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TARGET ARTICLE

The *DSM–III–R* Categorical Personality Disorder Diagnoses: A Critique and an Alternative

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The purpose of this article is to review the Diagnostic and Statistical Manual of Mental Disorders (DSM–III–R; American Psychiatric Association, 1987) categorical diagnosis of personality disorders and to provide an alternative. The results from a variety of studies indicate that the categorical distinctions provided in DSM–III–R lack empirical support and that a dimensional model of classification would provide more reliable and valid assessments of personality disorder. The arguments favoring the categorical model—familiarity, tradition, simplicity, ease, and consistency with clinical decisions—are also addressed. An alternative approach based on the five-factor model of personality is presented. Two concerns regarding this model are the relevance of the openness-to-experience dimension and the differentiation of abnormality from normality, but neither concern is problematic when personality disorders are understood to be maladaptive variants of normal personality traits.

The third and revised edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–III–R;* American Psychiatric Association [APA], 1987) provides categorical distinctions for the personality disorder diagnoses. For example, the clinical decision regarding avoidant personality disorder is whether the disorder is present or absent, not the extent to which a person is avoidant. It is stated in the introduction to *DSM–III–R* that "there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) ... between it and no mental disorder" (APA, 1987, p. xxii), but this denial is belied by the fact that the diagnoses consist of categorical distinctions with no method for assessing a continuum with normal personality functioning. The *DSM–III–R* is used by clinicians, researchers, and agencies to make categorical distinctions regarding the presence versus absence of personality disorders (Carson, 1991). Approximately 84 empirical studies have been published in the *Journal of Personality Disorders* from 1987 through 1990. The analyses of the data were confined to the *DSM–III–R* categorical distinctions in about 60% of these studies; only 21% included quantitative (dimensional) analyses of the extent to which the respective personality disorder or disorders were present (Widiger, 1992).

It is the purpose of this article to suggest that categorical diagnoses of personality disorders have little to no support with respect to empirical data or rational argument. The categorical diagnoses represent instead a simplistic and presumptive understanding of personality disorder pathology that is a hindrance to empirical research and clinical practice. The article concludes with an alternative approach to the assessment and classification of personality disorder pathology.

Empirical Support

Categorical distinctions would be appropriate if there was a clear distinction between the presence and absence of a personality disorder (Grove & Andreasen, 1989; Kendell, 1975). However, no empirical study has ever identified any clear distinction between the presence and absence of a personality disorder or any clear distinction among near-neighbor personality disorder diagnoses. Four recent studies have explicitly considered these questions, and, in each case, the authors concluded that the results they obtained were inconsistent with the categorical distinctions. Frances, Clarkin, Gilmore, Hurt, and Brown (1984) obtained personality disorder ratings on 76 psychiatric outpatients and concluded that "the DSM–III criteria for personality disorders do not select out mutually exclusive, categorical diagnostic entities. ... [The] frequency of multiple diagnoses supports the argument for a dimensional—rather than a categorical—system of personality

diagnosis" (p. 1083). Kass, Skodol, Charles, Spitzer, and J. Williams (1985) obtained personality disorder ratings from a consecutive sample of 609 psychiatric outpatients and concluded that "our data do not lend support to the usefulness of a categorical approach" (p. 628). "Since many more patients had some [maladaptive] personality traits or almost met DSM–III criteria than actually met the full criteria ... the categorical judgments of DSM–III necessarily resulted in the loss of information" (Kass et al., 1985, p. 630). Nestadt et al. (1990) obtained ratings of the histrionic personality disorder symptomatology from a representative sample of a local community ($N = 810$) and reported that "this personality diagnosis is rather arbitrarily given individuals who extend beyond a cut-off level, yet others less severe but similar in the nature of their dispositional features might have identical symptoms under certain life circumstances" (p. 420). Last, Zimmerman and Coryell (1990) obtained personality disorder ratings on 808 first-degree relatives of psychiatric patients and never-ill control subjects and concluded that the personality disorder "scores are continuously distributed without points of rarity to indicate where to make the distinction between normality and pathology" (p. 690).

In the absence of any clear distinction between the presence and absence of a personality disorder, one might ask on what basis the distinctions were made in *DSM–III* and *DSM–III–R*. In fact, there was no empirical support for the thresholds for 9 of the 11 personality disorder diagnoses. They were based simply on the expert consensus of the personality disorder advisory committee (Perry, 1990). Requiring five of the seven criteria for avoidant personality disorder appeared to the committee to be too restrictive, and requiring three appeared to be too inclusive. The arbitrary nature of the decisions was evident in Morey's (1988) comparison of the *DSM–III* and *DSM–III–R* cutoff points: The revisions resulted in "an 800% increase in the rate of schizoid personality disorder and a 350% increase in narcissistic personality disorder" (p. 575).

The definition of a personality disorder in *DSM–III–R* could provide a rationale for the setting of a threshold for a categorical distinction (Widiger, 1992). "It is only when personality traits are inflexible and maladaptive and cause either significant functional impairment or subjective distress that they constitute Personality Disorders" (APA, 1987, p. 335). That is, a person would be diagnosed as having a personality disorder when his or her personality traits are inflexible and maladaptive and/or result in significant impairment or distress. In the absence of inflexibility, distress, or impairment, the person would be said to be lacking a personality disorder. The thresholds for the *DSM–III–R* categorical distinctions bear little resemblance to this definition. For example, the *DSM–III–R* diagnosis of obsessive-compulsive personality disorder requires five of nine criteria, yet a person with only four could have inflexible and maladaptive personality traits that would likely result in social and/or occupational impairment and/or subjective distress—for example, perfectionism that interferes with task completion; overconscientiousness, scrupulousness, and inflexibility about matters of morality, ethics, or values; restricted expression of affection; and preoccupation with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost (APA, 1987). In fact, the possession of just the one trait of being excessively devoted to work and productivity to the exclusion of leisure activities and friendships is likely to be of sufficient maladaptivity as to cause significant social impairment and/or distress.

A person who has the single dependent item of being unable to make everyday decisions without an excessive amount of advice or reassurance, the single antisocial item of being irritable and aggressive as indicated by repeated physical fights or assaults, or the single schizoid item of neither desiring nor enjoying close relationships (including being part of a family) would have a maladaptive personality trait that would likely be of clinical significance. Most persons with any one of these three traits would likely find that the trait interfered significantly with social or occupational functioning, would find the trait to be troublesome and distressing, and would benefit from some form of psychotherapy. These persons, however, would be substantially below the threshold for a *DSM–III–R* personality disorder diagnosis.

