

Synthesizing dimensional and categorical approaches to personality disorders: refining the research agenda for DSM-V Axis II

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Abstract

Personality disorder researchers have long considered the utility of dimensional approaches to diagnosis, signaling the need to consider a dimensional approach for personality disorders in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). Nevertheless, a dimensional approach to personality disorders in DSM-V is more likely to succeed if it represents an orderly and logical progression from the categorical system in DSM-IV. With these considerations and opportunities in mind, the authors sought to delineate ways of synthesizing categorical and dimensional approaches to personality disorders that could inform the construction of DSM-V. This discussion resulted in (1) the idea of having a set of core descriptive elements of personality for DSM-V, (2) an approach to rating those elements for specific patients, (3) a way of combining those elements into personality disorder prototypes, and (4) a revised conception of personality disorder as a construct separate from personality traits. Copyright © 2007 John Wiley & Sons, Ltd.

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The personality disorders (PDs) field has taken a leading role in contemplating the utility of dimensional approaches to the diagnosis of mental disorders (Krueger et al., 2005; Kupfer et al., 2002). A previous American Psychiatric Institute for Research and Education (APIRE) meeting focused specifically on dimensional approaches to PDs (Widiger et al., 2005), and many advantages of dimensional approaches to PDs are well-documented in the literature. For example, dimensional representations of specific Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) PDs and other dimensional representations of personality pathology are better predictors of functional impairment when compared with categorical representations

of DSM-IV PDs in treatment seeking patients (Morey et al., in press; Skodol et al., 2005).

Depending on the exact details, however, a novel dimensional system for PDs in DSM-V could represent an unnecessarily abrupt departure from the constructs described in DSM-IV, some of which have garnered extensive clinical and research interest. Although implementation of dimensions in DSM-V is called for by the research literature, this implementation will likely be more successful if it is an orderly and logical progression from DSM-IV (cf. Helzer et al., 2006).

With this backdrop in mind, we set out to sketch an approach that might be considered a starting point for discussion related to Axis II of DSM-V. Our intent is

not to advocate for a specific proposal, as such advocacy would be premature at this early stage in the development of DSM-V. Rather, our intent is to provide some examples that emerged from our discussion, that we hope will be useful in catalyzing deliberations and framing initial field testing.

A central theme that emerged in our work was the importance of synthesizing various approaches in the literature, in particular, categorical and dimensional approaches to PDs. We begin by describing the foundation of the approach we developed in our discussion: a set of core elements for the description of the diversity of personalities seen in clinical settings.

Core elements for personality description in the DSM

The current DSM-IV system for PDs entails 10 categorical disorders. Embedded in these 10 disorders are 79 descriptive criteria (not counting ancillary criteria such as exclusionary criteria). A thorough differential diagnosis of the 10 DSM-IV PDs would involve considering the applicability of each of these 79 criteria to a specific patient. Although clinicians may not typically evaluate all 79 criteria, maintaining high fidelity to the DSM *per se* would involve taking on this rather significant burden. For example, when the DSM PD criteria are operationalized in comprehensive semi-structured interviews, such interviews need to cover each PD criterion to maintain fidelity to the DSM system (Widiger et al., 2006). Indeed, front-line clinicians often simplify the diagnostic task by matching their perceptions of patients with conceptual prototypes (Shedler & Westen, 2004), as opposed to evaluating numerous criteria individually. One of the reasons for taking this shortcut may be the burden created by the 79 distinct criteria on the current Axis II. Moreover, in spite of the large number of criteria on DSM-IV Axis II, there is evidence that the 10 disorders delineated by these criteria do not exhaust the diversity of personality pathology seen in clinical practice (Westen & Arkowitz-Westen, 1998). This may be one reason why PD-Not Otherwise Specified is a prevalent diagnosis (Verheul & Widiger, 2004).

Fortunately, research on the fine-grained structure of personality pathology points to a smaller number of fundamental elements or 'facets' that can be used to provide a comprehensive description of abnormal personality. Although a number of systems have been described in the literature, they are notably congruent,

especially in the way they delineate broad domains of personality functioning (Markon et al., 2005; Widiger & Simonsen, 2005). As an example, we focus here on one specific set of facets, those delineated by the Dimensional Assessment of Personality Pathology (DAPP; Livesley, submitted for publication).

