to specific PDs with this general symptom severity component covaried. This finding suggests that differences among PD constructs would be better explained by considering features external to the influences of normative personality than by FFM traits.

Empirical Evidence Supports Distinctions Between Personality Traits and Disorders

There are several areas of empirical nonoverlap between personality traits and disorders that suggest that important information would be lost should the PDs be reconceptualized as trait constellations. Some of these findings are potentially equivocal. For instance, normative traits are unlike PDs in that they have normal distributions. However, this could be due to the fact that the PDs reflect constellations of the tail ends of normal distributions (Widiger & Simonsen, 2005). Another example is that some research suggests that PDs are less stable, in the differential (rank-order) sense, than normative traits (Durbin & Klein, 2006; Morey et al., 2007). This is the case despite the fact that PD measures often insist that respondents or raters consider stable aspects of personality functioning. Indeed, the differential stability of PDs could be overestimated when such measures are used relative to systems in which PD symptoms are rated without the presumption of stability. Alternatively, differential stability differences between PDs and normative traits observed empirically could be due to the fact that PDs are usually assessed by interviews and traits by self-report, and that self-report methods tend to demonstrate greater stability than interviews (Ferguson, 2010; Samuel et al., in press). The relative distributions and differential stabilities of normative and pathological personality constructs, assessed with the same methods, are important questions for future research.

Other differences are less equivocal. For instance, longitudinal studies in clinical (Warner et al., 2004) and nonclinical (Lenzenweger & Willett, 2007) samples have found that previous levels of normative traits influence PD symptom changes, whereas previous PD levels do not influence normative trait changes. These results suggest that traits are somewhat more basic, whereas PDs reflect symptoms that wax and wane in part as a function of underlying personality dynamics, perhaps as well as changes in environmental contexts. Related to this point, instability in normative traits appears to be diagnostic of some forms of personality pathology, and particularly borderline symptoms (Hopwood et al., 2009; Hopwood & Zanarini, in press). The fact that features of normative traits other than their levels are influential on PDs highlights that the interaction of

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normative and pathological personality features is more complex than can be accommodated by a single, integrated system.

Traits and PDs also increment one another in clinical predictions (Hopwood & Zanarini, 2010; Morey et al., 2007; Trull et al., 2003). For instance, Morey et al. (2007) showed that the Revised NEO Personality Inventory (NEO PI–R; Costa & McCrae, 1992) domains and *DSM–IV* PD symptom counts incremented one another in predicting baseline, 2-year, and 4-year functioning scores (assessed by both interview and self-report) as well as the total number of concurrent and prospective Axis I disorders in a sample of patients followed naturalistically. If traits and disorders were redundant or if one set of variables was more valid than the other, they would be unlikely to increment one another. In fact, traits predict concurrent and prospective patient functioning whether or not patients have a PD (Hopwood et al., 2007). This finding illustrates that traits are not just useful for conceptualizing people with PDs; they are useful for conceptualizing people.

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Lower Order Facets Do Not Bridge Normative and Pathological Personality

Trait researchers often argue that a more refined picture of personality pathology can be obtained through considering lower level facets of higher order trait dimensions (Clark, 2007; Samuel & Widiger, 2008). However, lower order facets are not a viable bridge between normative and pathological personality for the following reasons.

First, studies that have used cross-validation techniques to test the incremental validity of lower order facets over higher order traits have found that they do not tend to meaningfully increment higher order trait predictions in nonclinical (Grucza & Goldberg, 2007) and clinical (Morey et al., 2007) samples. This is important because equations in the general linear model with more predictors tend to overfit data and inflate estimates of explained variance (Stevens, 2002). Thus, any time the 30 facets of the NEO PI–R are entered in a hierarchical regression model testing their increment over the five domains, the 30 facets will produce a higher R^2. However, cross-validation removes this artifact, so that more confidence should be placed in studies that have cross-validated such equations than those that have not. Overall, the results of such studies suggest that nuance in personality pathology is not likely to be found in the lower order levels of normative traits.