The failure of the *DSM–III* and *DSM–III–R* to provide clinically meaningful thresholds was evident in a study by McGlashan (1987). McGlashan was researching the co-morbidity of borderline personality disorder and depression, and he needed a comparison group of depressives without borderline personality disorder. Therefore, he obtained a group of depressed persons who did not meet the *DSM–III* criteria for borderline personality disorder. However, these subjects had on average three of the borderline criteria. "In short, the 'pure' ... cohort was not pure. ... The result is that our comparison groups, although defined to be categorically exclusive, may not have been all that different, a fact which, in turn, may account for some of the similarities" (p. 472) between the supposedly pure depressives and the borderlines. In other words, the persons who were diagnosed as not having a borderline personality disorder did in fact have borderline personality disorder pathology. To characterize these cases as not having borderline personality disorder was inaccurate and misleading. McGlashan concluded that the current categorical system "emerges as poorly constructed for the study of comorbidity" (p. 473).

In sum, the *DSM–III–R* cutoff points do not define the point at which personality traits become a personality disorder. This fact provides a considerable handicap for researchers attempting to identify other clinical correlates of the respective disorders. For example, the *DSM–III–R* threshold for the dependent personality disorder is unlikely to identify the point at which dependent traits provide a predisposition to depression. Research that attempts to assess the relation of dependency to depression would be substantially hindered by the *DSM–III–R* categorical distinction because the dependent personality disorder diagnosis is unlikely to distinguish dependency associated with depression from dependency not associated with depression. Many persons below the threshold for the diagnosis of dependent personality disorder will have dependent traits that are associated with depression (e.g., Overholser, 1991). Statistically significant group differences can be obtained with the *DSM–III–R* categorical distinctions (Gunderson & Zanarini, 1987), but this is as meaningful as arbitrarily distinguishing tall from short persons and finding that tall persons can reach higher than short persons. A more powerful and informative assessment of the correlates of height would clearly be provided by a more continuous and precise measurement.

It is unlikely that the thresholds for the *DSM–III–R* categorical diagnoses will be optimal for any clinical decision or theoretical prediction, as no empirical study has ever documented the validity of the current thresholds with respect to any external validator. The thresholds for the borderline and schizotypal personality disorder diagnoses were based on empirical data (Spitzer, Endicott, & Gibbon, 1979), but this consisted simply of maximizing agreement with a sample of clinical diagnoses. Setting the threshold at the level of agreement with clinical impressions regarding the presence of the disorder provides a standard of maximimizing interrater reliability, not external validity. Given that unstructured clinical diagnoses of personality disorders are notoriously inconsistent and unreliable (e.g., Mellsop, Varghese, Joshua, & Hicks, 1982), clinical judgments as to the presence or absence of a personality disorder provide at best a very questionable criterion for defining the threshold for a disorder.

Taxometric Techniques

There are a variety of taxometric techniques for identifying whether a dimensional or a categorical model is more consistent with the empirical data—including factor and cluster analyses, admixture analysis, maximum covariation (MAXCOV) analysis, latent class analysis, and discontinuous regression (Grayson, 1987; Grove & Andreasen, 1989). Meehl (in press) provided a sophisticated discussion of these techniques. All these approaches have limitations, but each is informative with respect to evaluating the construct of a personality disorder.

Compelling support for a categorical distinction would be obtained if one found that reliability and validity improved with the use of a dichotomous rather than a dimensional rating. A dichotomous variable will show a decreased relation to an external correlate (or at least no change) when it is dimensionalized, whereas a dimensional variable will show a reduced relation when it is dichotomized. The former occurs as a result of the inclusion of irrelevant, invalid information. If a more quantitative, dimensional rating simply provided irrelevant, tangential, and/or illusory distinctions, then the additional discrimination required by the dimensional rating would result in a decreased correlation with various external validators.

Widiger (1992) summarized the results of 16 personality disorder studies in which the data were analyzed both categorically (i.e., with *DSM–III* or *DSM–III–R* diagnoses) and dimensionally (e.g., using the total number of criteria). In all but one instance, the reliability and/or validity data were better with the dimensional analyses. The consistency of this finding is not a statistical artifact. It indicates that reliable and valid information is being lost by converting an ordinal, interval, or ratio scale to a nominal scale (Heumann & Morey, 1990). The implications for future research are clear. Correlates of personality disorder pathology will be more evident when the data are analyzed dimensionally.

A factor-analysis application relevant to the question of the validity of the dimensional versus categorical models is the comparison of factor solutions across groups purportedly distinct with respect to a latent class taxon. Measures that are highly discriminating between such groups should not correlate substantially within the groups, and the factor solution of the intercorrelation among such measures should not replicate across groups (H. Eysenck, 1987). Tyrer and Alexander (1979) reported that the factor solutions for the correlations among 24 personality variables assessed by a semi-structured interview replicated across 65 patients with a primary clinical diagnosis of a personality disorder and 65 patients with other diagnoses. Livesley (1991) reported similar findings using a self-report measure of 79 dimensions of personality disorder pathology, the intercorrelations of which were factor-analyzed in a sample of 274 normal subjects and 158 patients. Livesley concluded that "a dimensional model is ... supported by empirical evidence that the structure of traits describing the features of personality disorder pathology is the same in personality-disordered and non–personality-disordered individuals" (p. 53).

A variable that is fundamentally categorical should

obtain a bimodal distribution (Kendell, 1975). Admixture analysis examines the distribution of canonical coefficient scores derived from a discriminant-function analysis for evidence of bimodality. This technique has suggested the presence of discrete breaks in the distribution of measures of somatoform and psychotic disorders (Cloninger, Martin, Guze, & Clayton, 1985). No published study has reported an admixture analysis of personality disorder data. However, Cloninger (1989) indicated that he used it with personality disorder data and "found that underlying [the] relatively distinct subgroups appeared to be multiple dimensions of personality that were normally distributed" (p. 140). "The real take-home message to me is not that we do not have methods to detect relatively discrete groups but that with psychiatric disorders the groups are not totally discrete, and this finding may be consistent with extreme syndromes that develop superimposed on top of underlying dimensional variation" (p. 140).

MAXCOV analysis capitalizes on the fact that the covariation between any two signs of a categorical variable will be minimized in groups of subjects who share the class membership and will be maximized in mixed groups, whereas no such variation in covariation will be found across levels of a dimensional variable (Meehl & Golden, 1982). MAXCOV did suggest the presence of a latent class variable for a "schizoid" taxon in a study by Meehl and Golden (1982), using Minnesota Multiphasic Personality Inventory (MMPI) indicators of schizotypy. However, it should be noted that the schizoid taxon in this case did not refer to the schizotypal (or the schizoid) personality disorder, but rather to the full spectrum of schizophrenic pathology (including the schizotypal, schizoid, and other personality disorders, as well as psychotic disorders). Nevertheless, the findings of this study could be said to support the hypothesis that schizotypal personality is not on a continuum with normal personality traits.