The DAPP system consists of 30 facet level constructs. These constructs were generated by starting with trait descriptions and behavioral acts that were characteristic of PDs as described in DSM-III and in the broader literature on personality pathology (Livesley, submitted for publication). A series of psychometric and behavior genetic analyses (described in greater detail by Livesley, submitted for publication) were used to refine the initial set of descriptions, and this process resulted in the specific facets of the current DAPP system. Table 1 presents names of the facets and brief vignettes summarizing the characteristics of persons who have the personality features captured by the facets. In addition, the facets in Table 1 are arranged into four broad groups derived from research on the empirical structure of the facets (Livesley et al., 1998): emotional dysregulation, dissocial behavior, inhibitedness, and compulsivity.

The personality features described in Table 1 provide a starting point for translating facets into descriptive elements for DSM-V *per se* (Livesley, submitted for publication). Specifically, DSM-V could include descriptions of each facet, akin to those in Table 1. In addition, DSM-V would provide guidance to the user regarding how to rate the facets in describing a specific patient or research participant. Although a number of approaches could be considered, a straightforward option is portrayed in Table 2, involving a four-point scale with scale points linked to how characteristic the facet is of the person in general. An even simpler option is to rate each facet as present versus absent, but the disadvantage of this approach is that more information is contained in the more fine-grained four-point scale portrayed in Table 2.

Although we have focused here on the DAPP system for delineating the facet-level structure of personality pathology, it is important to note that we could have used a number of other prominent systems as examples (see Widiger & Simonsen, 2005, for a review). Indeed, these various systems are well-integrated in a hierarchical fashion, with different systems emphasizing different levels of breadth versus specificity in the description of abnormal personality features (Markon et al., 2005).

Table 1. The 30 facets of the DAPP Model

Secondary domain	Primary facet trait	Defining features
Emotional dysregulation	Anxiousness	Trait anxiety; rumination; indecisiveness; guilt proneness
	Emotional reactivity	Emotional lability; irritability; labile anger
	Emotional intensity	Expresses feelings intensely; experiences strong feelings; over-reacts emotionally; exaggerates emotional significance of events
	Pessimistic anhedonia	Anhedonia; pervasive pessimism; feelings of emptiness and boredom
	Submissiveness	Submissive; needs advice and reassurance about all courses of action; suggestible
	Insecure attachment	Fears losing attachments; coping depends on presence of attachment figure; urgently seeks proximity with attachment figure when stressed; strongly protests separations; intolerant of aloneness
	Social apprehensiveness	Fears hurt and rejection; poor social skills; desires affiliative relationships
	Need for approval	Strong need for demonstrations of acceptance and approval; constantly seeks reassurance that he/she is a worthy person
	Cognitive dysregulation	Depersonalization or derealization; schizotypal cognition; brief stress psychosis
	Oppositional	Oppositional behaviors
Dissocial behavior	Self-harming acts	Deliberate self-damaging acts, e.g. self-mutilation, drug overdoses
	Self-harming ideas	Frequent thoughts about hurting self and suicide
	Narcissism	Grandiose; seeks attention; needs to be admired
	Exploitativeness	Takes advantage of others for personal gain; charming and ingratiating when suits own purpose; believes that others are easily manipulated or conned; considers self to be adroit at taking advantage of others
	Sadism	Sadistic; contemptuous
	Conduct problems	Violence; addictive behavior; juvenile antisocial behavior; failure to adopt social norms
	Hostile-dominance	Interpersonally hostile; dominant
	Sensation seeking	Sensation seeking; reckless
	Impulsivity	Does things on the spur of the moment; many actions unplanned or without a lot of thought about the consequence; to follow established plans; impulsivity overrules previous experiences and hence appears not to learn from experience
	Suspiciousness	Suspicious; hypervigilant
Inhibitedness	Egocentrism	Preoccupied with self; perceptions dominated by own point of view, interests, and concerns; defines and pursues own needs without regard for those of others; believes he/she knows what is best for others
	Low affiliation	Seeks out situations that do not include other people; declines opportunities to socialize; has few friends; does not initiate social contact
	Avoidant attachment	Avoids attachment relationships; fearful of attachments; does not seek out others when stressed or distressed; shows little reaction to separations or reunions
	Attachment need	Desires attachment relationships; distressed by lack of intimacy