Second, PD symptoms vary from traits in more ways than their breadth. PD symptoms are also more pathological and narrower than traits. They might also be less stable, depending on the kind of stability being considered (e.g., results are equivocal with respect to differential stability as described earlier but less so with regard to absolute stability as described later). Because lower order traits vary in their associations to pathology, one approach to dealing with differences in pathology has involved conceptualizing only the pathological facets of traits (e.g., Clark, 2007; Krueger et al., 2007), as in the current *DSM–5* proposal. However, this necessarily leads to a limited conceptualization of the full range of personality by omitting normative or adaptive facets. Thus far, promoters of lower order facet representations of personality pathology have not effectively dealt with breadth or stability differences between traits and PD symptoms.

Third, unlike the structure of the higher levels of traits, the field has not approached consensus on the structure of lower order facets of personality. Thus even if it were possible in the future to fully integrate the lower levels of personality hierarchies with the symptoms of personality pathology, at this point evidence in this regard is not sufficient to justify replacing PDs with lower order traits in the *DSM–5*.

It Is More Useful Clinically to Assess Personality Traits and Disorders Separately

Separating traits and disorders would be more useful clinically than collapsing them for several reasons. First, doing so would emphasize to clinicians the importance of assessing every patient's personality, regardless of his or her diagnosis. Second, the separation of personality traits and disorders would allow for a focus on those PD symptoms that are most bothersome to patients and that are most likely to be targets of intervention. The absolute (mean) levels of traits are fairly stable in adults (Caspi et al., 2005), so clinicians are unlikely to target traits for intervention. Longitudinal research has shown that group levels of PD symptoms, in contrast, can change at higher rates than was previously thought (Grilo et al., 2004; Morey et al., 2007; Zanarini et al., 2007), and therapeutic interventions have shown the ability to decrease PD symptoms (e.g., Matusiewicz, Hopwood, Banducci, & Lejuez, 2010). Thus, distinguishing stable personality characteristics from the malleable elements of PDs would facilitate the assessment of treatment effects to a greater degree than conflating personality traits and disorders. Conceptualizing these malleable elements more distinctly might also promote research on those dynamic aspects of the environment that could impact PD expression, such as life stresses, relationship dynamics, treatment, or other potential influences.

Third, conflating traits and disorders could limit the potential impact of findings from personality science on clinical diagnosis. Trait assessment would be useful to surgeons who wish to predict patient response (Swami, Chamorro-Premuzic, Bridges, & Furnham, 2009), nurses seeking to understand how to care for those they discharge or how to screen for illness (Iwasa et al., 2009), occupational therapists or social workers endeavoring to help the mentally ill find employment (De Fruyt & Mervielde, 1999), marriage counselors trying to help individuals adapt to living with one another (Humbad, Donnellan, Iacono, & Burt, 2010), and many other applications. Regarding personality traits as primarily relevant for PD limits the likelihood that clinicians will recognize the broad utility of personality for their practice. If the authors of the *DSM–5* make the same mistake as the framers of the *DSM–III* and *DSM–IV* in conflating personality traits and disorders, the full potential for the science of personality to influence clinical practice will not have been fulfilled.

Finally, traits have broad integrative potential for clinicians operating from varying perspectives. Most trait researchers recognize that many trait models can be integrated with the FFM (e.g., Widiger & Simonsen, 2005). However, some personality assessors might be concerned that assessing stable, normative traits and dynamic, pathological PD symptoms would still miss the assessment of normative but dynamic personality processes. The FFM was not designed to assess dynamic processes, which might be better represented by the interpersonal model (Pincus, Lukowitsky, & Wright, 2010) that conceptualizes personality in the dynamic social environment, the attachment model that understands personality in the context of internalized representations affected by early relationships with caregivers (Hazan

TABLE 1.—Associations of dynamic personality model dimensions with Five-factor model traits.

Theory	Neuroticism	Extraversion	Openness	Agreeableness	Conscientiousness
Interpersonal		Agency		Communion	
Attachment	Anxiety			Avoidance	
Mood	Negative affects	Positive affects			Constraint
Motivation	Behavioral inhibition	Behavioral activation			
Temperament	Negative affectivity	Surgency			Effortful control

& Shaver, 1994), mood models that capture emotional fluctuations over time (Watson & Tellegen, 1985), motivational models that correspond to dynamic behavioral and neurobiological processes (Gray, 1987), or temperament models that emphasize developmental features of personality (Rothbart, 2007).

