The past decade has seen what may well turn out to be a watershed in the understanding of psychopathology. DSM-III (American Psychiatric Association, 1980) standardized and operationalized diagnosis in a way that allowed researchers for the first time to generate replicable data for a wide range of disorders. Almost immediately, what became apparent was that psychopathology was not the offspring of an obsessive-compulsive god who created depression on one day, anxiety on the next, and rested on the seventh day once he was certain that his disorders were cleanly separated. Instead, comorbidity among Axis I disorders, among Axis II disorders, and between the axes was the norm rather than the exception. The result was a veritable cottage industry on comorbidity, with thousands of articles exploring the associations between one disorder and its cousins, including cousins with little obvious family resemblance. And despite the best efforts of multiple DSM work groups and task forces to maximize the distinctness of diagnoses, comorbidity continues to be the wicked stepchild of psychiatric taxonomy.

Over the past decade, what has become clear is that we cannot readily rid our nosology of comorbidity because virtually all nonpsychotic syn-
dromes share common factors with other syndromes, and these factors comprise what we traditionally understand as aspects of personality—that is, enduring ways of thinking, feeling, regulating emotion, regulating impulses, and behaving that manifest across time or situation. The work of Watson and Clark (1984, 1992), Brown, Chorpita, and Barlow (1998), and Krueger (1999) has documented that negative affectivity or internalizing spectrum personality pathology is a common factor shared by virtually all the Axis I mood and anxiety disorders and accounts for much of their co-occurrence. Krueger and colleagues (2002) similarly suggest that a broad-band externalizing factor underlies many other DSM-IV disorders, notably substance use and antisocial personality disorders. The implication is clear: if we want to understand symptoms, we have to know something about the person who hosts them.

This insight is both exciting and eerily familiar. In the late 19th and early 20th centuries, Sigmund Freud formulated a theory of psychopathology intended to explain (and help ameliorate) a range of anxiety, mood, and other “neurotic” symptoms, most of which are now coded on Axis I of DSM-IV. He began with a model of discrete syndromes but ultimately came to believe that he could not understand his patients’ symptoms in isolation from what came to be called their character or personality structure. In many respects, the last century of psychoanalytic theory has been about the nature, structure, and dysfunction of character and how patients’ character structure provides the foundation for their symptoms—including the way two very different forms of personality organization can predispose patients toward a common symptom (final common pathway). Correspondingly, the length of psychoanalytic treatments has expanded dramatically from the 3- to 6-month treatments characteristic of Freud’s early encounters with his patients to long-term therapies aimed at characterological change.

Our goal in this chapter is to explore the relevance of the clinical understanding of personality that first emerged from psychoanalytic theory and observation for current questions about the relation between personality and psychopathology. We suggest that there is an important message in the fact that, a century ago, clinically trained observers, immersed in the lives of their patients, blazed trails where we now have the technology to bulldoze but until relatively recently did not recognize the importance of exploring. The issues with which clinical theorists have struggled over the past 100 years, we believe, are of tremendous relevance to our efforts to forge ahead in the next century of theory and research on psychopathology, and data from the clinic provide an important source of hypotheses, causal conjecture, and observation that is complementary to the sources of data on which empirical psychopathologists generally rely (see Westen & Weinberger, 2004, 2005).
Personality Structure as a Context for Psychopathology

We begin by briefly exploring the historical path from symptom neurosis to character neurosis in psychoanalytic theory (that is, from a view of symptoms as relatively independent of personality to a view of symptoms as emanations or expressions of personality). We then examine clinically informed conceptions of personality structure and relevant empirical data that challenge us to know history as well as, perhaps, to repeat it. We conclude with the question of whether and in what ways clinically derived and empirically derived views of personality structure can be integrated and how each might guide the clinical understanding of psychopathology and treatment.

Before beginning, we briefly address two meanings of personality structure. The concept of "structure" in psychoanalytic theory refers to repetitively activated, functionally defined processes, such as psychological processes involved in motivation, regulation of mood, and regulation of impulses. When Freud wrote about the "superego," he was referring to a set of functions often activated concurrently that allow a comparison of one's own actions, thoughts, or feelings with ideal standards and internalized values. Freud actually never used the mechanistic Latin terms for the structures that came to be labeled id, ego, and superego (Bettelheim, 1983). The original German for what became an (often reified) construct of super ego simply meant "above me," meaning a part of one's mind that stands apart and judges one's actions, as if from above. The "id" referred to wishes, feelings, impulses or symptoms that seemed like "not me" even though they were mine—that is, they felt like "an it" (id) instead of "me" (ego).

Psychoanalytic theorists today are much less likely to talk about the id, ego, and superego. However, when they talk about structure, what they have in mind is the dynamic interplay of repetitively activated processes that normally serve adaptive functions but can become dysfunctional, either on their own or in interaction. For example, conscience is an essential personality function that allows humans to interact relatively peaceably with conspecifics, but it can lead to psychopathology if it is overly severe on the one hand or hypoactive on the other. Thus, Freud (1933) described patients with a harsh, punitive superego, who mercilessly attack themselves and are vulnerable to mood disorders. Subsequent research on "introjective," "self-critical," or "autonomous" depression suggests that, indeed, harsh moral or other standards can predispose vulnerable individuals to depression (Blatt, 2004; Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982; Whisman, 1993). Nor would Freud the neurologist have been surprised to find that damage to the frontal lobes can cause irreversible moral pathology (Anderson, Bechara, Damasio, Tranel, & Damasio, 1999; Ishikawa & Raine, 2003).

Psychopathology can also reflect the interaction of enduring personality structures or functions, as when a patient develops a symptom that con-
stitutes a compromise among competing affective–motivational “pulls” (for empirical data, see Westen, Blagov, Feit, Arkowitz, & Thagard, 2005). For example, a patient whose father brutalized her as a child developed both the wish that he would die and a harsh, self-hating way of judging herself. The symptom with which she presented—an obsessional “thought” that her father would die, which she could not seem to “erase” from her mind—appeared to represent a compromise between her wish that something terrible would befall him in retribution for what he had done to her and her desire to avoid the guilt of attributing the wish to herself (hence, its repetitive appearance in her consciousness without attribution to its author, herself).

This concept of personality structure is very different from the corresponding psychometric concept of structure. From the point of view of trait theory, personality structure generally connotes a factor structure deemed to fit the data well, that is, a way of identifying patterns of covariation among items that provides insight into latent variables common to several of them. Part of the difference lies in the fact that this latter concept of structure is nomothetic rather than idiographic, describing patterns of covariation that emerge across individuals rather than covariation or coactivation of processes within individuals. However, as we shall see, nomothetic models of personality structure used to guide case formulation (idiographic analysis) in clinical practice also differ substantially from the psychometric concept of personality structure in their emphasis on functional domains. To what extent psychometric (factor) structure can be uncovered from data on personality structure functionally defined is unclear.

RETRACING STEPS: THE EVOLUTION FROM SYMPTOM TO CHARACTER IN PSYCHOANALYTIC THEORY

Contemporary thinking about the distinction between Axis I and Axis II in many respects mirrors a transformation that occurred in psychoanalysis in its early years of development. Tracing the evolution from symptomatic neurosis to character neurosis, and more broadly from a view that views symptoms as relatively discrete to one that places symptoms in characterological context, may be useful in laying a historical foundation for issues confronted by contemporary taxonomists.

From Symptom Neurosis to Character Neurosis

In the late 1890s, in his early work with Breuer, Freud (Freud & Breuer, 1895/1957) used hysterical symptoms as a prototype for the symptomatic neuroses upon which he founded psychoanalysis. According to his early
Personality Structure as a Context for Psychopathology

theoretical views, a symptom arises in the form of a compromise between the expression of a wish and defenses against it (because acknowledging the wish would lead to anxiety, guilt, or other unpleasant emotions). Hence, a young man might develop paralysis of the arm that simultaneously expresses a wish to strike his father and a defense against that wish. The defense is expressed by being unable to use his arm, and the aggression is indirectly expressed by his inability to do any work in the yard or around the house that his father demands of him. His father then ends up feeling infuriated by this passive expression of aggression in his son. According to this model, a symptom is a compromise formation—that is, a compromise among competing motivational “pulls” or dynamics.

This understanding of symptom formation informed Freud's early forays into treatment. Heavily influenced by Charcot and Janet, Freud relied on hypnosis and suggestion to do a great deal of the work. By placing his hand on the forehead of the patient and insisting that she fully remember the repressed memory, he thought he could de-repress an instinctually or emotionally charged memory and cure the patient of the symptom.

Freud soon found that his method led to short-lived results. He could not simply plow through these defenses using hypnosis and suggestion. Treatment was complicated. Freud's increasing understanding of the complexity and depth of what he later called “ego” functions—notably, the ways people chronically protect themselves from emotionally threatening information—led him to rethink the role of symptoms in psychopathology. Rather than viewing symptoms as isolated psychic “boils” that needed to be lanced to clean out a psychological infection, he gradually came to realize that his patients' symptoms emerged in the context not only of their enduring motives and conflicts but of a psychological “immune system” that was constantly surveying the landscape and sending out its killer cells when it detected threatening psychological material. (Interestingly, social psychologists have recently recast what Freud called defenses in terms of a psychological “immune system”; see Gilbert, 1998). Wilhelm Reich (1931) subsequently elaborated a view of entrenched, characterological defenses of this sort, arguing that people develop “character armor,” habitual ways of defending that become automatic and inflexible over time. Paradoxically, while protecting them from confronting unpleasant aspects of themselves, this armor ultimately limits their psychological freedom of action.