Table 1. *Continued*

Secondary domain	Primary facet trait	Defining features
Compulsivity	Inhibited sexuality	Lacks interest in sexuality; derives little pleasure from sexual experiences; fearful of sexual expression
	Self containment	Reluctant to self-disclose; self-reliant and self-sufficient
	Inhibited emotional expression	Does not display feelings; avoids emotionally arousing situations; does not reveal angry or positive feelings; appears unemotional
	Lack of empathy	Lacks empathy; remorseless; lack of responsibility
Compulsivity	Orderliness	Orderly; precise
	Conscientiousness	Strong sense of duty and obligation; completes all tasks thoroughly and meticulously

Table 2. An example scale for applying facet descriptors to specific persons

Specify how applicable the facet is to the person:

- (1) Highly uncharacteristic: the facet describes thoughts, feelings and behaviors that are rarely if ever seen in the person
- (2) Somewhat uncharacteristic: the facet describes the thoughts, feelings and behaviors of the person on a few occasions, but less than half of the time the person was observed
- (3) Somewhat characteristic: the facet describes the thoughts, feelings and behaviors of the person more than half of the time the person was observed
- (4) Highly characteristic: the facet exemplifies the typical thoughts, feelings and behaviors of the person and is a pervasive part of the person's personality

The use of any level of this hierarchy as an example would serve to make the general point that a comprehensive set of facet level personality pathology descriptors is a tractable goal for DSM-V. Indeed, if the DSM-V PD workgroup decides to pursue the ideas we have described here, a key task will be to carefully examine facet-level constructs associated with various systems, to arrive at the most clinically optimal set of facets. Widiger and Simonsen (2005) came to a similar conclusion, and they have detailed a number of considerations that are relevant to this task (e.g. overlap among facet scales and clinical relevance). In addition, the systems reviewed by Widiger and Simonsen (2005) are diverse in their goals and origins (e.g. describing 'normal' personality traits versus being designed specifically to

describe both 'normal' and 'abnormal' personality traits), and these differences between the systems are also important to consider in arriving at a clinically optimal set of facets. For example, the prototype matching system developed by Westen et al. (2006b) provides an explicit means of linking clinically rich facet level descriptions with the need to classify specific patients via their match to diagnostic prototypes.

There are a number of advantages of a smaller number of core descriptive facets for DSM-V, over the 79 criteria of DSM-IV. One notable advantage is that these facets simplify the task of PD assessment in both research and in the clinic. Rather than having to consider 79 criteria, the clinician or researcher interested in comprehensive PD assessment only needs to consider 30 facets. In addition, a comprehensive set of facets provides a comprehensive set of targets to further empirical research on PD. Indeed, a number of key investigations could be pursued as part of a PD field trial, to help refine the facets prior to finalizing them for DSM-V. For example, the facets described in Table 1 are intended to be rated by an observer (e.g. a clinician), but were developed initially through self-report. Correspondence between raters is not perfect and the discrepancies between raters may be of clinical importance (see Oltmanns and Turkheimer (2006) for a review of relevant research in the PD domain). Field trial studies could therefore be pursued to understand how to best combine data on the facets from multiple raters. Similarly, the facets may function differently in different cultural groups, or across genders, in terms of how they reflect underlying domains of personality functioning. Sensitivity to such group differences

are a core concern in work leading up to DSM-V (Alarcon et al., 2002), and a set of preliminary facets provides comprehensive targets for studying the ways in which culture influences the expression of personality pathology.

A comprehensive set of PD facets for DSM-V also provides a means of implementing an important aspect of DSM-IV that we see as underutilized. Specifically, DSM-IV notes that maladaptive personality traits that do not constitute a formal PD can be listed on Axis II, but DSM-IV does not provide an empirically-derived set of traits to use for this purpose. Because personality and psychopathology are intimately intertwined (see e.g. Krueger and Tackett, 2006), a formal system for describing the personality of any patient, independent of the extent to which that person could be said to have a PD, is likely to be quite helpful. For example, Harkness and McNulty (2002) described a number of ways in which personality traits concepts can be useful in clinical work, beyond their utility in conceptualizing PDs, including selecting intervention approaches that match the patient's personality. Consider two cases of 'garden-variety unipolar depression' that differ on the facet of oppositionality. The more oppositional unipolar depressive patient would be less likely to comply naturally with the extra-session demands of a cognitive-behavioral approach, and the treatment plan for this patient could be adjusted to take into account issues with compliance – issues that are less likely to affect intervention with the less oppositional patient.