As shown in Table 1, each of these more dynamic models can be described by dimensions that relate systematically to FFM traits (interpersonal: McCrae & Costa, 1989; attachment: Noftle & Shaver, 2006; mood: Watson & Clark, 1992; motivation: Smits & Boeck, 2006; temperament: Rothbart, 2007). As such, clinicians or researchers who work from these perspectives can make inferences that fit into their preferred theories with ratings of FFM traits, while also recognizing that dynamic features of these models are like PD symptoms in that they are not fully captured by such trait ratings. This potential suggests not only that an FFM assessment in the *DSM–5* would augment the manual's clinical utility, but also that it would pave the way for future research on the interaction among psychopathology, functioning, and important dynamic processes in personality and social behavior.

THE *DSM*–5 PROPOSAL

The *DSM–5* Personality and Personality Disorder Work Group proposal as of February 2010 conceptualizes three levels of personality assessment (Skodol et al., 2011). The first is an overall severity composite that would be similar to *DSM–IV* Global Assessment of Functioning (GAF) but specific to self and interpersonal dysfunction thought to be characteristic of personality pathology. The second involves five PD prototypes that are rated according to the patient's match to the prototype description. The third involves a list of six higher order but pathological and unipolar traits, as well as facets for each of these traits.

This system is an improvement over the *DSM–III*/*DSM–IV* model in several respects that are not discussed here. However, there are also significant limitations of the proposed system. To be consistent with the purpose of this article, I focus my critique on the *DSM–5* proposal for assessing traits.

It is implicit in the architecture of the *DSM–5* that traits should be rated for their relevance to personality pathology, rather than for their ability to describe people more generally. This constrains what can be done with the traits. For instance, if the purpose of traits is to assess personality pathology, it is difficult to justify including general traits because specific and pathological traits are more strongly related to PDs than general and normative ones (Clark, 2007). However, it makes little sense from a predictive standpoint to rate disorders as well as pathological traits that were selected because of their ability to connote PD. The point should not be to identify trait and disorder constructs that are redundant, but instead to provide data about constructs that are relatively distinct (i.e., discriminant valid) and mutually informative. Broad normative traits have the potential to provide a greater increment of PD constructs than pathological traits because they overlap less. As one example, the ability to predict adaptive life outcomes might be limited by an exclusive focus on pathological traits.

A related problem that is likely in part a consequence of the structure of the *DSM–5* is that the traits are unipolar rather than bipolar, even though normative traits such as those in the FFM are bipolar in nature (see Samuel, 2011/this issue). The *DSM–5*'s departure from the current state of understanding about trait concepts limits the degree to which the system can be described as supported by available evidence. This also creates problems related to clinical utility. For example, in some instances the tail of a trait dimension that is usually healthy can lead to dysfunction (e.g., pathological agreeableness can connote dependency; Lowe, Edmundson, & Widiger, 2009). Another problem is that, to the extent that only the pathological tails of normally distributed traits are represented in the *DSM–5,* clinicians will not be able to use the healthier tails to indicate personality strengths or predict adaptations.

At a broader level, the proposed traits amount to a new structure for conceptualizing personality. Several decades of research has led to a point where personality psychologists can begin to agree on an integrative structure for traits. In this context, offering a new structure with limited theoretical and empirical support would appear to be a step backward. In the end, the mandate to consider those traits that are the most strongly related to personality pathology appears to have constrained the ability of the Personality and Personality Disorder Work Group to represent traits in a clinically useful, scientifically viable, and theoretically coherent way.

AN ALTERNATIVE: NORMATIVE PERSONALITY TRAIT ASSESSMENT IN THE *DSM–5*

So how could *DSM–5* personality trait assessment be clinically useful, evidence-based, and theoretically coherent? I next offer a system that could achieve these goals.

What: FFM Traits

As described earlier, the FFM has more empirical support and demonstrated clinical utility than any other model of normative personality traits. Significant advances have also occurred in developing theoretical models for the FFM (McCrae & Costa, 2003; Wiggins, 1996). The assessment of normative personality in the *DSM–5* would therefore be on the most solid empirical, clinical, and theoretical footing if it assessed FFM traits.