Trull, Widiger, and Guthrie (1990) applied MAXCOV to the *DSM–III–R* criteria for the borderline personality disorder. The charts of 409 patients were systematically coded for symptoms of dysthymia (a presumably dimensional variable), biological sex (a categorical variable), and borderline personality disorder. A clear peak was found for biological sex, the curve was flat for dysthymia, and no peak in the middle of the distribution was found for borderline personality disorder. Trull et al. concluded that "the results are most consistent with the hypothesis that [borderline personality disorder] is optimally conceptualized as a dimensional variable" (p. 47). However, it should also be noted that Trull et al.'s findings were not unambiguous. The MAXCOV curve for borderline personality disorder did not peak in the center of the distribution, but it did peak at the end of the distribution, which is inconsistent with both the dimensional and categorical models.

Arguments Favoring a Categorical Model

The empirical research favors the hypothesis that the *DSM–III–R* personality disorders do not involve qualitatively distinct disorders. Instead, they may represent extreme and/or maladaptive variants of personality traits that are present across the entire population. One may then ask why the *DSM* continues to use a categorical model. Three arguments in favor of the categorical approach have typically been provided (Frances, 1990; Gunderson, Links, & Reich, 1991; Millon, 1981, 1991): (a) tradition and familiarity, (b) ease in conceptualization and communication, and (c) consistency with clinical decisions. We discuss each of these arguments in turn.

Familiarity and Tradition

The categorical system is more familiar to clinicians (Gunderson et al., 1991; Millon, 1981, 1991). All prior and current diagnoses within the the *DSM* have been categorical. Converting to a dimensional model would represent a major shift in clinical practice (Frances, 1990).

However, the dimensional model has been more acceptable and familiar for the classification of personality (Gangestad & Snyder, 1985; Widiger & Frances, 1985), and no survey has ever documented a preference among practicing clinicians for the categorical format. It is perhaps presumptive to argue that clinicians prefer the categorical system or would not accept a dimensional classification. Maser, Kaelber, and Weise (1991) surveyed 146 psychologists/psychiatrists in 42 countries. Eighty-nine percent considered the *DSM–III–R* to be at least fairly successful in providing diagnostic categories. However, the survey question that assessed the diagnostic categories concerned all the disorders, whereas "the personality disorders led the list of diagnostic categories with which respondents were dissatisfied" (Maser et al., 1991, p. 275). The personality disorders were considered problematic by 56% of the respondents; the second most frequently cited category—the mood disorders—was cited by only 28% of the respondents. In response to an optional, write-in question, "35 of 101 respondents (35%) chose to write in personality disorders ... 'most in need of revision'" (p. 275). Kass et al. (1985) indicated that feedback from staff and trainees during their study on dimensional ratings for the personality disorders suggested that a 4-point severity rating was both feasible and acceptable in routine clinical practice. Similar results were re-

ported in a much earlier study with medical students (Hine & R. Williams, 1975).

Diagnostic categories are consistent with the neo-Kraepelinian emphasis and clinical tradition of trying to define homogeneous, distinct syndromes (Robins & Helzer, 1986), but they may also reflect a simplistic cognitive economics that fails to appreciate the complexity and individuality of personality. Cantor and Genero (1986) developed this hypothesis most eloquently in their application of prototypal theory to the diagnosis of mental disorders.

Persons naturally categorize their external environment. It is an adaptive mechanism in that it facilitates daily functioning by limiting the amount and complexity of the information that we receive, process, and communicate. Failing to simplify this information through the use of categorical distinctions would likely be overwhelming. However, this natural categorization is also maladaptive "in that there is a tendency, once having categorized, to exaggerate the similarity among nonidentical stimuli by overlooking within-group variability, discounting disconfirming evidence, and focusing on stereotypic examples of the category" (Cantor & Genero, 1986, p. 235). This is most clearly evident in person categories and associated stereotypes (e.g., accountant, cop, Black, and female), and it can be equally problematic in the diagnosis of mental disorders (Ford & Widiger, 1989; Schacht, 1985).

The prototypal model of categorization was influential in the development of *DSM–III–R,* particularly for the personality disorders (Spitzer, 1987). The diagnostic criteria for some of the *DSM–III* personality disorders (e.g., avoidant) required all the defining features to be present. However, the authors of *DSM–III–R* recognized that the monothetic criteria sets were overly restrictive and were inconsistent with the heterogeneity of personality disorder symptomatology (Widiger, Frances, Spitzer, & J. Williams, 1988). The monothetic criteria sets described prototypic cases that rarely appeared in actual clinical practice (Livesley, 1985). Persons with the respective personality disorders usually share only a subset of the defining features, resembling the prototype with varying degrees of a family resemblance (Blashfield, 1984).

The *DSM–III–R* personality disorder criteria are therefore polythetic (Spitzer, 1987). A set of optional criteria is provided, only a subset of which is necessary for the diagnosis. However, this recognition of the heterogeneity among persons with similar personality disorders does not actually address or resolve the problem of the heterogeneity (Widiger & Kelso, 1983). It simply acknowledges and accepts the problem. The polythetic format still makes categorical, black–white distinctions that fail to appreciate the complexity that actually exists. For example, there are 93 different ways to meet the *DSM–III–R* criteria for the borderline personality disorder and 149,495,616 different ways to meet the *DSM–III–R* criteria for antisocial personality disorder (only 848 possible combinations if one does not count the different ways to meet the subcriteria for the conduct disorder and parental irresponsibility items). Yet, only one diagnostic label is provided to characterize all these different cases (i.e., presence of the disorder). One would not need to distinguish among all 149,495,616 different combinations of antisocial criteria to provide a useful description of a patient, but it is evident that not all antisocials are alike with respect to their antisocial symptomatology and that many of the differences can be of considerable importance to clinical practice and research (Harpur, Hare, & Hakstian, 1989).

There are 162 different possible combinations of the borderline criteria in persons who would not be given the diagnosis, but all these cases are simply labeled as not having a borderline personality disorder. The inadequacy of diagnosing these patients as simply lacking the respective personality disorder was noted by Skodol (1989) in his overview of *DSM–III–R.* The *DSM–III–R* provides the option of indicating the presence of "traits" on Axis II when the patient fails to meet the criteria for the diagnosis.

