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COMMENTARY ON TRULL

Drizzling on the 5 ± 3 Factor Parade

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The Five-Factor Model (FFM) and related trait models (hereafter, the 5 ± 3) tap important dimensions of personality that can be seen across samples, instruments, and cultures. The four-factor structure suggested by Trull (Chapter 19 in this volume), like the similar structure suggested by Widiger and Simonsen (Chapter 1 in this volume), is a very sensible extrapolation of the existing data. My goal in this commentary is not to rain on the 5 ± 3 factor parade but rather to drizzle a little, focusing on the issues of coverage and cutoff points raised by Trull. I address three issues: 1) the importance of distinguishing between categorical/dimensional versus person-centered/variable-centered diagnosis; 2) the extent to which the 5 ± 3 are as adequate for clinical purposes; and 3) potential advantages of prototype diagnosis.

Categorical Versus Dimensional and Person-Centered Versus Variable-Centered Diagnosis

Trull, like most contributors to this volume, generally assumes that a dimensional model will be a trait model. It is important, however, to distinguish two antinomies that are easily conflated: categorical versus dimensional, and person-centered (describing kinds of people) versus variable-centered (describing kinds of traits). We are accustomed to linking categorical diagnosis to person-centered approaches, as in the categorical typology of personality disorders in DSM-IV (American Psychiatric Association 1994); and to linking dimensional classification with variable-

centered approaches, as in the tradition of trait psychology. However, one can just as easily dimensionalize a typological system by viewing personality styles or configurations as prototypes or ideal types that a patient can approximate more or less.

In revising DSM-V, should we abandon person-centered approaches, even if dimensionalized? This seems to me an empirical question that requires comparing the two kinds of diagnosis on reliability, validity, and clinical utility. Although trait approaches tend to convey as much or more information as typological approaches, some typological approaches have proven useful, such as Moffitt and colleagues' (1996) early- versus late-onset delinquency, characterized by phenotypically similar behavior but tremendous differences in etiology and prognosis (see also Hicks et al. 2004). Several research groups have now also distinguished subtypes of eating-disordered patients who are indistinguishable in their eating behavior and eating disorder diagnoses but differ in adaptive functioning, developmental history, family history, and treatment response in just the ways suggestive of a valid taxonomic distinction (see Thompson-Brenner and Westen 2005; Westen and Harnden-Fischer 2001).

The Goals of Classification and the Question of Content Validity

A second issue pertains to the goals of classification. How we classify, and whether our measures and models have content validity (an important issue raised by Trull), depends on our goals. From the point of view of trait psychology, the convergence of many aspects of the FFM with trait models developed more recently to cover the realm of personality pathology (Widiger and Simonsen, this volume) suggests that these models have indeed covered well the universe of traits they aspire to cover. The question is whether they have equally well covered the domains of import for diagnosing and treating personality in practice (clinical utility). Although the goals of clinical assessment and research assessment overlap, they are not identical (see Westen et al. 2002). (In what follows, I use examples from the Shedler and Westen Assessment Procedure–200 [SWAP-200] Q-sort [Shedler and Westen 2004; Westen and Shedler 1999], a personality disorder instrument designed for clinically experienced observers rather than for self-report, to illustrate what may not be adequately covered for clinical purposes by the 5 ± 3.)

What is figure to clinicians often is ground to trait researchers. In wrestling with how to define dysfunction, Trull (this volume) suggests that "extreme levels [of traits] must also be accompanied by dysfunction of one or more *psychological processes* (e.g., cognitive, motivational, behavioral, emotional, or some other psychological mechanism)," defined independently of personality (traits). Yet such functions, processes, and mechanisms are precisely what clinicians consider most clinically relevant about personality, because these processes concern what is work-

ing, what is not working, and what needs to be a target of intervention. Consider the following item from the SWAP-200: "Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship." This item reflects theory (attachment theory, or, more broadly, evolutionary theory), empirical observation of children (as long ago as World War II) whose disrupted attachments appeared to produce serious personality pathology, and clinical observation of a characteristic seen in many personality disorder patients. Yet it has no obvious counterpart in the 5 ± 3.