Another important aspect of a comprehensive set of PD facets is the ability to translate back to key PDs described in DSM-IV. The facets can be combined to form PD prototypes, akin to the way the 79 criteria of DSM-IV are combined to form the 10 DSM-IV PD categories.

Combining facets to describe PD prototypes

The PD categories of DSMs since DSM-III have been criticized on various grounds, but it is nevertheless the case that some of these categories describe clinical personality constructs in which there is substantial interest. Blashfield and Intoccia (2000) conducted a very informative systematic review of articles listed on MEDLINE, to determine if specific DSM-defined PDs were linked to a growing as opposed to a stagnant or shrinking literature. They found that most DSM-defined PDs were associated with very little literature. Only three PDs (schizotypal, borderline, and

antisocial) were associated with literatures that were 'alive and well' and only borderline was associated with a literature that was not only alive, but also growing.

This variation in the level of interest in specific DSM-IV PDs needs to be taken into account in working toward DSM-V. In particular, there are likely to be understandable objections to a DSM-V PD section that lacks criteria for PDs that have generated substantial interest and research. Fortunately, a comprehensive set of personality facets provides a way of linking the burgeoning literature on dimensional representations of PDs with literatures on specific categorical PD constructs. In particular, facets such as those portrayed in Table 1 can be combined to describe the configurations of personality features that exemplify prototypical cases of specific PDs. We will focus here on borderline PD as an example because, as noted by Blashfield and Intoccia (2000), this is the single example of a DSM-defined PD in which interest seems to be growing. Clearly, the DSM-V PD workgroup will also have to think very carefully about this issue with reference to other PDs delineated in DSM-IV and in the broader clinical literature.

Table 3 shows the authors' judgment of the DAPP facets that, when combined, define the prototypical borderline PD case (see also Pukrop (2002) for a study of the DAPP in borderline PD patients). These facets could be listed in DSM-V as diagnostic criteria for borderline PD, in the same way that the nine criteria for borderline PD are listed in DSM-IV. By adding up scores on these facets, the user of the DSM-V would generate a dimensional score representing the extent to which a given patient resembles the personality of the prototypical borderline PD patient (cf. Oldham and Skodol, 2000; Westen et al., 2006b). However, this

Table 3. Prototypical borderline personality features (see Table 1 for detailed descriptions)

Anxiousness
Emotional reactivity
Emotional intensity
Attachment need
Cognitive dysregulation
Impulsivity
Insecure attachment
Pessimistic anhedonia
Self-harming acts
Self-harming ideas

score would not be the equivalent of a borderline PD diagnosis. Rather, we see the concept of a diagnosable PD as involving the combination of personality traits and a separate but complementary evaluation of personality dysfunction.

General PD criteria for DSM-V

One of the deeper and more challenging issues in psychopathology research relates to demarcating the distinction between normality and abnormality. This problem is especially acute for PDs by the very nature of the concept. The term 'personality disorder' suggests that something everyone has (a personality) has gone awry (become disordered); the term itself highlights the importance of conceptualizing the distinction between individual differences (personality traits) and the ways in which personality mechanisms in a specific individual fail to perform their intended functions (personality disorders). One way of dealing with this problem is to simply define PD as extreme personality traits in the statistical sense. This solution is generally considered inadequate because it leaves the question of what constitutes 'extremity.' Widiger et al. (2002) discuss how extremity could be defined as the point along a personality continuum where associated impairment becomes clinically significant. What it means for something to become 'clinically significant' can be informed by data on the correlates and consequences of personality traits, such that this approach neatly combines evidence about personality variation with evidence about clinical correlates of personality traits. This is an appealing model, and it has been successful in application to other clinical phenomena (e.g. defining the level of IQ that constitutes cognitive impairment; defining the level of blood pressure that constitutes hypertension).