For example, a patient with obsessive-compulsive personality dynamics, who was chronically quietly angry but would not allow himself to express or acknowledge it, came to his analyst's office 5 minutes early for every session. He dutifully entered the office and nodded obsequiously to his analyst each day. He paid his bill on the first day after receiving it, and he dutifully arranged his vacations to coincide with those of his analyst. He tried to be the perfect patient in every way, including an avoidance of any
expression of disagreement or anger toward his analyst. On the few occasions when his analyst was late, the patient immediately forgave him and denied any feelings whatsoever about the inconvenience. During the sessions, he kept an eye on his watch and always ended right on time. He bid adieu to his analyst in the same way each day: “Thank you, and I’ll see you tomorrow.”

The conflicts and “character armor” the analyst observed in the consulting room appeared to restrict any spontaneity in the patient’s life and led to a range of work inhibitions in which he feared being too aggressive or too ambitious. He worried that his boss would think of him as someone who wanted to replace him. He worried that his analyst might think of him as someone who could have angry or aggressive feelings toward him or who might doubt his “interpretations” (which of course any sensible patient would). In understanding this patient, one would be hard-pressed to identify specific symptoms of a neurosis. His character was his neurosis. He lived an orderly existence, designed to avoid aggression and conflict, but he had little pleasure in his life. He also denied himself the success of which he was capable.

Freud never abandoned the concept of compromise formation, which is probably one of the most useful of all psychoanalytic constructs (Brenner, 1982, 1994; Gabbard, 1998; for research, see Westen, 1998b; Westen, Blagov et al., 2005; Westen & Gabbard, 2002). However, his recognition of the pervasive role of maladaptive as well as adaptive defenses gradually led him to move from a symptom-focused theory of psychopathology to a view that recognizes the importance of character in the development of psychological symptoms. This shift can be seen, for example, in his early work on the “anal character” (Freud, 1908). Freud noted that certain people could be characterized by a triad of personality traits: obstinacy, parsimony, and orderliness. Factor-analytic work supports the covariation of these personality traits (as well as several relatively specific hypotheses about “anal” dynamics that have proven surprisingly robust empirically; Fisher & Greenberg, 1996), which are today often described as obsessive-compulsive personality traits or extreme conscientiousness.

Freud believed that such traits were precipitates of the anal phase of development, when children are learning about self-control, authority (and resistance to it), and, more concretely, potty training. Setting aside his etiological theories, which in this case likely underemphasize genetic contributions to personality, Freud made some trenchant observations about the covariation of certain personality traits and dynamics and of the types of symptoms that seemed to beset individuals with what we now call, in less scatological language, an obsessive-compulsive personality style (see, e.g., Shapiro, 1963; Westen, 1999a, 1999b). Freud observed that patients who fit his description of the “anal” character, like the obsessional patient de-
scribed above, tend to be "tight" (i.e., overly constrained), self-righteous (insistent on certain forms of authority and moral perfection), self-critical, critical of others, and uncomfortable with affect. Beneath their demands for order, control, and "appropriate" behavior from others was often a simmering anger. Perhaps not surprisingly, when they became symptomatic, they often developed obsessional symptoms, compulsions, and somatic complaints reflecting a relatively high "ambient" level of stress that often accompanies an unwillingness to acknowledge emotions such as anger (Shedler, Mayman, & Manis, 1993). Further, unlike the "oral" character, who was likely to become depressed when her dependency needs were not met, the anal character was most likely to become depressed because of failure to meet rigid internal standards. In different language, Blatt (e.g., Blatt & Zuroff, 1992) and Beck (Bieling, Beck, & Brown, 2004) have offered similar descriptions of characterological diatheses for depression.

**Ego Psychology**

A major step forward in understanding the relation between character and psychopathology emerged in the years before Freud's death, in the body of literature known as psychoanalytic ego psychology (Blanck & Blanck, 1974, 1979). Anna Freud (1936) delineated various mechanisms of defense and suggested that they may be hierarchically organized, from relatively immature and problematic to more mature and adaptive. Vaillant (Vaillant, 1977, 1992; Vaillant & McCullough, 1998) elaborated the concept of hierarchically organized defenses and developed a body of longitudinal empirical work examining the relation between defenses in young adulthood and later outcomes. At the bottom level of the hierarchy are psychologically primitive defenses, such as projection, in which the person cannot acknowledge his own wishes or attributes and instead sees them in others and attacks them there. Supporting this theory as applied to homophobia, Adams and colleagues (Adams, Wright, & Lohr, 1996) (who were, interestingly, not themselves psychoanalytically inclined) found that when homophobic men viewed gay porn, they showed stronger arousal as assessed by genital plethysmography than nonhomophobes. Baumeister (Baumeister, Dale, & Sommer, 1998; Newman, Duff, Schnopf-Wyatt, Brock, & Hoffman, 1997) has similarly examined some of the cognitive mechanisms involved in projection, and Westen and Shedler (1999a; Shedler & Westen, 2004b) have documented empirically its centrality to paranoid personality disorder. At the top of Vaillant's hierarchy are psychological processes that can transform conflict and distress into more socially appropriate and adaptive forms, such as humor and sublimation.

Vaillant has linked characterological ways of defending against unwanted thoughts or feelings to different forms of psychopathology and life
outcomes in several longitudinal studies (e.g., Vaillant, 1977). For example, in a longitudinal study of 306 inner-city men, Vaillant and McCullough (1998) identified five groups of men based on observer ratings of defenses from transcripts of 2-hour semistructured interviews. The group of men who used the fewest mature and the greatest number of immature defenses (such as acting out, passive aggression, hypochondriasis, and dissociation) evidenced the greatest severity on measures of global mental health as well as life problems such as antisocial behavior, unemployment, and alcohol use problems at the time of assessment. In addition, they were more likely to show downward social mobility and had the worst psychosocial functioning approximately 15 years later (at about age 50). The men in the groups defined as having the least mature defenses also had the most marital instability over time. In contrast, men who used mature defenses (e.g., altruism, suppression, and sublimation) scored the highest on most domains of functioning, lending support to the evidence for a hierarchy of characterological defense styles.

More generally, ego psychologists argued that the way people chronically defend is of substantial consequence to the way they are likely to fall ill psychologically. Someone who deals with adversity by blaming him- or herself is likely to be vulnerable to depression; someone who rigidly defends against painful memories of abuse is likely to develop posttraumatic stress symptoms, often alternating between unbidden images that come “out of the blue” and numbness, dissociation, or lack of memory; someone who regulates anxiety by binge eating may leave him- or herself vulnerable to developing bulimia nervosa. Recent cognitive-behavioral theories of generalized anxiety disorder propose a similar mechanism, whereby rumination begins as a way of regulating anxiety but backfires by exacerbating it (Borkovec, Shadick, & Hopkins, 1991; Borkovec & Sharpless, 2004). Common to these views is the notion that people develop ways of regulating their emotions that become habitual and unconscious, rendering them less able to confront situations or information in the long run, so that “the solution becomes the problem.”

Along with its focus on defense, or what today we might call implicit forms of emotion regulation (Westen, 1985, 1994; Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997), ego psychology focused on other psychological functions that foster adaptation. Guided by evolutionary theory and the cognitive-developmental theories of the time (particularly Werner and Piaget), Heinz Hartmann (1939/1958) and his colleagues (see Hartmann, Kris, & Loewenstein, 1946) attempted to delineate a range of processes involved in cognition and self-regulation, with an eye to understanding what happens when these functions go awry. For example, Redl and Wineman (1951) observed a large group of delinquent adolescents and delineated a range of deficits that appeared to inhibit their ability to regulate their im-
Personality Structure as a Context for Psychotherapy

243

pulses. Bellak, Chassan, Gediman, and Hurvich (1973) developed a taxonomy of ego functions that they operationalized for systematic empirical investigation, and Loewinger (Loewinger, 1979; Loewinger & Wessler, 1970) developed a model and measure of ego development that generated thousands of empirical studies (see Cohn & Westenberg, 2004; Westenberg, Jonckheer, Treffers, & Drewes, 1998). From an ego-psychological standpoint, we cannot understand a symptom such as depression without understanding its characterological "scaffolding." A person who has a strong need for connection to others but minimal capacity for regulating affects or impulses is going to have tumultuous, short-lived relationships, and is hence going to be vulnerable to depression.

Object Relations Theory

Although psychoanalysis is often seen as quintessentially impractical (e.g., four or five times a week on the couch), theoretical developments in psychoanalysis have often been nothing if not pragmatic. Ego psychology was an attempt to understand repetitive, counterproductive ways of thinking and behaving and deficits in functioning in character-disordered patients that could not be readily understood in terms of specific conflicts. The same was true of object relations theories, which emerged to explain the behavior of patients with severe personality disorders, whose difficulties seemed more entrenched, wide-ranging, and systemic than the encapsulated psychological "infections" of early Freudian theory.