> In practice, however, this option was seldom utilized: in reviewing 200 multiaxial diagnostic evaluations, I found that fewer than 5% had personality traits listed on Axis II. Several of my colleagues and I believed that personality traits play such a significant role in determining treatment approach, especially in psychotherapy, that we instituted a scaled system for rating DSM–III personality disorders in the outpatient clinic at the Columbia–Presbyterian Medical Center. ... Using this system, we found that, in addition to the approximately 50% of clinic patients who meet criteria for a personality disorder, another 35% warrant information descriptive of their personality styles on Axis II. (Skodol, 1989, pp. 385–386)

In sum, categories are more familiar to and may at times be preferred by clinicians. However, this tradition may reflect in part a natural inclination toward simplification that fails to appreciate the complexity of personality functioning. Diagnostic categories do provide vivid, clear descriptions (Frances, 1990; Gunderson et al., 1991), but, to the extent that most patients do not provide prototypic cases, these descriptions will be misleading and stereotyping (Cantor & Genero, 1986; Schacht, 1985). A more quantitative description of the extent to which each personality disorder (or a set of fundamental dimensions) is evident would provide a more precise description that would be more informative and less stereotyping. The heterogeneity would

then be retained and would in fact inform clinical decisions. It is somewhat ironic that, for a diagnosis in which reliability and validity are among the most problematic, reliable and valid information is being excluded from the classification.

Ease in Conceptualization and Communication

It has also been argued that, even if a dimensional classification of personality functioning is more informative, it would be too difficult and cumbersome to make in clinical practice (Gunderson et al., 1991; Millon, 1981, 1991). Categories are helpful in simplifying a complex set of information (Cantor & Genero, 1986). It is easier to consider and discuss the presence of one or two disorders than a profile of the degree to which all the various disorders are present. One category (e.g., borderline) can communicate a great deal of vivid information (Frances, 1990). Diagnoses within a categorical model require only one decision: whether the patient has or does not have a particular personality disorder. Diagnoses within a dimensional model would require more specific and detailed assessments. To the extent that a dimensional model retains more information, it requires the acquisition and communication of more information (Widiger, 1991).

In practice, however, the personality disorder diagnostic categories of *DSM–III–R* are more complex and cumbersome than most dimensional models. The current taxonomy requires the assessment of 104 diagnostic criteria. Most semistructured interviews can require 2 hr to provide a systematic and comprehensive assessment of the 11 diagnoses (e.g., Loranger, 1988; Pfohl, Blum, Zimmerman, & Stangl, 1989). Two hours is substantial, but even this amount of time allows only for an average of 1 min 9 sec to assess each personality disorder criterion. It is then understandable that most clinicians do not systematically follow the *DSM–III–R* criteria (Morey & Ochoa, 1989) as it is neither practical nor even feasible in routine clinical practice.

A dimensional model that eliminates the redundancy and overlap among the *DSM–III–R* categorical distinctions would be much easier to use. For example, the five-factor model (discussed in more detail later) would require the assessment of only five dimensions—a task of considerably less complexity than working with the 11 diagnostic categories of *DSM–III–R*.

The *DSM–III–R* categorical system also results in a variety of confusing multiple diagnoses (Cloninger, 1989; Widiger & Rogers, 1989). The average number of personality disorder diagnoses per patient tends to be around four (e.g., Skodol, Rosnick, Kellman, Oldham, & Hyler, 1991), and yet most clinical charts provide just one personality disorder diagnosis (Morey & Ochoa, 1989). One reason that clinicians fail to provide all the diagnoses that apply is that it is confusing and not particularly meaningful to indicate that the patient is suffering from four, five, or even six distinct and co-morbid personality disorders. It would be simpler and more meaningful to state that the person suffers from a personality disorder characterized by excessive neuroticism, introversion, and antagonism than to state that the patient has three co-morbid personality disorders (e.g., borderline, avoidant, and histrionic).

Consistency With Clinical Decisions

The final apparent advantage of the categorical model is that clinical decision-making tends to be categorical. Treatment decisions are not usually in shades of grey. Therefore, many clinicians would convert a dimensional profile to categories in order to facilitate their decisions. The MMPI, for example, provides the potential for detailed assessments along dimensions, but it is often converted to typological code types. There might then be little advantage to increasing the complexity of diagnosis by requiring ratings, along a continuum, that are ignored in clinical practice.

However, consistency with clinical decision-making is readily retained in a dimensional model simply by providing recommended cutoff points for various clinical decisions. The reverse option is not possible. After a categorical diagnosis is provided, the ability to return to a more precise description (e.g., the degree to which the person approaches a prototypic case) cannot be recovered.

Many clinicians convert an MMPI dimensional profile to a categorical code type, but these clinicians are unlikely to prefer being given only the code type and not being given the additional information obtained from the profile description. A dimensional profile provides the flexibility to use alternative code types and cutting scores for different situations and clinical decisions. For example, some clinical or research situations are likely to require more liberal or more restrictive thresholds than those provided by the *DSM–III–R* diagnoses. Different cutoff points will be optimal for predicting responsivity to different treatment modalities, need for hospitalization, future course, likelihood of family history, or predisposition to experience future episodes of depression (Finn, 1982; Kendler, 1990; Widiger & Trull, 1991). A dimensional profile of the extent to which each personality disorder is present would allow for this flexibility; the categorical diagnoses do not.

Alternative Proposals

A variety of options for incorporating a more dimensional approach to the classification of the personality disorders is being considered for *DSM–IV* (APA, 1991;

Widiger, 1991). These proposals were developed in collaboration with the DSM–IV Personality Disorders Work Group; no proposal, however, has yet received the consensus support of the work group. One proposal is to retain the categorical system but to provide a table for converting the categories to a dimensional format that would provide more quantitative information (see Table 1).

Six levels are provided: absent, traits, subthreshold, threshold, moderate, and prototypic. The rating in each case is compatible with the current format. "Absent" means what it implies—an absence of any of the specified symptoms. "Traits" means that there are simply one to three symptoms (*DSM–III–R* currently recommends that the clinician code personality disorder "traits" on Axis II when the patient meets some of the criteria but not enough to be given the diagnosis; APA, 1987, p. 17). "Subthreshold" means that the person is only one symptom short of having the disorder. "Threshold" means that the person just barely meets the criteria for the disorder. "Moderate" means that the person has more than enough of the criteria. Last, "prototypic" means that all the diagnostic features are present.

This coding is compatible with the current categorical format and still provides a uniform terminology and method for describing the extent to which a patient has each disorder. The terminology and criteria would facilitate uniform discussion among clinicians and researchers who wish to indicate the extent to which the disorder is present without disrupting the current diagnostic system.