However, it is also useful to consider how PD may constitute something more than clinically significant extremity of personality (Livesley and Jang, 2005). In particular, the notion of disorder implies a mechanism that is not functioning in the manner intended – a mechanism that is dysfunctional and that is keeping the individual from functioning adaptively (cf. Wakefield, 1992). In particular, as discussed by Livesley and Jang (2005), the consequences of personality for adaptive functioning in adulthood need to be considered in defining PD. Personality involves not only traits – nomothetic constructs that differentiate people – but also intra-psychic systems designed to pursue valued

and need-fulfilling life-tasks (Westen et al., 2006a). Adult life-tasks include creating stable and cohesive working models of the self and others that allow a person to be able to get along (e.g. pursue close and meaningful intimate relationships), while still being able to get ahead (e.g. working to establish one's self in a chosen occupation). The inability to pursue these fundamentals tasks of adult life is central to clinical observations about the intra-psychic structure of personality in personality disordered patients, and diminished probability of success in these tasks is associated with personality pathology (Skodol et al., 2005).

This distinction between what a person's personality is in the nomothetic 'between-persons' sense (personality traits) and how it can fail to do what it is designed to do in adulthood (a 'within-person' PD) is important for DSM-V. Indeed, we would argue that the transition to DSM-V provides an important opportunity to better articulate the concepts of both 'personality' and 'disorder'. As we described earlier, a specific model of facet-level personality traits would provide a notable advance over DSM-IV in the sense that DSM-IV encourages recording of traits, but lacks provision of a set of trait concepts for clinical and research use. Along with this, however, we would suggest that DSM-V include a new set of general criteria for PD. Our specific suggested criteria are listed in Table 4.

The set listed in Table 4 is somewhat simpler than the set listed in the DSM-IV, and its adoption would involve deleting criteria A, B, C, D, and E from the DSM-IV (criterion F from DSM-IV is represented in Table 4 as criterion C). DSM-IV criterion A is eliminated because it relates to personality *per se* (referring, e.g. to persistent deviant behavior, such as deficient impulse control). We have eliminated this criterion because it refers to nomothetic personality variation, which would be encoded by facet traits such as those in Table 1, as opposed to disorder *per se*. DSM-IV criterion B requires that the personality style referred to by criterion A be pervasive, and this idea of personality consistency is covered in Table 4 by criterion D, requiring at least one facet trait that is rated highly characteristic or highly uncharacteristic. DSM-IV criterion C describes clinically significant distress or impairment, and this idea of impairment is covered in Table 4 by criterion A, which reflects impaired ability to accomplish basic life tasks, a clinically significant problem. DSM-IV criterion D requires the PD to be stable and of long duration, and to be traceable back to

Table 4. Suggested general diagnostic criteria for a PD in DSM-V

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- A. Persistent inability to accomplish one or more of the following basic tasks of adult life:
- (1) Establishment of coherent and adaptive working models of the self and others (e.g. is capable of formulating a clear and consistent sense of her/his goals and values in life; perceives other people as coherent entities)
 - (2) Establishment of intimate relationships and activities (e.g. a longer term relationship that involves mutual emotional support)
 - (3) Establishment of occupational relationships and activities (e.g. employment that provides a stable source of income)
- B. 18 years of age or older
- C. The inability to accomplish life tasks is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. head trauma)
- D. Specify features of the PD by recording facet traits rated as highly characteristic or highly uncharacteristic.
- E. Specify the degree of correspondence of the PD to personality prototypes by recording the number of prototypical features present (rated as highly characteristic or highly uncharacteristic). If more than a critical number of features (determined by a field trial) of a personality prototype are present, record the prototype as the subtype of personality disorder.
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adolescence or early adulthood. We eliminated this criterion because the stability of personality features is contained in Table 4, criterion D, via the facet rating scale.

DSM-IV criterion E requires the PD to not be a 'manifestation or consequence' of another mental disorder. We eliminated this criterion because it is unclear how to establish that one mental disorder is a 'manifestation or consequence' of another mental disorder (see Boyd et al. (1984) for a classic discussion of the practical difficulties inherent in implementing such exclusionary criteria). For example: Must one disorder (B) always occur after another (A) to be considered a consequence? This sort of mechanistic co-occurrence is not typically observed in data on mental disorders, so then does 'consequence status' require some probabilistic relationship between A and B over time? What probability of B after A is sufficient to consider B to be a 'consequence' of A, and what temporal sequence is required? Such exclusionary criteria were attempted in

DSM-III and mostly eliminated in subsequent DSMs because it is essentially impossible to operationalize such criteria meaningfully. At the very least, this criterion (E) is subject to multiple interpretations, and such ambiguity is not helpful in creating reliable criteria for psychopathology.