Object relations refers to interpersonal behavior in intimate relationships and to the cognitive, affective, and motivational processes that mediate that behavior (particularly representations of self, others, and relationships) (Westen, 1991b). What psychoanalysts call "internalized object relations," or internalized patterns of thinking, feeling, and behaving in relationships, are hypothesized by most contemporary psychoanalytic theorists to be implicated in many if not most forms of psychopathology (Aron, 1996; Aron & Harris, 2003; Gabbard, 2005; Mitchell & Aron, 1999). Considerable research supports a broad role for such dynamics in psychopathology; indeed, object relations theory (and its offshoot, attachment theory; see, e.g., Shaver & Mikulincer, 2005) has been the most generative area of psychoanalytically oriented research in the past two decades (Huprich & Greenberg, 2003; Stricker & Healey, 1990). For example, patients with specific Axis II disorders can be distinguished in terms of the complexity with which they view themselves and others, the extent to which they attribute benevolence or malevolence to others' actions, their capacity to invest emotionally in another person (i.e., their ability to show genuine caring and concern vs. viewing others as objects to gratify their needs or desires), and their ability to understand why people behave as they

From an object relations standpoint, a symptom or syndrome such as depression can be the product of many different kinds of object relational dynamics, and appropriate treatment requires attention to these dynamics (Benjamin, 1996a, 1996b; Blatt, 2004; Masterson, 1976; McWilliams, 1998; Scharff, 2004). A patient could be depressed because he or she has internalized attitudes of hostile, abusive, critical, or neglectful parents. As a result, he or she may be vulnerable to fears of abandonment, self-hatred, feelings of emptiness, or chronic self-criticism. These are very different vulnerabilities, reflecting very different development histories in the context of genetic endowments.

Problematic internalizations of the attitudes or behaviors of significant others can lead to depression in a different, and often complementary, way as the patient unknowingly creates situations that would make anyone depressed, even if he or she had no specific liability toward depression. For example, one patient with a highly critical father continually chose work environments that were “safe,” in which he could not fail. As a result, he constantly felt bored, unchallenged, demeaned by his station in life, and as if he were sleepwalking through his job 8 hours a day. Another patient, who had been the victim of severe physical abuse in childhood, was constantly vigilant for signs of mistreatment by authority figures and, not surprisingly, frequently lost jobs during altercations with superiors. As a result, she often found herself both financially and socially destitute. She brought malevolent expectations into her romantic relationships as well, which similarly led her to experience a constant series of losses, as one relationship after another would crash and burn. Yet another patient, a professor, could never produce enough to make himself feel worthy, despite an objectively impressive career. Although these patients have similar Axis I diagnoses (dysthymic disorder, with periodic major depressive episodes), from a psychoanalytic point of view, it is difficult to see how one could understand who they are, why they chronically feel dysphoric, why they periodically become deeply depressed, and how to help them without thoroughly understanding these object-relational processes.

From an object relations standpoint, patients with severe personality pathology tend to have difficulty forming mature, constant, multifaceted representations of the self and others. This may leave them vulnerable to emotional swings when significant others are momentarily disappointing, particularly given their difficulty understanding or imagining what might be in the minds of the people with whom they interact (Fonagy, Steele, & Steele, 1991; Fonagy & Target, 1997; Fonagy, Target, Gergey, Allen, &
Personality Structure as a Context for Psychopathology

Bateman, 2003). Research has linked these “mentalization” deficits (difficulties forming complex representations of others’ mental states, involving relatively accurate perspective taking) with early maltreatment (Cicchetti, Rogosch, Maughan, Toth, & Bruce, 2003; Cicchetti & Toth, 2003; Toth, Cicchetti, & Kim, 2002; Toth, Cicchetti, Machic, Maughan, & Vanmeenen, 2000), although they appear to have multiple causes. Similarly, attachment research has linked difficulties forming coherent expectations about others’ behavior, and particularly about contingencies between one’s own behavior and that of attachment figures, with attachment relationships with primary caregivers who have unresolved loss and trauma from their own past (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004; Goldberg et al., 2003; Koos & Gergely, 2001; Lyons-Ruth & Jacobvitz, 1999; Lyons-Ruth, Melnick, Bronfman, Sherry, & Llanas, 2004; Main, Kaplan, & Cassidy, 1985; Ward, Lee, & Lipper, 2000). Clinical theorists have repeatedly observed the difficulty severely personality disordered patients often have in forming realistic, balanced views of the self that can help them weather momentary failures, criticisms, or ruptures in relationships. A substantial body of research supports many of these propositions, particularly vis-à-vis borderline personality disorder, the most extensively studied personality disorder (Baker, Silk, Westen, Nigg, & Lohr, 1992; Gunderson, 2001; Westen, 1990a, 1991a).

Two recent clinical trials of psychodynamically based treatments for borderline personality disorder have in fact focused on precisely these kinds of deficits in mental representations and are achieving promising initial results in randomized controlled clinical trials. Fonagy and Bateman (Bateman & Fonagy, 2003, 2004; Fonagy, 2002) have developed a mentalization therapy aimed at helping patients with borderline personality disorder imagine others’ minds. Kernberg and colleagues (Yeomans, Clarkin, & Kernberg, 2002) have developed a therapy aimed at helping patients form complex, multifaceted representations of self and others that integrate positive and negative feelings. What will be of particular interest over the long run is the extent to which these treatments can alter the risk of future episodes of Axis I symptoms such as depression, anxiety, and bulimic binge purging, all of which are common in patients with borderline personality disorder, and whether they are able to maintain their effects over time.

To summarize, psychoanalysis began with a focus on discrete symptoms but evolved over time into an approach to psychopathology and treatment that places symptoms in their characterological context. This does not mean that all symptoms are emanations of character, that personality is not shaped substantially by biology, that no one ever becomes phobic after a dog bite, or that addressing personality will erase symptoms that have developed functional autonomy over time or burned neural tracks through re-
peated activation (Westen, 2000). What it does suggest, however, is a very different conception of symptoms and treatment than has become the norm during the past decade with the empirically supported therapies (EST) movement, which assumes discrete syndromes, each of which requires its own treatment manual (Westen, Novotny, & Thompson-Brenner, 2004). Psychoanalytic theorists have long argued that one cannot separate the symptom from the person in treatment—and the amassing data on the relation between psychopathology and personality described in this volume support that view.

**CLINICAL CONCEPTUALIZATIONS OF PERSONALITY STRUCTURE**

We move now from history to contemporary clinical understanding of personality structure informed by empirical research. Although cognitive-behavioral theorists have recently begun to offer accounts of personality functioning in patients with personality disorder (Beck, Freeman, & Davis, 2004; Linehan, 1993; Young, 1990), we focus here primarily on psychodynamic models of personality structure, which provide a clinically grounded complement and counterpoint to models of personality structure that have evolved outside of the clinic (Kernberg, 1984; McWilliams, 1994; McWilliams, 1999; Westen, 1998a; Westen & Gabbard, 1999).

As Max Weber noted years ago (Weber, 1949), the way we classify depends not only on the nature of the phenomenon we are classifying but also on our purposes in classifying it. One of the major differences between models of personality structure that emerged from clinical practice and trait models that emerged from research on normal personality is that the former reflect the demands of clinical practice, particularly the need to make systematic case formulations that can guide practice. Dynamic clinical models of personality structure address three distinct but related aspects of personality organization: functional domains, levels of disturbance, and personality configurations.

**Functional Domains**

From a clinical perspective, a useful assessment of personality is a functional assessment, that is, an assessment of how the individual tends to function cognitively, affectively, and behaviorally under conditions relevant to psychological and social adaptation. A functional assessment presupposes a model of domains of function and dysfunction. It also focuses, by necessity, on areas of health as well as maladaptation because helping a patient requires knowledge of his or her adaptive capacities as well as limita-
Personality Structure as a Context for Psychopathology

A comprehensive functional assessment will thus address personality characteristics in the normal range as well as those that are more or less problematic.

For years Freud’s structural model provided the primary model of personality for clinical case formulation. In contemporary practice, however, no single model predominates, although theorists such as Kernberg (1983) and McWilliams (1999) have offered compelling accounts. Gabbard (2005) proposes a contemporary psychoanalytic perspective on character that includes a set of internalized object relations, a specific constellation of defense mechanisms (often associated with a characteristic cognitive style), a biologically based temperament, and an enduring sense of self (Gabbard, 2005).

For heuristic purposes, we focus here on a model of functional domains designed to integrate dynamic concepts of personality structure with empirical research in personality, developmental, clinical, cognitive, and social psychology (Heim & Westen, 2005; Westen, 1995, 1996, 1998a). The model suggests that three sets of variables, defined by three questions, provide a relatively comprehensive roadmap of personality:

1. What does the person wish for, fear, and value, and to what extent are these motives conscious and mutually compatible?
2. What are the individual’s psychological resources for adapting to internal and external demands?
3. What is the person’s capacity for engaging in intimate relationships, and how does the individual experience the self, others, and relationships?

Each of these questions comprises multiple specific variables, elaborated below, that together describe the way the person tends to respond cognitively, affectively, motivationally, and behaviorally over time or circumstance (Table 11.1).