The DSM–IV Personality Disorders Work Group is also considering a more fundamental revision in which the diagnostic categories would be replaced by a set of dimensions that are on a continuum with normal personality functioning. A major difficulty with this proposal has been the lack of consensus within the work group and among personality disorder researchers regarding which dimensions to include. Several dimensional models for the personality disorders have been proposed (e.g., Clark, 1990; Cloninger, 1987; Costa & McCrae, 1992; H. Eysenck, 1987; Kass et al., 1985; Kiesler, 1991; Livesley, 1991; Siever & Davis, 1991; Tellegen & Waller, in press). The proposal having the least opposition among the work group members—no proposal has substantial support—is to develop a compromise, consensus model that attempts to represent equally each of the major alternatives. This is comparable to the procedure used to develop the *DSM–III* criteria for borderline personality disorder. During the construction of *DSM–III,* it was evident that there should be a borderline personality disorder diagnosis, but there was substantial disagreement regarding the optimal criteria set for this diagnosis. Therefore, Spitzer et al. (1979) developed a compromise, consensus model in consultation with leading borderline researchers (Drs. Gunderson, Kernberg, Rinsley, Sheehy, & Stone). Disagreements regarding the optimal criteria still remain (e.g., Zanarini, Gunderson, Frankenburg, Chauncey, & Glutting, 1991), but there is substantial agreement that a flawed representation was better than no representation.

The dimensional proposal being considered by the DSM–IV Personality Disorders Work Group was developed in consultation with Drs. Cloninger, Costa, Eysenck, McCrae, Siever, Tellegen, and Wiggins and consists of seven dimensions: (a) neuroticism (from H. Eysenck, 1987), (b) extraversion (from H. Eysenck, 1987), (c) constraint (from Tellegen & Waller, in press), (d) agreeableness (from Costa & McCrae, 1985), (e) openness (from Costa & McCrae, 1985), (f) reward dependence (from Cloninger, 1987), and (g) cognitive disorganization (from Siever & Davis, 1991). Each dimension would be briefly discussed within an appendix to *DSM–IV* (or within the introduction to the Personality Disorders section) as an alternative model for the diagnosis of personality disorder pathology.

Table 1. *Converting the Diagnostic Categories to Dimensional Ratings*

	Number of Criteria					
Personality Disorder	**Absent**	**Traits**	**Subthreshold**	**Threshold**	**Moderate**	**Prototype**
Paranoid	0	1–2	3	4	5–6	7
Schizoid	0	1–2	3	4	5–6	7
Schizotypal	0	1–3	4	5–6	7–8	9
Antisocial[a]	0	1–2	3	4–5	6–9	10
Borderline	0	1–3	4	5	6–7	8
Histrionic	0	1–2	3	4–5	6–7	8
Narcissistic	0	1–3	4	5–6	7–8	9
Avoidant	0	1–2	3	4	5–6	7
Dependent	0	1–3	4	5–6	7–8	9
Compulsive	0	1–3	4	5–6	7–8	9
Passive-Aggressive	0	1–3	4	5–6	7–8	9

[a]Confined to items occurring since age 15.

Widiger (1992) provided further details regarding this proposal.

However, my opinion is that the five-factor model of personality—consisting of the dimensions of neuroticism, extraversion, openness, agreeableness, and conscientiousness—is largely sufficient for characterizing normal and abnormal personality functioning (Widiger & Trull, 1992). The remainder of this article discusses this alternative model for the classification of personality disorder pathology.

Five-Factor Model of Personality

Empirical support for the five-factor (or "Big Five") model is extensive. A comprehensive overview of this research is beyond the scope of this article but is readily available elsewhere (e.g., Digman, 1990; John, 1990; McCrae & Costa, 1990; Wiggins & Pincus, 1992). Only a brief overview is presented here.

Initial derivation of this model was based on the compelling rationale that the most important and fundamental traits of personality could be identified through an empirical (lexical) analysis of natural language. "Those individual differences that are the most significant in the daily transactions of persons with each other will eventually become encoded into their language" (Goldberg, 1982, p. 204). The importance of a trait will be indicated by the number of terms that describe the trait, and the structure of these traits will be evident by the relation among these terms. Many such lexical analyses have been conducted, and the findings have consistently supported the five-factor model (John, Angleitner, & Ostendorf, 1988). On the basis of his review of this research, Digman (1990) concluded that, over a 20-year period, "the domain of personality attributes had been successfully analyzed, not just once, but by five competent, independent investigators, all of whom came to the same general conclusion: that the domain could be adequately described by five superordinate constructs" (p. 420). One of the more recent efforts was by Goldberg (1990), who analyzed a sufficiently comprehensive set of 1,431 trait adjectives across a variety of factor-analytic techniques. Goldberg suggested that

> it now seems reasonable to conclude that analyses of any reasonably large sample of English trait adjectives in either self-descriptions or peer descriptions will elicit a variant of the five-factor structure, and therefore that virtually all such terms can be represented within this model. (p. 1223)

Good to excellent replications of the five factors have also been found with other languages, including German (Angleitner, Ostendorf, & John, 1990), Dutch (De Raad, Mulder, Kloosterman, & Hofstee, 1988), Japanese (Bond, Nakazato, & Shiraishi, 1975), Filipino (Church & Katigbak, 1989), and Chinese (Yang & Bond, 1990), using either natural-language or questionnaire measures.

The five-factor structure has also been replicated across self, peer, spouse, and other observer ratings (e.g., Borkenau & Ostendorf, 1989; Goldberg, 1990; McCrae & Costa, 1987). The five factors have been replicated across age groups, including children (Digman & Inouye, 1986), young adults (Goldberg, 1990), and older adults (McCrae & Costa, 1985b). Substantial temporal stability has been reported across 6-, 7-, and even 30-year periods (Costa & McCrae, 1988, 1992). The five factors have also been very successful in subsuming and accounting for the traits included within other models of personality and personality assessment (e.g., Borkenau & Ostendorf, 1989; Costa & McCrae, 1988; McCrae & Costa, 1985a, 1989). John (1990) concluded the following on the basis of his review of this latter research:

> For one, the Big Five dimensions capture, at a broad level of abstraction, the commonalities among most of the existing systems of personality description. Second, and even more important, most other personality scales can be interpreted in the context of these five dimensions. That, I believe, is one of the major goals of scientific, "synthetic" description. (p. 33)

The five-factor model is not without its critics (e.g., Tellegen & Waller, in press; Waller & Ben-Porath, 1987), but much of the concern is with technical and/or secondary issues (e.g., optimal label for a factor or the optimal delineation of the facets within a factor). There is no alternative model that has comparable empirical support. Even the most vocal critics of the five-factor model acknowledge that it does provide the point of departure for the understanding of the personality disorders. Grove and Tellegen's (1991) "view is that the Big Five ... provide a good starting point for describing normal and disordered personality" (p. 36).