In addition to elimination of criteria from DSM-IV, Table 4 suggests the inclusion of new criteria for DSM-V. Criterion A operationalizes the ideas we described earlier, about how PD involves inability to accomplish basic tasks of adult life. Writing a concise description of criterion A(1) of the sort that is in Table 4 was especially challenging because the result is somewhat telegraphic relative to the richness of the concept we mean to convey. What it means to 'perceive other people in coherent ways' has been the subject of extensive clinical scholarship that is not easily reduced to a straightforward DSM-style criterion (indeed, one could argue that deficits in the ability to conceptualize others' minds and motives coherently forms the crux of an entire influential school of thought on clinical psychopathology, object relations; Greenberg and Mitchell, 1983). This problem could be dealt with in DSM-V by including accompanying text that describes in as clear and coherent a way as possible the specific and objective clinical evidence that corresponds to criterion A(1). Some may object that a criterion like A(1) backslides into the vagueness that plagued the DSM prior to DSM-III, but we feel A(1) is too central to the clinical nature of personality pathology to not struggle with its inclusion.

Criterion B requires that the individual receiving a PD diagnosis be at least 18 years of age. In DSM-IV, a diagnosis of PD is allowed in individuals under 18 years of age, but this situation is deemed 'relatively unusual,' the PD features need to be present for at least a year, and such features are described as rarely persisting into adult life. This discomfort with assigning a PD diagnosis to minor is understandable, and by our definition, the concept of PD does not apply to minors because they have not yet faced the basic tasks of adult life. Nevertheless, characterizing the personalities of children and adolescents is important in both clinical and research settings, in part because personality is systematically related to psychopathology in individuals younger than 18 (Shiner, 2005; Tackett and Krueger, 2005). Our proposal provides a means to facilitate clinical and research use of personality concepts through the facet traits and personality prototypes, which can

be used regardless of the presence versus absence of a diagnosable adult PD.

Criterion C in Table 4 is criterion F of DSM-IV, as noted earlier. This criterion is preserved because it is obviously clinically important to distinguish personality pathology from the direct effects of CNS trauma. Criterion D in Table 4 requires that the user of the DSM record the personality features of the specific PD. Criterion D also requires the PD to involve at least one personality feature that is sufficiently florid to receive a rating of highly characteristic or uncharacteristic. In addition, criterion E requires that the user of the DSM specify correspondence with any personality prototypes that might be developed for DSM-V, akin to the borderline prototype described in Table 3. By recording the number of prototypical features present, the DSM would include a dimensional representation of prototype resemblance (cf. Oldham and Skodol, 2000). Criterion E also specifies that the user assign a subtype label to the PD if a yet-to-be determined number of all of the features that comprise a prototype are present. Thresholds for subtype status could be set based on data collected as part of a field trial process. For example, the number of prototype criteria present could be used to predict key clinical outcomes (e.g. suicidality) and thresholds set accordingly (cf. Widiger et al., 2002).

According to this system, the PD diagnosis in DSM-V could be moved to Axis I, and Axis II of DSM-V could be revised to correspond to facet traits such as those in Table 1, a rating scale such as the one in Table 2, and prototypes such as the borderline prototype in Table 3 and others that may be developed by the DSM-V PD workgroup. This could be controversial, but may also have a number of fundamental benefits. First, a multiaxial diagnosis would routinely involve evaluating the patient's personality features, which would be recorded on Axis II, regardless of whether a PD is present. This corresponds well to the original intent in DSM-III of recognizing personality as an aspect of any patient by recording it on an axis separate from the axis used to record current diagnoses. Second, the diagnosis of PD would be given a status equivalent to that of other mental disorders. This could prove fundamentally helpful in facilitating third party payment for professional services to assist PD patients and in recognizing PDs as debilitating conditions with social costs similar to – if not greater than – those of other major mental disorders (Skodol et al., 2005). It also recognizes calls to conceptualize some features of PD in terms of their

link with features of Axis I disorders (e.g. a desire for change and subjective suffering in borderline PD patients; Tyrer, 1999). More broadly, moving PD to Axis I would recognize research showing that PDs are more similar to than different from Axis I disorders in many diverse respects (Krueger, 2005).

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