This view of personality is dynamic, in two senses. First, it views personality as the interaction of psychological processes activated under specific conditions, not as the possession of particular traits to particular degrees. Indeed, as described below, the same trait could reflect different interactions of processes. Second, although delineation of these variables drew extensively from research across several subfields of psychology, the questions address, respectively, the concerns of classical psychoanalytic theory (motivation and conflict); ego psychology (adaptation); and object relations theory, self psychology, and more recent relational approaches (experience of self, others, and relationships). This model was designed both to reflect and to systematize the kind of judgments most skilled clinicians intuitively make in a way that is both clinically and empirically sound.
TABLE 11.1. Outline of a Clinical Model of Personality Structure

<table>
<thead>
<tr>
<th>I.</th>
<th>What does the person wish for, fear, and value, and to what extent are these motives conscious or conflicting?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Fears</td>
</tr>
<tr>
<td>b.</td>
<td>Wishes</td>
</tr>
<tr>
<td>c.</td>
<td>Values</td>
</tr>
<tr>
<td>d.</td>
<td>Conflicts among fears, wishes, and values</td>
</tr>
<tr>
<td>e.</td>
<td>Conscious awareness of motives</td>
</tr>
<tr>
<td>f.</td>
<td>Notable compromise formations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II.</th>
<th>What psychological resources (affective, cognitive, and self-regulatory) does the person have to deal with reality and attain his/her goals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Cognitive functions</td>
</tr>
<tr>
<td>i.</td>
<td>Intellectual functioning</td>
</tr>
<tr>
<td>ii.</td>
<td>Coherence or disorder of thought processes</td>
</tr>
<tr>
<td>iii.</td>
<td>Cognitive style</td>
</tr>
<tr>
<td>b.</td>
<td>Affective experience</td>
</tr>
<tr>
<td>i.</td>
<td>Positive and negative affect</td>
</tr>
<tr>
<td>ii.</td>
<td>Tendency to experience particular affects</td>
</tr>
<tr>
<td>iii.</td>
<td>Intensity of affective experience</td>
</tr>
<tr>
<td>iv.</td>
<td>Lability of affect</td>
</tr>
<tr>
<td>v.</td>
<td>Affect recognition and tolerance</td>
</tr>
<tr>
<td>vi.</td>
<td>Capacity for experiencing ambivalent emotions</td>
</tr>
<tr>
<td>c.</td>
<td>Affect regulation</td>
</tr>
<tr>
<td>i.</td>
<td>Coping strategies</td>
</tr>
<tr>
<td>ii.</td>
<td>Defenses</td>
</tr>
<tr>
<td>iii.</td>
<td>Affect-regulatory behavior</td>
</tr>
<tr>
<td>d.</td>
<td>Impulse regulation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III.</th>
<th>How does the person experience the self, others, and relationships, and to what extent is s/he capable of mature, intimate relationships?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Cognitive structure of representations of self and others</td>
</tr>
<tr>
<td>i.</td>
<td>Complexity of representations</td>
</tr>
<tr>
<td>ii.</td>
<td>Integration of diverse elements</td>
</tr>
<tr>
<td>iii.</td>
<td>Differentiation of different representations from each other</td>
</tr>
<tr>
<td>b.</td>
<td>Affective quality of representations</td>
</tr>
<tr>
<td>c.</td>
<td>Capacity for emotional investment in relationships</td>
</tr>
<tr>
<td>i.</td>
<td>Developmental level (from need-gratifying approach to mature interdependence)</td>
</tr>
<tr>
<td>ii.</td>
<td>Style (e.g., attachment status)</td>
</tr>
<tr>
<td>d.</td>
<td>Capacity for emotional investment in values and moral standards</td>
</tr>
<tr>
<td>e.</td>
<td>Understanding of social causality</td>
</tr>
<tr>
<td>f.</td>
<td>Identification and disidentifications</td>
</tr>
<tr>
<td>g.</td>
<td>Dominant interpersonal concerns (chronically activated wishes, fears, and constructs)</td>
</tr>
<tr>
<td>h.</td>
<td>Social skills</td>
</tr>
<tr>
<td>i.</td>
<td>Self-structure</td>
</tr>
<tr>
<td>i.</td>
<td>Sense of self-continuity or coherence; sense of self as thinker, feeler, and agent; experience of self as continuous over time</td>
</tr>
<tr>
<td>ii.</td>
<td>Implicit and explicit self-representations</td>
</tr>
<tr>
<td>iii.</td>
<td>Self-with-other representations</td>
</tr>
<tr>
<td>iv.</td>
<td>Self-esteem</td>
</tr>
<tr>
<td>v.</td>
<td>Feared, wished-for, ouija, and ideal self-representations</td>
</tr>
<tr>
<td>vi.</td>
<td>Self-presentation (how the person wants to be perceived)</td>
</tr>
<tr>
<td>vii.</td>
<td>Identity</td>
</tr>
</tbody>
</table>
Personality Structure as a Context for Psychopathology

- Question 1: What does the person wish for, fear, and value, and to what extent are these motives conscious and mutually compatible? The first question regards motivation: What does the individual wish, fear, and value? To put it another way, what representations of desired, feared, and valued states has the patient come to associate with affect such that these representations guide behavior as goal states? Contemporary views of motivation, rooted in research with both human and nonhuman animals, emphasize approach and avoidance systems motivated by positive and negative affect (Carver, 2001; Davidson, Jackson, & Kalin, 2000; Gray, 1990). For decades clinical supervisors have exhorted young psychotherapists to “go where the affect is” (or where it should be but does not seem to be), reflecting the recognition that the quality and intensity of emotion attached to various representations is what tends to drive both healthy striving and problematic motives and conflicts.

These affectively imbued representations can be conscious, unconscious, or somewhere in between from a dynamic standpoint (e.g., acknowledged but only in alternation or recognized with considerable clinical probing and support, such as wishes for revenge, or unpleasant memories). They can also be organized at varying hierarchical levels, such as a strong need to be liked, to be liked by authority figures, or to be liked by male authority figures (Westen, 1997). Central to psychodynamic formulations is that wishes, fears, and values, including emotionally invested ideals and standards (see Higgins, 1990; Strauman, 1992) can be in conflict, and that the resolutions to these conflicts (compromise formations) can be adaptive or maladaptive (see Brenner, 1982). Whereas these postulates were once based exclusively on clinical data, today a considerably body of empirical evidence supports them (McClelland, Koestner, & Weinberger, 1989; Weinberger, in press; Westen, 1998b; Westen, Blagov, et al., 2005; Westen & Gabbard, 1999; Westen, Weinberger, & Bradley, in press).

From a psychoanalytic standpoint, knowing a person requires understanding the structure of his or her motivation. People with very different constellations of motives could show similar overt behavior or self-report similar personality characteristics. From the surface, the obsessional patient described above might be described (and describe himself) as relatively low in aggression or hostility. In fact, however, he may be quite hostile or angry but overregulate his aggression. In so doing, he may inadvertently keep himself angry and focused on other people’s flaws, slights, or insults (on the paradoxical effects of suppression, see Wegner & Bargh, 1998). From a clinical point of view, this combination of angry criticism of others and defenses against it is not readily described as either hostile or not hostile; it is both, depending on which level of consciousness one is describing.

- Question 2: What psychological resources—cognitive, affective, and behavioral dispositions—does the individual have at his or her disposal? The second question regards adaptive functioning. It comprises several
subdimensions, largely focusing on patterns of cognition, emotion, and self-regulation. The first set of dimensions pertains to the cognitive resources at the individual's disposal. One such dimension (or set of dimensions) is intellectual functioning in multiple domains, particularly as it reflects on the capacity to problem solve (Gardner, 1999). A second cognitive variable, first studied by psychoanalytic ego psychologists, is the degree to which a person's thought processes are intact or disordered (Coleman, Levy, Lenzenweger, & Holzman, 1996; Johnston & Holzman, 1979; Perry, Minassian, Cadenhead, Sprock, & Braff, 2003; Rapaport, Gill, & Schafer, 1945). Research from our laboratory suggests that “subclinical” (i.e., not overtly psychotic) disturbances in thinking have diverse etiologies, some reflecting a genetic liability for schizophrenic spectrum pathology (Kalker & Gale, 1995; Walker, Logan, & Walder, 1999) and others reflecting adverse developmental experiences, notably childhood separations and sexual abuse (Heim, Thomas, & Westen, unpublished data). Another cognitive variable is cognitive style (Shapiro, 1965) (e.g., such as the global, impressionistic, hysterical style that usually co-occurs with defenses such as pseudonaiveté or denial of obvious but unpleasant ideas).

A second domain of psychological resources regards the person's emotional experience. Individuals differ on a number of affective dimensions, many of which have been studied empirically, including affective lability (the extent to which their emotions fluctuate from one emotional state to another) (Koenigsberg et al., 2002; Mitropoulou, New, Koenigsberg, Silverman, & Siever, 2001; Tolpin, Gunther, Cohen, & O'Neill, 2004), affect intensity (the extent to which emotions are strong: Larsen, Billings, & Cutler, 1996; Schimmack & Diener, 1997), the extent to which they chronically experience positive and negative (i.e., pleasant and unpleasant) affects (Watson & Clark, 1992), the extent to which they experience specific affects such as shame and guilt (Tangney, 1994; Watson & Tellegen, 1985; Westen, 1994), their comfort with conscious awareness of affect (Pennebaker, 1997; Shedler et al., 1993), and, as emphasized by Kernberg (1975), their ability to recognize and experience conflicting affective states and appraisals simultaneously (that is, capacity for ambivalence: for empirical work on the capacity for ambivalence: see Baker et al., 1992; Harter, 1999; Whitesell & Harter, 1989).