When: Always

FFM traits should be rated for every person who is diagnosed with the *DSM–5,* whether or not personality pathology is significant, because every person has a personality. However,

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it is not only the case that all people should be assessed; all trait aspects of all people should be assessed as well. To limit the possibility that important aspects of personality might be missed, the traits should be bipolar—meaning that both high and low scores on each trait should be regarded as meaningful (see Samuel, 2011/this issue). The assessment of bipolar trait dimensions would be more consistent with common personality trait models (including but not limited to the FFM) than unipolar traits. Bipolar traits would also provide greater clinical utility than unipolar traits, for example, in cases in which adaptive tails of some dimensions could be used to predict positive patient outcomes.

Where: Separate From PDs

To ensure that personality traits are treated as relevant for all people rather than as markers of specific forms of PD, all clinicians should rate all patients on FFM traits regardless of their diagnosis. This will be most likely if traits and PDs are assessed in separate sections of the manual. Using the *DSM–III* and *DSM–IV* multiaxial lingo, traits should be listed on Axis II, whereas disorders, including PDs, should be listed on Axis I (see Ruocco, 2005).

How: Clinician Ratings Potentially Supplemented by Formal Assessment Data

Rating forms have been developed for the FFM that could be adopted readily by the *DSM–5* (e.g., Mullins-Sweatt, Jamerson, Samuel, Olson, & Widiger, 2006). There are also several longer assessment methods for the FFM that could supplement or inform clinician ratings. These methods vary in format (e.g., self, other, or interview), length (e.g., long questionnaires with facet scales, brief questionnaires, or rating sheets with one item per trait), and cost (proprietary or public domain). The availability of these methods permits flexibility among clinicians, who could choose optimal assessment methods according to the clinical situation, psychometric evidence, and their preferences.

Issues and Limitations of This Proposal

Assessing FFM traits in the *DSM–5* in the manner I have proposed represents a straightforward strategy for increasing the likelihood of routine personality assessment in clinical practice and linking psychiatric diagnosis and personality science more closely. However, several issues would need to be addressed before this system could be implemented.

One issue is that openness to experience has demonstrated relatively less validity in clinical predictions than the other four FFM traits. It is also unlike the other traits in that it has not been effectively linked to biological structures or pathways (De Young et al., 2010) and is not represented consistently in either stable (Widiger & Simonsen, 2005) or dynamic models of personality (Table 1). Finally, there is the risk that, because the concept of openness is compelling, clinicians could overinterpret this dimension by making clinical inferences that are not supported by research evidence. Thus, good arguments could be made in favor of dropping this dimension. However, there are two reasons to prefer including openness to experience. First, it (or a variant often labeled intellect/imagination; cf. Goldberg, 1993) has been an important part of the FFM since the model was developed, and eliminating it would make trait assessment less comprehensive. Second, the validity of openness to experience for clinical assessment remains an open question. From a prediction standpoint those traits that are least related to psychopathology have the most potential for incremental validity because their partial coefficients are least constrained by predictive utility of covariates. This fact of prediction suggests some potential for openness to experience in predicting outcomes that are mostly unrelated to psychopathology, such as treatment preferences, optimal work environments, or preferred recreational outlets.

A second issue involves whether or not to incorporate lower order facets of the FFM. It is intuitive that describing a person at the level of the 30 facets of the NEO PI–R provides a more nuanced portrait than a five-domain description, and many clinicians would regard facet assessment as an opportunity to add nuance to descriptions of patient personalities. It is also possible that facet-level description could have specific diagnostic or predictive purposes. For instance, it might be helpful to know if an individual's social behavior is driven primarily by affects or interpersonal motives, as might be indicated by his or her constellation of scores on extraversion facets. Facet descriptions might furthermore be useful for representing psychological traitedness, or the degree to which a given trait is relevant for a particular person (Tellegen, 1988). For instance, some patients are both neurotic (e.g., prone to self-doubt and depression) and emotionally stable (e.g., acquiescent and nonaggressive). Such a person might be described as very high in vulnerability but very low in hostility, suggesting that knowing this person's neuroticism score would not provide as fully accurate a picture of his or her behavior as would knowing the person's score on the neuroticism facets.