Five-Five Model and the *DSM–III–R* Personality Disorders

Table 2 presents an interpretation of the *DSM–III–R* personality disorders from the perspective of the five-factor model developed by Widiger, Trull, Clarkin, Sanderson, and Costa (1993) on the basis of a systematic review of each of the respective diagnostic criteria and associated features presented in the *DSM–III–R* (APA, 1987) and provided in the clinical literature. It is evident from Table 2 that there is little difficulty in providing an adequate characterization of each of the *DSM–III–R* personality disorders using the dimensions and facets of the five-factor model. An understanding

Table 2. *DSM–III–R Personality Disorders and the Five-Factor Model*

	DSM–III–R Personality Disorder[a]										
Factor	**PAR**	**SZD**	**SZT**	**ATS**	**BDL**	**HST**	**NAR**	**AVD**	**DEP**	**OBC**	**PAG**
Neuroticism											
Anxiety	h		h	h/L	H			H	H		
Hostility	H	L	h	H	H	H	H			h	H
Depression				h	H		h/L	h	H	h	
Self-Consciousness		l	H	L	H	H	H	H	h	h	
Impulsiveness				h	H						
Vulnerability			h		H	h	H	H	H		
Extraversion											
Warmth	l	L	L	l		H		L/H	h	L	
Gregariousness	l	L	L		h	h		L			
Assertiveness					h		H	L	L	H	
Activity						h					
Excitement Seeking		L		H		h		L		l	
Positive Emotions	l	L			h	H				l	
Openness											
Fantasy			H			h	H				
Aesthetics	l										
Feelings	l	L	L			H				L	
Actions	L					h		L			
Ideas			H			l					
Values			h							L	
Agreeableness											
Trust	L		L			h					
Straightforwardness	L			L	L	l	l				L
Altruism				L		L	L		H	L	
Compliance	L	h		L	L				H	L	L
Modesty	l			L			L		H		
Tender-Mindedness	l			L			L		h		
Conscientiousness											
Competence	h					l	h				L
Order										H	
Dutifulness				L						H	L
Achievement Striving		l			L		h		L	H	
Self-Discipline				L		L					L
Deliberation				L						H	

Note: H and L = high and low, based on *DSM–III–R* diagnostic criteria; h and l = high and low, based on associated features provided in *DSM–III–R* (APA, 1987); **H, L, h,** and **l** = high and low based on clinical literature.
[a]PAR = paranoid, SZD = schizoid, SZT = schizotypal, ATS = antisocial, BDL = borderline, HST = histrionic, NAR = narcissistic, AVD = avoidant, DEP = dependent, OBC = obsessive-compulsive, and PAG = passive-aggressive.
[b]From Widiger et al. (1993).

of personality disorder pathology from the perspective of the five-factor model is in fact helpful in addressing a variety of problematic findings obtained with the *DSM–III* and *DSM–III–R* diagnostic categories—as well as in highlighting inconsistencies between the *DSM–III–R* and the clinical literature, as in the case of the extraversion facet of warmth for the avoidant personality disorder.

For example, borderline personality disorder involves primarily excessive elevations on all or most of the facets of neuroticism (particularly hostility, impulsivity, trait anxiety, trait depression, and vulnerability). Conceptualizing borderline personality disorder as extreme neuroticism is helpful in explaining the excessive prevalence and co-morbidity of this popular but controversial diagnosis (Widiger & Frances, 1989). Neuroticism, as a characteristic level of personality dysfunction (i.e., vulnerability to stress, impulse dyscontrol, and negative emotionality) is almost ubiquitous within clinical populations (H. J. Eysenck & M. W. Eysenck, 1985). Personality dysfunction to the point of needing inpatient hospitalization usually involves excessive neuroticism. A diagnostic category that consists essentially of excessive neuroticism should be very prevalent and the most common personality disorder within inpatient settings. To the extent that the other personality disorders involve some degree of neuroticism (see Table 2), one would also expect considerable overlap and co-morbidity with borderline personality disorder. The excessive prevalence and co-morbidity of borderline personality that are so problematic for its validity as a distinct personality

disorder (Cloninger, 1989; Gunderson & Zanarini, 1987; Widiger & Frances, 1989) are then readily understandable from the perspective of the five-factor model.

Conceptualizing borderline personality disorder as excessive neuroticism is also consistent with Kernberg's (1984) concept of borderline personality organization, thereby providing a means for integrating the competing formulations developed by Kernberg and the *DSM–III–R* (APA, 1987). Kernberg interpreted borderline personality organization as a fundamental level of personality organization that cuts across the *DSM–III–R* personality disorders. Likewise, neuroticism is a characteristic level of personality dysfunction that cuts across other important individual differences (e.g., degree of extraversion and conscientiousness). Kernberg would prefer to use a more inferential means for assessing a patient's level of personality organization (e.g., assess the degree of identity diffusion, reliance on primitive defenses, and reality testing within object relations), but a substantial correlation between Big Five neuroticism and level of personality organization is likely. The nonspecific manifestations of borderline personality functioning identified by Kernberg (e.g., anxiety tolerance, impulse control, and vulnerability to stress) are very close to the facets of neuroticism identified by Costa and McCrae (1985).

The five-factor model is also helpful in explaining an anomaly reported in the the factor-analytic studies of personality disorders. Hyler and Lyons (1988) and Kass et al. (1985) provided factor-analytic results that, they suggested, supported a three- dimensional model for the personality disorders that was consistent with the three-cluster arrangement provided in *DSM–III–R* (i.e., odd-eccentric, dramatic-emotional, and anxious-fearful). However, both studies had in fact obtained four-factor solutions, with the fourth factor anchored in each case by the compulsive personality disorder. Hyler and Lyons and Kass et al. both dismissed the fourth factor as a methodological artifact, but it is readily understood from the five-factor perspective as representing a maladaptive variant of conscientiousness. Conscientiousness, as defined by Costa and McCrae (1985), contrasts the tendency to be organized, reliable, hard-working, self-disciplined, punctual, scrupulous, neat, ambitious, and persevering with the tendency to be aimless, unreliable, lazy, careless, lax, negligent, and hedonistic. Maladaptive conscientiousness would clearly suggest an obsessive-compulsive personality disorder—involving such symptoms as perfectionism; preoccupation with details, rules, order, and organization; excessive devotion to work and productivity; and overconscientiousness (as defined by *DSM–III–R;* APA, 1987). A factor that contrasts the compulsive personality disorder with the antisocial and the borderline (as in Kass et al., 1985) does appear to represent maladaptive variants of high and low conscientiousness respectively.