A third domain of psychological resources is emotion regulation, which refers to the conscious and unconscious procedures used to maximize pleasant and minimize unpleasant emotions (see Gross, 1998; Westen, 1985; Westen, 1994; Westen et al., 1997). Emotion regulation strategies that are explicit (i.e., under conscious control) are usually referred to as coping strategies (e.g., anticipation, cognitive reframing, self-distraction, suppression). Emotion regulation strategies that are implicit or unconscious are usually referred to as defenses. People also use overt behavior to try to alter reality to eliminate an aversive situation or to alter the affect directly
Personality Structure as a Context for Psychopathology

(e.g., by ingesting drugs or alcohol). The lines among explicit, implicit, and behavioral emotion regulation strategies are, of course, somewhat arbitrary (see Haan, 1977; Plutchik, 1980).

A fourth and related domain of psychological resources involves the regulation of impulses. Block (1971) has described empirically the dangers that can beset people who either overcontrol or undercontrol their impulses. Impulsivity appears to be a multidimensional construct (Barratt, 1993; Webster & Jackson, 1997) that plays a significant part in many forms of psychopathology. For example, as described below, a substantial percentage of patients with eating disorders have a tendency to overregulate their impulses, whereas others show the opposite pattern; and these personality patterns are associated with a range of variables including but not limited to their eating symptoms (Thompson-Brenner & Westen, 2005; Westen & Harnden-Fischer, 2001).

- Question 3: How does the person experience the self and others, and to what extent can the individual enter into intimate relationships? The third question, regarding interpersonal functioning, has been the focus on object relations theory, self psychology, and relational theories in psychoanalysis (Aron, 1996; Aron & Harris, 2005; Greenberg & Mitchell, 1983; Mitchell, 1988; Mitchell & Aron, 1999; Westen, 1991b). Several dimensions of object relations are empirically distinguishable and have been examined in studies using samples of normal and clinical children, adolescents, and adults (Blatt & Lerner, 1983; Huprich & Greenberg, 2003; Stricker & Healey, 1990; Westen, 1991b; Westen, Huebner, Lifton, Silverman, & Boekamp, 1991; Westen, Klopser, et al., 1991; Westen, Lohr, Silk, Gold, & Kerber, 1990; Westen, Ludolph, Lerner, et al., 1990; Westen, Ludolph, Silk, et al., 1990). As described earlier, people differ in not only the content but the cognitive structure of their representations of people and relationships. People's representations of significant others differ in their complexity and integration (particularly of elements with contrasting affective valences). Patients with severe personality pathology often have difficulty forming complex multidimensional representations of people, and instead tend to think about others in simplistic or black-and-white ways. People also differ in the affective quality of their representations of people, that is, on the extent to which they tend to expect relationships to be destructive or enriching.

The capacity for emotional investment in relationships—the ability to care about another person for more than what that person can give or what desires that person can gratify—is another central aspect of object relations, as is the capacity for emotional investment in moral values and standards (e.g., the capacity to feel or anticipate guilt, rather than primarily concern about punishment when committing or thinking of committing a moral infraction). The understanding of social causality (i.e., why people do what they do) is another central dimension of object relations that has received
empirical attention. In different terms, social causality has also been a focus of attachment research, which has linked the experience of unpredictable caregiving to the inability to develop coherent expectations and internal working models of relationships that allow the growing child to predict, understand, and hence adapt optimally to significant others (Cassidy & Mohr, 2001; Lyons-Ruth & Jacobvitz, 1999; Main et al., 1985). Other dimensions of object relations include identifications and disidentifications (e.g., fears of becoming like one's mother; Benjamin, 1996a; McWilliams, 1998); dominant interpersonal concerns (fears, wishes, and cognitive constructions; that repetitively emerge in the person's relationships and are manifest in narratives of interpersonal encounters (e.g., in psychotherapy hours; Baldwin, Fehr, Keedian, Seidel, & Thomson, 1993; Horowitz, 1999; Luborsky & Crits-Christoph, 1990); and social skills, which are often deficient in patients with Axis II Cluster A pathology (paranoid, schizoid, and schizotypal) but can be seen in more attenuated forms in people who have difficulty reading other people's emotions, do not maintain culturally appropriate physical proximity from others while talking, and so forth (Lancelot & Nowicki, 1997; McClure & Nowicki, 2001; Nowicki & Duke, 2002).

A final set of variables related to interpersonal functioning and of obvious relevance to many forms of psychopathology involves aspects of self (see Gabbard, 2005). Although the term "self" is often used to refer to multiple different phenomena (see Westen, 1992), clinically relevant aspects of self include the coherence of the person's sense of self (i.e., sense of agency and continuity through time); the nature of chronically recurring implicit and explicit self-representations; self-esteem (implicit and explicit) and self-esteem regulation; feared, wished-for, and ideal self-representations that serve as standards or guides for behavior (Higgins, 1990; Strauman & Higgins, 1993); and what Erikson (1986) referred to as identity, which includes the sense of self, representations of self, the recognition of one's selfhood by the social milieu, and an emotional weighting of elements of self (such as roles) the person experiences as self-defining.

From a clinical perspective, these domains of functioning are essential in case formulation because they describe what the person is characterologically able or unable to do—and hence provide targets for intervention. They are also crucially important in understanding the ways people become symptomatic. A person with rigid values regarding his feelings and impulses, who believes (consciously or unconsciously) that he is culpable for his thoughts as well as his deeds, may be vulnerable to alternations of compulsive rigidity and breakthroughs of impulsive actions (as appeared to be the case with the televangelists who fell from grace in the 1980s, who preached by day against the evils of sex and practiced by night one or another colorful, illicit, or perverse version of it). A person
with an avoidant or dismissing adult attachment style who regulates emotion by denying or suppressing it may become vulnerable to panic attacks or generalized anxiety disorder precisely because he is working so hard to avoid feeling (and hence responding adaptively) to his emotions. A person with low intelligence is, empirically, more likely to succumb to posttraumatic stress disorder in wartime (Macklin et al., 1998; McNally & Shin, 1995). A person whose enduring attitude toward herself, or view of herself under particular circumstances, is characterized by self-loathing is likely to be vulnerable to mood, anxiety, and substance use disorders. Below we explore the question of how well these functional domains and their implications for psychopathology map on to prominent trait models of personality.

**Level of Pathology**

Nancy McWilliams (1999) tells the charming story of a not terribly psychologically minded friend who did not understand how someone could spend her days listening to other people’s problems. To him, people could be grouped into two large classes: nuts and not nuts. McWilliams suggests that a psychoanalytic view places everyone in the first class (nuts) but asks two questions about their character: how nuts, and what kind of nuts? In this section, we address the issue of how nuts (levels of personality pathology). In the next, we address the issue of what kind.

Freud inherited from Kraepelin the distinction between patients with neurotic and psychotic pathology (see McWilliams, 1999). As we have seen, over time, Freud and other psychoanalysts began to differentiate “neurosis” into symptom neuroses (relatively isolated pockets of pathology) and character neuroses (pathology widely dispersed throughout the person’s personality). Over time, however, what became clear was that in the characterological realm patients varied from relatively functional to relatively dysfunctional. As early as the 1920s, clinicians and clinical theorists began to write about patients who were not psychotic but who were too sick to consider merely neurotic (what today we call severe personality pathology). Menninger, Mayman, and Pruyser (1962) proposed that patients could be described on a continuum of functioning in terms of their capacity for coping and adaptation.

The concept of a general health-sickness continuum that emerged from the Menninger Clinic ultimately led to the development of the Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976), later renamed Global Assessment of Functioning (GAF), which is now Axis V of the DSM and can be coded with high reliability (Hilsenroth et al., 2000). Although useful as a rough index of pathology, however, the GAF mixes severity of current symptoms, degree of medical risk (e.g., severity of suicidality), and
level of personality functioning at each of its levels, rendering it a somewhat rough index of personality health-sickness.

Kernberg (1975) systematized the notion of levels of personality health/sickness in distinguishing three levels of character organization, which he called neurotic, borderline, and psychotic. The gist of the notion of levels of pathology in Kernberg's work, which is shared now by most psychodynamic theorists, is as follows. Personality pathology lies on a continuum reflecting the extent to which the individual is able to love, work, and enjoy life. Patients at a neurotic to normal level are capable of forming meaningful relationships, finding and maintaining steady employment, and generally attending to the demands normally placed on adults in their society. They may, nevertheless, have substantial neurotic conflicts, symptoms, and defensive and relational patterns that decrease their life satisfaction (e.g., rigid obsessional defenses, high levels of anxiety, a tendency to get into repetitive patterns in relationships that interfere with their happiness). At the lower (more troubled) end of the neurotic range (often called a low-functioning neurotic), the person may be seriously compromised in love, work, or play (e.g., working far below his abilities because of inhibitions, unable to commit to an enduring love relationship without repetitive affairs) but is typically able to adjust to the demands of reality (e.g., meeting rent payments, keeping a job, having some friends).

Empirically, much of personality pathology encountered in clinical practice is in this range. For example, Westen and Arkowitz-Westen (1998) asked 238 experienced clinicians to describe 714 nonpsychotic patients in treatment for personality patterns that were dysfunctional or led to significant distress regardless of whether or not they met PD criteria. Clinicians completed checklists for all DSM-IV personality disorders, Axis I categories, and problems that did not necessarily meet the criteria for any personality disorder (e.g., problems with intimacy, self-esteem, emotional constriction, impulsivity). Roughly 60% of patients had personality difficulties deserving clinical attention and yet could not be diagnosed by the DSM-IV because they were not of sufficient severity to merit a diagnosis of personality disorder.