However, the structure of facets is not well-established and facets have not shown an ability to increment the domains in clinical predictions in cross-validated prediction models, as discussed earlier. There are also concerns related to the need to limit the complexity of the *DSM–5* system, because greater complexity increases the burden for training clinicians on how to use the manual and for the amount of time and resources required for diagnosis. With these considerations in mind, one potential compromise would be to mandate all clinicians to provide ratings on the FFM trait domains for all patients, and to give clinicians the additional option to rate facets for those cases in which the broad domains do not appear to adequately capture the personality traits of a particular patient.

A third issue involves whether this, or any other system, would increase the likelihood that clinicians would routinely assess personality. Indeed, just because a revised system would offer clinicians a better reason than in the *DSM–III* or *DSM–IV* to assess personality does not mean that clinicians will do so. Overall, personality and PD researchers need to demonstrate more effectively the utility of personality assessment to clinicians and train clinicians in how to adequately assess personality than they have in the past. One way to begin this process is to render personality assessment in the diagnostic manual as straightforward, economical, and evidence-based as possible. Listing carefully selected traits and disorders with the most robust empirical support and least overlap might thus contribute to an increased focus among clinicians on personality assessment.

Comparison of This Proposal With Other Proposals for Personality/PD Assessment

To summarize, in this proposal FFM trait domains would be listed in a section that is completely separate from the PD

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TABLE 2.—Four models proposed for *DSM–5* personality/personality disorder assessment.

Model	Normative Personality	Personality Disorder
DSM–5 Work Group	Absent	37 pathological traits 2 general severity dimensions 5 PD prototypes
FFM of PD	5 FFM traits 30 FFM facets	Absent
Bornstein (1998)	Adaptive aspects of 10 PDs	1 general severity dimension 10 PD dimensions (with separate ratings for impairment and severity)
Current proposal	5 FFM traits	1 general severity dimension 5–10 PD dimensions

Note. DSM = Diagnostic and Statistical Manual of Mental Disorders; FFM = Five-factor model; PD = personality disorder.

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section. Clinicians would be required to make ratings on each of the FFM traits for all patients, with the option of also rating facets. There is not sufficient space in this article to outline in detail a model for how to assess the PDs as separate from these traits. In a previous article (Hopwood, Malone, et al., in press) my colleagues and I described a model that is based somewhat on Bornstein's (1998, 2011/this issue) proposal to assess three levels of personality functioning: overall severity, impairment and severity related to specific PDs, and adaptive features of specific PDs. The main difference involves whether or not the normative and adaptive features of personality are best assessed by normative traits or by rating the potentially adaptive features of PDs.

Thus, as shown in Table 2, the PD model in this proposal would include two of Bornstein's three levels: generalized PD severity and stylistic PD dimensions. However unlike Bornstein's proposal, clinicians would rate five normative personality dimensions in a section separate from the PDs. They would rate a global severity dimensions as well as the symptoms of between 5 (e.g., *DSM–5* proposal; Hopwood, Malone, et al., in press) and 10 (e.g., *DSM–IV*) stylistic PD dimensions in another section. A general severity dimension, analogous to the *g* factor in intelligence or the *DSM–IV* GAF score for more general functional difficulties, has been an important part of some theories of personality pathology (e.g., Kernberg's [1984] personality organization), and researchers have developed methods to assess it (e.g., Bornstein, 2011/this issue). In terms of stylistic PD dimensions, initial decisions about which constructs to retain could be based first on accumulated validity evidence. However, achieving consensus about which PDs are supported by available evidence is unlikely. As described in Hopwood, Malone, et al. (in press), a second and perhaps more influential consideration would involve identifying PD constructs that are maximally distinct from one another and from normative traits. The purpose of focusing on the discriminant validity of various elements of personality assessment would be to provide clinical information that is minimally overlapping and incrementally useful.