As a final illustration of the relation of the five-factor model to the personality disorders—Widiger et al. (1993) provides a more comprehensive discussion—the five-factor model is also helpful in explaining the confusion and differentiation of the avoidant and schizoid personality disorders. This differential diagnosis has been controversial (Livesley, West, & Tanney, 1985). However, both the overlap and the differentiation of the schizoid and avoidant personality disorders are readily understood from the perspective of the five-factor model. The avoidant and schizoid personality disorders both involve excessive, maladaptive introversion. However, to the extent that an excessively introverted person is also characteristically self-conscious, anxious, and vulnerable, he or she would likely be diagnosed with avoidant personality disorder (see Table 2). The avoidant and schizoid personality disorders may also be distinguished in part by the facets of introversion that are primarily involved. A pure case of schizoid personality disorder would involve primarily the facets of low positive emotions in addition to low warmth and low gregariousness, whereas the avoidant personality disorder involves primarily the facets of low warmth, low gregariousness, and low assertiveness (see Table 2). However, it is important to emphasize that the typical case will share some combination of these facets—as well as some degree of neuroticism—and hence may often be difficult to diagnose as either schizoid or avoidant. It is precisely for these typical cases that the more individualized and precise description provided by the five-factor model would be particularly useful.

There have been only four published empirical studies concerned with the relation between the personality disorders and the five-factor model (Costa & McCrae, 1990; Trull, in press; Widiger et al., 1991; Wiggins & Pincus, 1989), and one of these did not include an independent measure of the five factors (Widiger et al., 1991). Additional studies and discussion are provided in Costa and Widiger (in press). For the most part, the findings have been very supportive. However, questions regarding the adequacy and application of the five-factor model to the personality disorders have been raised by this research. Two major concerns addressed in this target article are (a) the importance of openness to experience and (b) the distinction of abnormality from normality.

Openness to Experience

The factor-analytic studies of Hyler and Lyons (1988) and Kass et al. (1985) obtained only four factors

(i.e., not five)—none of which suggested openness to experience. Neuroticism, Extraversion, Agreeableness, and Conscientousness have obvious and well-supported relations to the *DSM–III–R* personality disorders, but Openness to Experience has not obtained consistent empirical support with respect to the personality disorders. Widiger et al. (1993) suggested that the schizotypal and histrionic personality disorders are characterized in part by a maladaptively extreme openness (to ideas and fantasy for the schizotypal; to feelings for the histrionic) and the obsessive-compulsive, paranoid, schizoid, and avoidant personality disorders are characterized in part by being excessively closed to experience, but there are both conceptual and empirical limitations to these hypotheses. In the interest of space limitations, this discussion is confined to the schizotypal hypothesis.

Costa and McCrae (1990) reported no significant correlations between the Morey, Waugh, and Blashfield (1985) MMPI Schizotypal scale and self, spouse, or peer NEO Personality Inventory (NEO–PI) Openness ratings (Costa & McCrae, 1985) or between the revised Millon Clinical Multiaxial Inventory Schizotypal scale (MCMI–II; Millon, 1987) and self-report NEO–PI Openness. In fact, they obtained a significant negative correlation ($r = -.19, p < .01$) with the MCMI–II Schizotypal scale. Trull (in press) reported nonsignificant correlations between the NEO–PI Openness scale and the MMPI Schizotypal scale ($r = .21, p > .05$), the Personality Diagnostic Questionnaire–Revised (Hyler & Rieder, 1987; $r = .09$), and the Structured Interview for DSM–III–R Personality Disorders (Pfohl et al., 1989; $r = -.07$). The only study to obtain any direct empirical support for this hypothesis was by Wiggins and Pincus (1989). In their factor analysis of the NEO–PI, the Big Five version of the Interpersonal Adjective Scales (IAS–B5; Trapnell & Wiggins, 1988), the MMPI Personality Disorder scales, and the Personality Adjective Check List (Strack, 1987), the only scale to load on the Openness to Experience factor—defined by both the NEO–PI and IAS–B5 Openness scales—was the MMPI Schizotypal scale. However, that no other personality disorder scale loaded on this factor would also suggest that openness to experience was not particularly important or useful in assessing personality disorder pathology.

There are reasons to expect that there may be no maladaptive variant of excessively high openness to experience. The NEO–PI Openness scale was derived in part from prior research on self-actualization, self-realization, and personal growth—in particular, Coan's (1974) work on mental health. From this perspective, extreme openness should correlate with indicators of ideal mental health rather than with personality disorder pathology. The unusual and aberrant beliefs of the schizotype may be endorsed by a creative and open-minded individual (McCrae, 1987), but the endorsement of these same beliefs by a schizotypic person may be due to rigidity of thinking. Schizotypic persons may not really be open to new ideas but may instead be impelled to believe in a variety of aberrant and unusual ideas to which a truly open person would at times be receptive.

It may then be that a highly elevated openness to experience is not indicative of personality disorder pathology but may be indicative instead of the potential for self-actualization or self-realization. This is not problematic to a five-factor model for personality disorder pathology, as there is no requirement that each pole of each of the five dimensions have equivalent implications for maladaptivity. Equivalent degrees of maladaptivity will not be suggested by equivalent levels on extraversion, introversion, agreeableness, or antagonism. Elevations on antagonism are more likely to be suggestive of maladaptive dysfunction than equivalent elevations on agreeableness, and maladaptivity is more closely associated with excessively high neuroticism than with excessively low neuroticism. Likewise, the dogmatism, rigidity, and closed-mindedness of low openness may be more suggestive of maladaptivity than high openness.

On the other hand, Tellegen and Waller (in press) suggested that the five-factor model is limited in its ability to characterize abnormal personality by the exclusion of evaluative trait terms (e.g., *bad, awful,* and *vicious*) from the original lexical analyses of Goldberg (1982) and others. Goldberg said that these terms provide little substantive information with respect to the content of personality traits. However, they may be particularly important when describing the extreme, aberrant, and maladaptive variants of normal personality traits. When these terms were included in analyses, Tellegen and Waller obtained a seven-factor rather than a five-factor solution. The two additional dimensions were titled *positive* and *negative valence.* Particularly important to this discussion is their reformulation of the Openness factor. They indicated that the inclusion of the evaluative terms resulted in a dimension of conventionality rather than openness. Persons who are extremely unconventional are characterized by terms such as *odd, strange, unusual, peculiar,* and *weird,* which are clearly more indicative of schizotypic persons than an excessive openness to experience.