Other research has documented the consequences of subthreshold personality pathology, or "neurotic-level" character disturbances. Daley et al. (1999) used dimensional measures of personality disorder symptomatology based on a diagnostic questionnaire and the SCID-II (First, Spitzer, Gibbon, & Williams, 1997) with a sample of 135 girls in late adolescence to predict Axis I problems prospectively. Only about 6% qualified for a formal personality disorder diagnosis; however, subthreshold endorsement predicted depression at 2- to 3-year follow-up, holding initial depression constant. In another longitudinal study (Daley, Burge, & Hammen, 2000), the investigators found that subthreshold levels of nearly all personality disorders pre-
dicted romantic stress, interpersonal conflicts, and dysfunction (e.g., unwanted pregnancy) at 4-year follow-up. Similar findings emerge from studies of adult attachment status. In prospective and longitudinal studies, insecure attachment predicts difficulty at work and in the family (Vasquez, Durik, & Hyde, 2002), interpersonal aggression (Crowell, Treboux, & Waters, 2002), and later psychopathology (Carlson, 1998). Retrospective studies (e.g., Klohnen & Bera, 1998) have found avoidant attachment to predict increasingly unhappy relationships over the lifespan. Although most people with personality disorders have attachment problems, most people with insecure attachment styles do not have personality disorders (Brennan & Shaver, 1998).

Patients at a personality disordered level (what Kernberg calls borderline personality organization) can generally distinguish reality from their own thoughts (i.e., they do not have hallucinations or fixed delusions), but their capacity to love and work is seriously compromised. From a descriptive point of view, they may have difficulty holding a job, may have few or tumultuous relationships, or may find themselves in and out of psychiatric hospitals. From a more dynamic standpoint, Kernberg suggests that what they share are immature or maladaptive defenses and difficulty forming complex, multifaceted, integrated representations of the self and others (Kernberg, 1975, 1984). Patients with paranoid personality disorder, for example, tend to project and externalize, and their representations of others are rigidly malevolent and one-dimensional. Patients with borderline personality disorder, have difficulty regulating powerful affect states, turning instead to behaviors such as cutting and suicide attempts, and their representations of others tend to be highly state-dependent (e.g., unidimensional and malevolent when confronted with turbulence in an emotionally significant relationship). Empirically, these long-held clinical beliefs have stood the test of time (Shedler & Westen, 2004b; Westen & Shedler, 1999a).

Within the broad range of disorders defined as personality disorders in DSM-IV, however, is considerable variability in level of pathology in Kernberg’s sense. Although the criteria for DSM-IV obsessive-compulsive personality disorder describe a severely disturbed personality, empirically many patients who meet criteria for this disorder actually have reasonably high GAF scores (because they are capable of working, often with a high level of productivity) and can maintain relationships over time (even if compromised by their lack of emotional connection; e.g., Gunderson et al., 2000; Westen & Shedler, 1999a). Patients with borderline personality disorder range from those who can encapsulate their work so that they retain some degree of functionality, or can maintain relatively stable relationships with friends over time, to patients often described as just “north of the border” (of psychosis), whose reality testing can become extremely compromised. Interestingly, in our research, we have repeatedly found that clini-
Cicians of all theoretical orientations are able to make a simple 5-point rating of level of personality health–sickness based loosely on Kernberg’s model of levels of functioning that is more predictive of dimensional measures of personality disorders than is the GAF, and these single-item ratings show surprisingly high interjudge reliability (see Westen & Muderrisoglu, 2003).

**Forms of Personality Organization (Personality Disorders and Personality Styles)**

The concept of personality styles or constellations should be familiar to readers because it formed the basis of Axis II of DSM-IV. The current personality disorders were largely derived from the clinical observations of psychoanalytically and biologically oriented taxonomists. As noted above, the concept of personality disorder emerged from psychoanalytic clinical observation and led to the development of diagnoses such as borderline and narcissistic personality disorder. Pioneering psychiatric taxonomists of the early 20th century noted that many first-degree relatives of patients with severe mental illness themselves appeared a bit “touched,” ultimately leading to constructs such as schizotypal personality disorder.

In classifying personality pathology, Kernberg (1967, 1984, 1996) proposed a severity axis (described earlier) that is orthogonal to an axis of personality styles or types such as the personality disorders on Axis II of DSM-IV. For example, a patient could have a narcissistic personality style organized at a neurotic level, a high-functioning personality disorder level, or a low-functioning personality disorder level. Individuals with a narcissistic character style organized at a neurotic level tend to be self-absorbed and overly sanguine about their abilities and accomplishments, but they are still capable of forming long-lasting love relationships and friendships, and they are often highly productive. Narcissistic patients organized at a more severely disturbed level tend to have little capacity for empathy, little interest in others except for what they can provide, and few if any close relationships. They may even undo themselves occupationally by virtue of their difficulty in regulating angry outbursts or their inability to let the obstacles most people encounter on their way up in an organization “roll off their back.”

Drawing on Kernberg’s work, McWilliams (1994) offered a diagnostic grid in which columns represent personality styles, each distinguished by its complaints, affects, relational problems, primary defenses, strengths, and so forth, and rows represent levels of severity. As in Kernberg’s model, different personality styles may present at neurotic, borderline, psychotic, or intermediate levels of disturbance. Based on clinical experience and available empirical data, McWilliams describes psychopathic, narcissistic, schizoid, depressive and/or manic, obsessive and/or compulsive, masochistic (self-defeating), hysterical (histrionic), and dissociative personality styles.
Kernberg has offered a similar typology. Both suggest that, although different personality styles can occur at different levels of personality organization (severity), not all sectors of McWilliams's grid are equally populated. People with genuinely schizoid dynamics, for example, are less likely to be well adapted to social life and hence are more likely to fall into the lower ranges of personality pathology. However, many individuals who are introverted—but who do not show the tendency toward either concrete representations of self and others or the overly elaborated fantasy life often attributed to schizoid characters—function in the normal to neurotic range.

Kernberg, McWilliams, and virtually all psychoanalytically oriented taxonomists of character have drawn on Shapiro's 1965 classic work on "neurotic styles." These styles include characteristic conflicts, defensive strategies, and cognitive styles. For example, the hysterical style is characterized by an impressionistic, overly glib and global cognitive style and a tendency to rely on repressive defenses. Individuals with a hysterical style may seem polyannish, overly optimistic, and naive, and they tend not to think deeply about information that might be threatening. They tend to be conflicted about their sexual impulses and to sexualize interactions with others without acting on their desires, often leading others to feel confused, disappointed, or "led on." People often perceive them as naively romantic, immature, flighty, or shallow.

At a neurotic level, an individual with a hysterical style is likely to be extroverted, to have multiple friends and acquaintances, to be flirtatious (but generally not to "mean it"), to disavow negative affect, and to be valued by others for his or her positive outlook (e.g., the classic high school cheerleader). The same character style, when organized at a borderline level of personality organization, often manifests as histrionic personality disorder and is characterized by substantially greater egocentrism, self-centeredness, powerful affects that seem to come and go by the moment, and a level of seductiveness that can be socially inappropriate. The notion of a hysterical style organized at different levels of pathology was first described in some detail by Zetzel (1968), who distinguished between the "good hysteric" and the "bad hysteric." The latter would today be diagnosed with borderline or histrionic personality disorder, or both.

Although personality disorders now constitute an axis of the diagnostic manual (lumped unceremoniously with mental retardation), neurotic styles did not make their way into the official diagnostic nomenclature for historical reasons (Bayer & Spitzer, 1985). Personality pathology received minimal research attention until DSM-III instituted a multiaxial diagnostic system (American Psychiatric Association, 1980). The personality disturbances in DSM-I (American Psychiatric Association, 1952) and DSM-II (American Psychiatric Association, 1968) were never operationalized, and were mixed in with syndromes such as depression and schizophrenia. The
move toward operationalization that began with the Research Diagnostic Criteria (Spitzer, Endicott, & Robins, 1978), and ultimately DSM-III, introduced high diagnostic thresholds defined by relatively arbitrary cutoffs (Widiger, 1993). Whereas the descriptions of personality categories in DSM-I and DSM-II were phrased in ways that allowed clinicians to use them to describe higher or lower levels of dysfunction (but to do so unreliably), DSM-III and its descendants maximized reliability by limiting personality diagnoses to relatively severe forms of personality disturbance. Thus, paradoxically, by emphasizing the importance of diagnosing personality pathology (placing it on its own axis), DSM-III passed over the less severe and probably more common forms of personality disturbance.

Not surprisingly, because of their absence from the diagnostic manual, neurotic styles have received minimal empirical attention (except in terms of subthreshold personality disorders). Blagov and Westen (in preparation) have recently attempted to derive diagnostic prototypes of naturally occurring personality styles at a neurotic level. The investigators asked a random sample of 168 clinicians to describe a randomly selected patient in their care for personality difficulties that did not meet DSM-IV cutoffs for a PD. Clinicians described the patients using the Shedler-Westen Assessment Procedure—200 (SWAP-200; Westen & Shedler, 1999a), a 200-item personality pathology Q-sort instrument. The investigators then used Q-factor analysis (also called inverted factor analysis, a procedure for grouping together individuals based on shared characteristics) to try to identify neurotic styles empirically. Aside from the high-functioning obsessional character style identified in their prior work (in contradistinction to the DSM-IV obsessive–compulsive personality disorder, which describes someone much more severely ill; see Westen & Shedler, 1999b), Q-factor analysis identified three additional neurotic styles: a high-functioning depressive style (similar to a prototype previously identified as a depressive or dysphoric personality disorder subtype); a hostile/competitive style, characterized by strong needs for power, dominance, and success, coupled with acknowledged and unacknowledged anger; and a hysterical personality style resembling Shapiro’s (1965) description. Whether a typological approach (or in this case, dimensional typology, or prototype approach) or trait approach to personality pathology (or some combination) will prove more useful in prediction is, however, an open question.