Table 2 shows similarities and differences between this proposal and the *DSM–5* proposal as well. There are two major differences. First, whereas in the *DSM–5* proposal traits and disorders (types) are intermingled, I would separate them to focus more on their potential discriminant validity. Not only would traits and disorders be rated in separate sections, but they would also be constructed to differ in terms of their distributions (normal/bipolar vs. positively skewed/unipolar), stability (stable vs. dynamic), and breadth (broad vs. narrow). We (Hopwood, Malone, et al., in press) showed that orthogonal PD dimensions can be derived that correlate only modestly with normative traits but are nevertheless valid predictors of specific kinds of functioning. This finding indicates that it is possible to derive discriminantly valid and mutually informative normative and pathological personality dimensions. Second, the PDs would be diagnosed according to symptoms rather than prototype descriptions. The reasons for this are practical. Symptoms permit a more nuanced description of pathology, provide a more precise indication of treatment targets than global ratings, and allow for a more specific assessment of change. Rating PD dimensions with symptoms also encourages clinicians to think about PDs the way they think about any other Axis I diagnoses—as pathological, changeable, and meaningfully separate from the personality context in which they occur.

Finally, Table 2 shows how the proposed model is different from the FFM of PD (Widiger & Trull, 2007). Rather than presuming that the pathological elements of personality can be adequately conceptualized with normative traits, the current model explicitly separates normative and pathological personality features.

FUTURE DIRECTIONS

Whatever happens in the *DSM–5,* future research should focus on developing a better understanding of how traits predispose symptoms and what dynamic processes interact with traits to produce PD symptoms and other forms of psychopathology. Such processes are most likely to be identified if researchers balance the current focus on individual differences with an increased focus on intraindividual change (e.g., see Russell, Moskowitz, Zuroff, Sookman, & Paris, 2007, for an example of this sort of research with borderline personality) and if they balance the current overreliance on interview and self-report data with an increased use of other methods (e.g., see Klonsky & Oltmanns, 2002, for a discussion of other-report data and Huprich & Bornstein, 2007, for a discussion of performance-based personality assessment methods). That such future research will be more fruitful if it capitalizes on the accumulated knowledge of personality science represents another reason that the *DSM–5* should avoid departing from evidence-based models of personality.

CONCLUSION

It is possible that personality traits and disorders might in the end fit into an integrative framework that achieves scientific and clinical consensus and is continuous in terms of individual difference variables, but also in terms of normality–pathology, stability–change, and breadth–depth, and that can account coherently for different systems, such as affects, interpersonal behaviors, cognitions, functional outcomes, and motives. Such a system would have numerous and obvious advantages over any current or proposed diagnostic framework. It is also possible that, in the end, there is something important about the difference between enduring, normative traits and narrower, more dynamic, personality pathology symptoms, and that it is most sensible to conceptualize these as interpenetrating but

meaningfully independent domains. Current evidence is insufficient to determine which of these models will end up being more viable, or if some other model will best explain future data.

What is known now is that traits are important, PDs are important, personality traits relate to but are not redundant with PDs, and traits and disorders increment one another for clinical predictions. Based on what is known, it would not be prudent to integrate personality traits and disorders in a manner that would risk missing important assessment information. Conversely, distinguishing traits, the severity of personality pathology, and the stylistic expression of PD symptoms would allow each element of personality assessment to be useful for different kinds of questions (Hopwood, Malone, et al., in press). Traits could be consulted for questions regarding the enduring and pervasive personality context of a person's difficulties and thus the likelihood of quick remittance (e.g., To what degree is this patient's depression predisposed by neuroticism vs. more contextual factors?), general severity would be relevant for making predictions about optimal levels of care (e.g., Should this patient be hospitalized?), and PD symptom constellations would be important for determining treatment strategies (e.g., Would transference-focused psychotherapy be appropriate for this patient?).

What has been presented here offers a balance between accounting for personality traits and disorders broadly and inclusively, and in such a way that most of the assessment data would be incremental rather than redundant. This model would achieve the original promise of the multiaxial format of the *DSM–III* and *DSM–IV* to explicitly separate personality from pathology by regarding PDs as more disorder than personality and liberating personality to occupy its own, unencumbered section of the manual. Given that Spitzer's goal that all clinicians would diagnose personality has not been achieved in the most recent editions of the *DSM* and in light of the significant advances in personality science over the past few decades, it is time for the official diagnostic manual to give clinicians a reason to diagnose personality in all people.

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