Clinicians attend to internal states and their transformations, both of which are absent from the FFM and many (but not all) related models. Consider the following: "Tends to 'catastrophize'; is prone to see problems as disastrous, unsolvable, etc." This is a construct central to both cognitive and psychodynamic theories of personality but missing from trait models, which tend to be silent on how people process information. Clinicians also attend to what Mischel and Shoda (1995) call "if/then contingencies"—that is, behaviors or mental processes that are contingent on some eliciting event, which are difficult to capture in adjectival terms. For example, "When distressed, perception of reality can become grossly impaired (e.g., thinking may seem delusional)." Although Axis II is substantially stronger in this respect than the FFM, I suspect one of the major reasons that borderline and paranoid personality disorders show such high comorbidity is the failure to distinguish the chronic suspiciousness of the paranoid patient (well indexed by the 5 ± 3 facet of *mistrust*) from the contingent malevolent expectations of the borderline patient (which have no counterpart in any trait model). In addition, clinicians attend to distinctions between implicit (unconscious) and explicit (conscious) processes, a distinction central to contemporary research in cognitive neuroscience and social psychology but absent from trait psychological approaches (see Westen 1998b). For example, a large body of research now suggests that motives can be implicit or explicit, and that implicit and explicit motives have different antecedents in childhood and different consequences in adulthood (McClelland et al. 1989). Or consider grandiosity in narcissistic patients that is elicited by threats to self-esteem. It can be indispensable clinically to distinguish between the implicit feeling of being small, inferior, or "dissed" and its explicit transformation of grandiosity.

More generally, clinicians attend to *functional domains* (see Westen 1998a), only some of which are well represented in the 5 ± 3, and only some of which are likely to be addressed by models based in self-reports (see Westen et al. 2006). Consider, for example, the following domains of functioning:

- Integrity of thought processes: "Thought processes or speech tend to be circumstantial, vague, rambling, digressive, etc."; "Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance."

- Cognitive style: "Tends to perceive things in global and impressionistic ways (e.g., misses details, glosses over inconsistencies, mispronounces names)."
- Affect regulation (implicit and explicit): "Tends to think in abstract and intellectualized terms, even in matters of personal import"; "Attempts to avoid feeling helpless or depressed by becoming angry instead."
- Complexity of representations of people: "Appears unable to describe important others in a way that conveys a sense of who they are as people; descriptions of others come across as two-dimensional and lacking in richness."
- Capacity for self-reflection: "Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings."
- Beliefs and feelings toward the self: "Has a deep sense of inner badness; sees self as damaged, evil, or rotten to the core (whether consciously or unconsciously)."
- Sexuality: "Has difficulty directing both tender feelings and sexual feelings toward the same person (e.g., sees others as nurturing and virtuous or sexy and exciting, but not both)."

It is difficult to see how a model built largely from adjectives used by lay people could approach the complexity of clinical language that has evolved over a century of treating patients with personality pathology. Indeed, this statement is a straightforward extrapolation from the lexical hypothesis that underlies the FFM (Shedler and Westen 2004).

Prototype Diagnosis

In addressing cutoffs, Trull suggests developing a measure of disability independent of personality. The notion of a personality health-sickness scale that does not confound symptoms, states, and traits (as does the GAF) is certainly sensible. The fact that one could devise such a measure that is independent of personality, however, suggests precisely what is limited about trait models from a clinical standpoint: They leave out many of the personality processes that can interfere with the capacity to love, work, and find satisfaction in life.