However, Widiger and Trull (1992) suggested that the positive- and negative-valence dimensions of Tellegen and Waller (in press) may represent maladaptive variants of the existing five factors. Negative valence is defined by terms such as *cruel, mean, vicious, nasty, evil, depraved, treacherous,* and *deceitful,* which could suggest extreme antagonism. Positive valence is

defined by terms such as *excellent, outstanding, superior, impressive, remarkable,* and *flawless,* which may suggest excessively low neuroticism. In any case, it may be that the NEO–PI assessment of the five factors is hindered by the failure to include items that represent the most extreme variants of each factor (Clark, Vorheis, & McEwen, in press). The NEO–PI was constructed to assess the five factors within normal populations and may not provide adequate representation of the most extreme elevations on each factor. Beyond a degree of openness to experience may be an *odd, peculiar,* and *weird* unconventionality that would be descriptive of the schizotypal personality disorder.

Normality Versus Abnormality

The *DSM–III–R* is a manual for the diagnosis of mental disorders. Replacing the personality disorder diagnostic categories with the five-factor model would extend the classification beyond the scope of providing mental disorder diagnoses. A criticism of *DSM–III* is the extent to which it appears to subsume most problems in living as (medical, psychiatric) mental disorders (Schacht, 1985). Replacing the Axis II personality disorders with the five-factor model would add substantial fuel to this controversy.

However, the inclusion of normal with abnormal personality traits is consistent with the spirit of a multiaxial diagnostic system (J. Williams, 1985). Their inclusion would enable the clinician to provide a comprehensive description of a patient's personality, including adaptive as well as maladaptive manifestations. Any description of a person's personality that is confined to the features that are maladaptive would clearly be incomplete and potentially distorting. The patient would be described simply with respect to aberrant, abnormal, and dysfunctional traits, ignoring the ways in which the person is functional and adaptive. For example, knowing the extent to which an avoidant patient tends to be conscientious, agreeable, or open to new ideas or experiences would likely be of considerable use in developing a treatment plan and in understanding the patient's social and occupational functioning.

Likewise, individual personality disorder diagnoses are also confined to the more florid or immediate personality dysfunction, ignoring additional domains of dysfunction that may be equally important in understanding the patient's personal, social, and occupational functioning. For example, the diagnosis of borderline personality disorder provides only limited information with respect to a person's characteristic manner of functioning—being confined largely to the domain of neuroticism. Knowing the extent to which a borderline tends to be low in conscientiousness, antagonistic, or closed to new ideas or experiences would be of considerable help in understanding and explaining difficulties at work or within social, personal relationships. A complete understanding of a person's social and occupational functioning requires a consideration of not only a person's level of neuroticism but also of the person's level of extraversion–introversion, agreeableness–antagonism, conscientiousness, and openness–closedness. The same limitation will occur with every personality disorder diagnosis. For example, knowing that a person has a schizoid personality disorder does indicate that the person is maladaptively introverted—excessively low in warmth, positive emotions, and gregariousness—but a schizoid person could also be characteristically agreeable or antagonistic or characteristically high or low in conscientiousness. A personality description confined to the domain of introversion would provide a very narrow, limited, and distorted description.

One final concern with replacing the *DSM–III–R* diagnostic categories with the five factors of personality is how one would diagnose abnormality on the basis of a profile along the five factors. The five-factor model does not provide explicit thresholds for when a score along the continuum indicates the presence of clinically significant personality dysfunction. To the extent that personality disorders represent extreme variants of normal personality traits, maladaptivity would be suggested by the extent to which a person is excessively antagonistic, agreeable, introverted, or extraverted (Kiesler, 1991; Widiger & Kelso, 1983; Wiggins, Phillips, & Trapnell, 1989), but diagnosing personality dysfunction is not simply a matter of identifying a point along the continuum at which the trait becomes excessive or extreme. In fact, it would be inconsistent with a dimensional model of personality disorder pathology to provide a single cutoff point to demarcate the presence–absence of clinically significant personality dysfunction. Maladaptivity of personality functioning is suggested when the personality trait "causes either significant impairment in social or occupational functioning or subjective distress" (APA, 1987, p. 335), but it should be assessed relative to a person's personal, social, cultural, and occupational environments. The level of antagonism that would be maladaptive for a pastoral counselor might not be maladaptive for a police officer; the level of antagonism that would be adaptive for a soldier at war might not be adaptive for the solder during peace time; and the level of antagonism that would be adaptive for the police officer employed to arrest drug dealers might not be adaptive for this same officer within his or her marital relationship. The failure to consider the environmental context has been one of the major criticisms of the controversial proposal to include a masochistic or self-defeating per-

sonality disorder diagnosis in *DSM–III–R* (Caplan, 1987; Walker, 1987). Many of the self-defeating traits—for example, engages in excessive self-sacrifice, fails to accomplish tasks crucial to personal objectives, and incites angry or rejecting responses in others (APA, 1987)—could represent situational responses to an abusive marital relationship that may be adaptive within the context of this disturbed, dysfunctional relationship.

The *DSM–III–R* does not currently provide the means for assessing distress or social-occupational dysfunction independently of the personality disorder diagnosis. However, several instruments for such an assessment are available. For example, Dohrenwend, Shrout, Egri, and Mendelsohn (1980) developed the Psychiatric Epidemiology Research Interview (PERI) to assess important dimensions of psychopathology independent of any particular mental disorder. The instrument consists of 38 scales, including Anxiety, Demoralization, Drinking Problems, Insomnia, Suicidality, Sexual Problems, Somatic Problems, Housework Neglect, School Dissatisfaction, Relationship Instability, and Relationship Dissatisfaction. The PERI (or any comparable instrument) used in conjunction with an assessment of the five factors of personality would then provide a comprehensive description of the personality along with an independent assessment of the maladaptivity of personality functioning within the person's current social and occupational environments.

Conclusions

The empirical research favors a dimensional model for the classification and conceptualization of personality disorder pathology. The empirical research also favors the five-factor model for the classification of normal personality functioning. It is then only natural and reasonable to propose that personality disorders be classified and understood from the perspective of the five-factor model.

Perhaps the only substantial limitation with a five-factor alternative to the *DSM–III–R* personality disorders is the absence of familiar treatment and clinical implications for the various dimensions and their facets. There have been many chapters, books, and articles on the treatment of the compulsive, histrionic, antisocial, schizoid, and borderline personality disorders but very little on the treatment of excessive conscientiousness, extraversion, antagonism, introversion, and neuroticism. Table 2 is useful in providing a translation from the more familiar concepts of *DSM–III–R* to the five-factor model, but clinicians would likely have some difficulty, at least initially, in developing treatment plans with the less familiar five-factor trait terms. Nevertheless, it is anticipated that, with additional experience and training (Costa & Widiger, in press), clinicians will find that it is more helpful to conceptualize treatment as involving an effort to decrease the extent to which a person is impulsive, self-conscious, mistrusting, unassertive, overly compliant, or closed to emotions within particular situations in which such tendencies are maladaptive, than to cure an avoidant, borderline, or histrionic personality disorder.

Notes

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