**Integrating the Three Components of the Clinical Model of Personality Structure: Functional Domains, Levels of Pathology, and Personality Styles or Constellations**

Clinical theorists have been relatively clear in their writing about the relation between levels and types of personality pathology. Patients with simi-
lar personality styles can be organized at different levels of pathology, depending on the extent to which their pathology is severe, rigid, ubiquitous across roles and relationships, and destructive of the capacity to love, work, and enjoy life. Different theorists have offered particular criteria for linking functional domains to levels of pathology. For example, Kernberg emphasizes maturity of defense and integrity of representations of self and others in distinguishing patients at different levels of pathology. Using the model of functional domains described here, disturbances in motivation (e.g., lack of a well-developed conscience), deficits in adaptive psychological resources (e.g., inability to regulate affects and impulses in mature ways), and difficulties in understanding and interacting with people in mature, mutually pleasurable, and socially competent ways are all of relevance in assessing levels of pathology.

With respect to the relation between functional domains and personality styles (or, as we suggest below, personality traits), we would argue that descriptive diagnosis (whether of personality disorders in the DSM tradition or traits in the tradition of personality psychology) can and should be derivative of a functional assessment. Indeed, the goal of clinical work is to alter functioning in dysfunctional domains; hence, functional diagnosis and descriptive diagnosis must be closely related if descriptive diagnosis is to be clinically useful.

Case Illustration

To illustrate how functional diagnosis can be translated into descriptive diagnosis, and equally important, how a nomothetic approach using a standardized psychometric instrument designed for clinically experienced observers can be used for idiographic personality assessment, we briefly describe a quantified case study. The case was taken from a study using the SWAP-200 Q-sort, in which a random national sample of 530 clinicians was asked to describe a patient with a personality disorder. Our description of this patient, whom we shall call Ms. Z, reflects only the data provided by the treating clinician.

Ms. Z is a 36-year-old woman who has been in treatment for 2 years. Despite a college education, she works as a semiskilled worker. The reporting psychiatrist gave her an Axis I diagnosis of major depressive disorder, recurrent. The clinician reported that the patient described a history of severe physical abuse beginning at age 7 and a history of repeated sexual abuse by a neighbor for slightly less than 1 year at age 13. The clinician also reported a family history of substance abuse and depression in first-degree biological relatives.

An Idiographic Narrative Description. The following narrative was obtained by listing the SWAP-200 items the clinician assigned to the three
highest (most descriptive) categories (categories 5, 6, and 7) of the Q-sort. The items are reprinted verbatim, except for minor grammatical changes to aid the flow of the narrative.

Ms. Z lacks close friendships and relationships. She lacks social skills, tending to be socially awkward or inappropriate. She tends to feel like an outcast or outsider, and avoids confiding in others for fear of betrayal, expecting that the things she says will be used against her. She tends to believe she can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise “special.” Her relationships tend to be unstable, chaotic, and rapidly changing.

Ms. Z is exclusively homosexual in her sexual orientation. She tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), and so on. She tends to get drawn into or remain in relationships in which she is emotionally or physically abused, and she has difficulty directing both tender feelings and sexual feelings toward the same person (e.g., she sees people as respectable and virtuous, or sexy and exciting, but not both). She has a sexual perversion or fetish, a rigidly scripted or highly idiosyncratic condition that must be met before she can experience sexual gratification.

Ms. Z tends to use her psychological or medical problems to avoid work or responsibility (whether consciously or unconsciously). She tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.). She is hypochondriacal, tending to have unfounded fears of contracting medical illness, and interpreting normal aches and pains as symptomatic of illness. She tends to be preoccupied with food and diet. She also tends to be preoccupied with death and dying.

Ms. Z tends to enter altered, dissociated states of consciousness when distressed (e.g., the self or the world feels strange, unfamiliar, or unreal). She tends to be superstitious or believe in magical or supernatural phenomena (e.g., astrology, tarot, crystals, ESP, “auras,” etc.). Her reasoning processes or perceptual experiences seem odd and idiosyncratic (e.g., she may make seemingly arbitrary inferences; may see hidden messages or special meanings in ordinary events), and her speech tends to be circumstantial, vague, rambling, digressive, and so on. Her verbal statements often seem incongruous with her accompanying affect, or incongruous with accompanying nonverbal messages.

Ms. Z tends to think in abstract and intellectualized terms, even in matters of personal import. She tends to describe experiences in generalities and is unwilling or unable to offer specific details. She has difficulty acknowledging or expressing anger and appears, more generally, to have a limited or constricted range of emotions. She has difficulty allowing herself to experience strong pleasurable emotions (e.g., excitement, joy, pride). She tends to feel unhappy, depressed, or despondent.
Ms. Z tends to be passive and unassertive. She appears inhibited about pursuing goals or successes; her aspirations or achievements tend to be below her potential. She tends to be conflicted about authority (e.g., may feel she must submit, rebel against, win over, defeat, etc.), although she is conscientious and responsible. She tends to be suggestible or easily influenced.

Clinical Formulation. Research assessing the relation between SWAP-200 data obtained from treating clinicians and from independent observers using a systematic clinical interview finds interobserver correlations on dimensional Axis II diagnoses and on trait dimensions derived factor-analytically between \( r = .70 \) and .80 (Westen & Muderrisoglu, 2003, in press). Thus, the description of Ms. Z above is likely to be very similar to the description that would be generated by any competent, experienced clinician using the SWAP-200.

Based on this description, we can offer a tentative case formulation, or set of clinical hypotheses. Ms. Z has difficulty forming meaningful relationships because her past experiences have engendered deep distrust. She attempts to protect herself by keeping others at a distance, and her social skills deficits likely interfere with her capacity to form and maintain relationships. She feels like an outsider and attempts to compensate through fantasies of superiority, but at some level she probably feels deeply defective socially.

Unwittingly, Ms. Z re-creates her abusive childhood world by forming inappropriate relationships in which she feels abused or mistreated. Sexual relationships are particularly problematic, perhaps because she has learned to associate love with abuse. Her sexual perversion most likely contains sadomasochistic elements.

Like many abuse survivors, Ms. Z is numb to her emotions. She employs a range of defensive processes to avoid affect-laden memories, including intellectualization, thinking in generalities, and ultimately dissociation. Along with chronic depression, the language she uses to express her pain is the language of the body: she turns her anger, fear, and sadness into somatic complaints and hypochondriacal concerns. She has little awareness of her anger, and likely learned to inhibit anger that might provoke her physically abusive parents.

Cognitively, Ms. Z is prone to disorganization, digression, “empty” generalizations without the accompanying memories and feelings, and idiosyncratic and superstitious thinking, which are also likely sequelae of her severe abuse history. In many ways her behavior appears peculiar to others, both because of the way she thinks and speaks but also because of the incongruities between what she expresses verbally and nonverbally (e.g., in her behavior). She probably has difficult telling a coherent life narrative, or even coherent “stories” about relatively circumscribed events, because of
her inability to think in a clear, linear way and to take the perspective of the listener.

Ms. Z's social and cognitive idiosyncrasies, as well as her tendency to somatize and hence to miss work frequently, probably contribute to her inability to maintain employment commensurate with her level of education. Although she is diligent and conscientious, she is passive, unassertive, and inhibited in asking for, and taking the necessary steps to achieve, what she wants. She has problems with authority figures and may see her bosses as unfair or abusive, like her parents. At the same time, she handles anger by being compliant and self-effacing, and doing what is asked. In her occupational life, as in her personal life, her inability to use her feelings as guides leaves her rudderless.

SWAP-200 DSM-IV PD and Factor (Trait) Profiles. Figure 11.1 shows Ms. Z's dimensional Axis II profile, using the SWAP-200. For ease of interpretation the scores are converted to T-scores (mean = 50, SD = 10), similar to a Minnesota Multiphasic Personality Inventory—2 (MMPI-2) profile. Because the normative sample for the SWAP-200 comprised only patients with personality disorders, a T-score of 60 would typically translate to a DSM-IV categorical diagnosis, and a T-score of 55 would translate to “features.” (We are currently norming the latest version of the instrument, the SWAP-II, using a sample and procedures that will allow more ready translation to a DSM-IV diagnosis, although the instrument is intended primarily for dimensional diagnosis.) As can be seen from the figure, Ms. Z would receive a diagnosis of schizotypal PD. As can be seen from her score on the high-functioning or health index, she is below the mean on personality health—sickness even for a PD sample.