A prototype-matching approach applied to person-centered (typological) diagnosis does not face the same difficulty because the more a person matches a pathological prototype, the more pathological they are on that dimension (psychopathy, narcissism, etc.). One of the advantages of the simple 5-poinr prototype matching procedure we have proposed (see Westen and Bradley 2005; Westen and Shedler 2000; Westen et al. 2006) is that clinicians rate the extent to which the patient matches each prototype (dimensional diagnosis) but for purposes of communication can consider a rating of 4 or 5 to indicate "caseness" (categorical diagnosis) and 3 to indicate "features." Although Trull appropriately wonders if clinicians can rate such prototypes reliably (or whether prototype diagnosis would be

a "throwback" to DSM-II [American Psychiatric Association 1968]), data just collected find interrater reliability averaging .70 from clinicians' ratings of paragraph-long personality disorder prototypes based on the first 4–5 psychotherapy hours. With respect to clinical utility, Spitzer and colleagues (personal communication, December 2004) recently conducted a "nonpartisan" study of different proposals for Axis II for DSM-V. They found that experienced psychiatrists and psychologists consistently rated prototype approaches to diagnosis more clinically useful than trait models, including the FFM.

Conclusion

There are four ways we might integrate a 5 ± 3 trait model into a clinically useful revision of the DSM. The first would be to use an instrument such as the SWAP-200 to identify personality process correlates of traits. The second would be to identify the traits that in combination constitute personality constellations such as those represented on Axis II. The third would be to factor-analyze SWAP-200 (or its latest iteration, SWAP-II) and major 5 ± 3 item sets jointly to see whether new dimensions are necessary or useful. A final possibility would be to supplement a dimensionalized typology with a set of functional domains for clinicians to rate (e.g., affect regulation, impulse regulation) and to use well-validated trait dimensions where they adequately cover a given domain. Whether one of these approaches might be more useful will depend on its clinical utility as well as its structural elegance.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd Edition. Washington, DC, American Psychiatric Association, 1968

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

Hicks BM, Markon KE, Patrick CJ, et al: Identifying psychopathy subtypes on the basis of personality structure. Psychol Assess 16:276–288, 2004

McClelland DC, Koestner R, Weinberger J: How do self-attributed and implicit motives differ? Psychol Rev 96:690–702, 1989

Mischel W, Shoda Y: A cognitive-affective system theory of personality: reconceptualizing situations, dispositions, dynamics, and invariance in personality structure. Psychol Rev 102:246–268, 1995

Moffitt T, Caspi A, Dickson N, et al: Childhood-onset versus adolescent-onset antisocial conduct problems in males: natural history from ages 3 to 18 years. Dev Psychopathol 8:399–424, 1996

Shedler J, Westen D: Dimensions of personality pathology: an alternative to the Five Factor Model. Am J Psychiatry 161:1743–1754, 2004

Thompson-Brenner H, Westen D: A naturalistic study of psychotherapy for bulimia nervosa, part 1: comorbidity and therapeutic outcome. J Nerv Ment Dis 193:573–584, 2005

Westen D: Case formulation and personality diagnosis: two processes or one? in Making Diagnoses Meaningful. Edited by Barron J. Washington, DC, American Psychological Association, 1998a, pp 111–138

Westen D: The scientific legacy of Sigmund Freud: toward a psychodynamically informed psychological science. Psychol Bull 124:333–371, 1998b

Westen D, Bradley RG: Prototype diagnosis of personality, in Handbook of Personology and Psychopathology. Edited by Strack S. New York, Wiley, 2005, pp 238–256

Westen D, Harnden-Fischer J: Personality profiles in eating disorders: rethinking the distinction between Axis I and Axis II. Am J Psychiatry 165:547–562, 2001

Westen D, Shedler J: Revising and assessing Axis II, part 1: developing a clinically and empirically valid assessment method. Am J Psychiatry 156:258–272, 1999

Westen D, Shedler J: A prototype matching approach to diagnosing personality disorders toward DSM-V. J Personal Disord 14:109–126, 2000

Westen D, Heim AK, Morrison K, et al: Simplifying diagnosis using a prototype-matching approach: implications for the next edition of the DSM, in Rethinking the DSM: A Psychological Perspective. Edited by Beutler LE, Malik ML. Washington, DC, American Psychological Association, 2002, pp 221–250

Westen D, Gabbard GO, Blagov P: Back to the future: personality structure as a context for psychopathology, in Personality and Psychopathology. Edited by Krueger RF, Tackett JL. New York, Guilford, 2006, pp 335–384