Figure 11.2 shows Ms. Z's profile on the 12 SWAP-200 factors (traits) derived by factor analysis (Shedler & Westen, 2004b). Once again for ease of interpretation, the factor scores have been converted to T-scores. Ms. Z shows a marked elevation on dissociated consciousness (more than two standard deviations above the mean), indicating disconnected thoughts, feelings, and memories, gaps in memory, and a tendency to enter altered, dissociated states (common in survivors of childhood sexual abuse). Her profile also reveals an elevation on thought disorder, indicating gaps in reality testing and peculiar and idiosyncratic reasoning (hence the schizotypal diagnosis). (As described above, we have identified what appear to be at least two pathways to schizotypy, one related to schizophrenia spectrum pathology and the other to a history of childhood trauma; this patient's pathology appears to reflect the latter pathway.) A marked elevation on histrionic sexualization (which includes a tendency to choose inappropriate or unavailable partners) plus some elevation on sexual conflict indicates disturbed sexual functioning and problematic romantic relationships. Ms. Z is
more than a standard deviation below the mean on hostility and emotional
dysregulation, suggesting constricted affect and difficulty in expressing anger.

We describe this case as an example of how a model of personality
structure that emerged from clinical practice and was designed to meet the
needs of clinical work could be operationalized in a rigorous quantitative
way. Although items from the SWAP-200 were derived from multiple

![SWAP-200 personality disorder profile of Ms. Z.](image1)

![SWAP-200 trait profile of Ms. Z.](image2)
sources (including the diagnostic criteria for the personality disorders listed on Axis II from DSM-III through DSM-IV, and clinical writing and research on neurotic-range personality pathology), we used the model of functional domains described above to maximize content validity, that is, to ensure that the item set comprehensively sampled the domains central to the clinical assessment of personality. What we hope to have shown with this example is that one need not choose between clinical "thick description" and empirical rigor.

INTEGRATING CLINICAL AND PSYCHOMETRIC PERSPECTIVES ON PERSONALITY STRUCTURE

We conclude with some reflections on the question of whether, and in what ways, the models of personality structure that emerged from psychoanalytic clinical observation over the past century may be integrable with contemporary trait approaches to personality that have breathed new life into the marriage of personality and psychopathology following a period of prolonged estrangement. We briefly address two issues: the relation between traits generated by self-reports and clinician reports (as in the SWAP); and the extent to which trait models of personality structure can provide adequate models for clinical practice, notwithstanding their obvious merits for research purposes.

Traits Generated by Self-Reports and Clinician-Reports

Although much of the taxonomic work using the SWAP-300 (and its latest version, the SWAP-II) has focused on identifying personality configurations as a way of revising Axis II personality disorder diagnoses and diagnostic criteria, as should be clear from Figure 11.2, nothing in the nature of the instrument prevents the derivation of traits by conventional factor analysis. Westen, Shedler, and colleagues have derived traits in both adult and adolescent samples using the SWAP-200 (Shedler & Westen, 2004; Westen, Dutra, & Shedler, 2005). The traits identified using the SWAP and the "Big Four" traits identified in recent research with psychopathological samples (see Markon, Krueger, & Watson, 2005; Trull & Durrett, 2005; Widiger & Simonsen, in press) have substantial overlap. For example, both the adolescent and adult versions of the SWAP-200 include dimensions relevant to negative affectivity or neuroticism (dysphoria, anxious obsessiveness); introversion or low positive affectivity (schizoid orientation, peer rejection); antagonism or low agreeableness (hostility, malignant narcissism); and impulsivity, low constraint, or low conscientiousness (psychopathy, delinquent behavior).

Some traits identified using the SWAP-200, however, are not easily un-
Personality Structure as a Context for Psychopathology

understood in terms of the Big Four or Big Five. For example, emotional dysregulation refers to the tendency for emotions to spiral out of control and appears to be empirically distinct from neuroticism or negative affectivity. The difference between the two constructs is perhaps best exemplified by the difference between patients who are stably depressed or anxious (e.g., patients with dysthymic disorder or generalized anxiety disorder) and patients with borderline personality disorder, whose emotional dysregulation may or may not be superimposed on stable characterological depression or anxiety. The distinction between emotional dysregulation and negative affect has now emerged in several samples using multiple instruments (Shedler & Westen, 2004a; Westen et al., 1997; Westen et al., 2005). We suspect it has largely been overlooked because emotional dysregulation is a relatively low base rate phenomenon in the normal samples from which most trait constructs were derived. (Interestingly, emotional dysregulation has emerged as a factor, though not distinct from negative affect, on self-report instruments intended to assess personality pathology and derived from clinicians’ ratings of items prototypic of different personality disorders; see Larstone, Jang, Livesley, Vernon, & Wolf, 2002; Wang, Du, Wang, Livesley, & Jang, 2001.)

Westen, Jenet, Walsh, and Bradley (2005) recently used factor analysis to “decompose” each DSM-IV personality disorder into its component traits or endophenotypes, using the SWL-4P-200 to identify item sets of 20–25 items per disorder. The procedure generated 3–6 factors per disorder. By way of illustration, Table 11.2 presents the trait structure of schizotypal personality disorder (including any secondary factor loadings ≥.30). As can be seen, the factor structure captures three central features of the disorder but may also help explain its overlap with other disorders. For example, social avoidance is characteristic not only of schizotypal personality disorder but of paranoid, schizoid, and avoidant personality disorder; and schizotypy is characteristic of patients with paranoid personality disorder.

Of particular relevance to the present discussion, once the investigators identified the factor structure of each personality disorder in isolation, they conducted a second-order factor analysis of the 31 traits identified across disorders. This higher-order factor analysis yielded six factors: negative affect, schizotypy, hostility, constraint, emotional dysregulation, and attachment pathology. Convergence with the Big Four is clear. However, schizotypy was a broader and somewhat different construct than extreme introversion, as it also included peculiar thinking. Emotional dysregulation and attachment pathology also have no obvious representation among the Big Four. To what extent they predict incremental variance on relevant criterion variables is as yet unknown.

Moving from personality traits to personality patterns or prototypes (i.e., constellations of traits or relatively specific attributes that empirically
### TABLE 11.2. Trait Structure of Schizotypal Personality Disorder

<table>
<thead>
<tr>
<th>SWAP-200 item</th>
<th>Social avoidance</th>
<th>Schizotypy</th>
<th>Impoverished thought/affec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tends to avoid social situations because of fear of embarrassment or humiliation.</td>
<td></td>
<td>.76</td>
<td></td>
</tr>
<tr>
<td>Tends to be shy or reserved in social situations.</td>
<td></td>
<td>.75</td>
<td></td>
</tr>
<tr>
<td>Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.</td>
<td></td>
<td>.66</td>
<td></td>
</tr>
<tr>
<td>Lacks social skills; tends to be socially awkward or inappropriate.</td>
<td></td>
<td>.57</td>
<td></td>
</tr>
<tr>
<td>Lacks close friendships and relationships.</td>
<td></td>
<td>.55</td>
<td></td>
</tr>
<tr>
<td>Tends to avoid confiding in others for fear of betrayal; expects things s/he says or does will be used against him/her.</td>
<td></td>
<td>.42</td>
<td></td>
</tr>
<tr>
<td>Appears to have little need for human company or contact; is genuinely indifferent to the presence of others.</td>
<td></td>
<td>.41</td>
<td></td>
</tr>
<tr>
<td>Reasoning processes or perceptual experiences seem odd and idiosyncratic (e.g., may make seemingly arbitrary inferences; may see hidden messages or special meanings in ordinary events).</td>
<td></td>
<td>.95</td>
<td></td>
</tr>
<tr>
<td>Tends to be superstitious or believe in magical or supernatural phenomena (e.g., astrology, tarot, crystals, ESP, “auras,” etc.).</td>
<td></td>
<td>.72</td>
<td></td>
</tr>
<tr>
<td>Perception of reality can become grossly impaired under stress (e.g., may become delusional).</td>
<td></td>
<td>.64</td>
<td></td>
</tr>
<tr>
<td>Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or “off”):</td>
<td></td>
<td>.61</td>
<td></td>
</tr>
<tr>
<td>Feels some important other has a special, almost magical, ability to understand his/her innermost thoughts and feelings (e.g., may imagine rapport is so perfect that ordinary efforts at communication are superfluous).</td>
<td></td>
<td>.55</td>
<td></td>
</tr>
<tr>
<td>Speech tends to be circumstantial, vague, rambling, digressive, etc.</td>
<td></td>
<td>.55</td>
<td></td>
</tr>
<tr>
<td>Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.</td>
<td></td>
<td>.38</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td>.72</td>
<td></td>
</tr>
<tr>
<td>Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.</td>
<td></td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td>Has little psychological insight into own motives, behavior, etc.; is unable to consider alternate interpretations of his/her experiences.</td>
<td></td>
<td>.54</td>
<td></td>
</tr>
<tr>
<td>Has difficulty making sense of other people’s behavior; often misunderstands, misinterprets, or is confused by others’ actions and reactions.</td>
<td></td>
<td>.43</td>
<td></td>
</tr>
<tr>
<td>Appears to have a limited or constricted range of emotions.</td>
<td></td>
<td>.59</td>
<td></td>
</tr>
<tr>
<td>Verbal statements seem incongruous with accompanying affect; or incongruous with accompanying nonverbal messages.</td>
<td></td>
<td>.43</td>
<td></td>
</tr>
</tbody>
</table>
tend to covary, reflecting broader personality “styles”), our most recent efforts to derive such constellations empirically using large, relatively unselected samples of adults ($N = 1,201$) and adolescents ($N = 950$) with personality pathology have led to substantial concordance with trait models developed by Krueger and colleagues (Krueger, 1999; Krueger, Markon, Patrick, & Iacono, in press; Krueger & Piatecki, 2002). Applying Q/person-centered, rather than variable-centered) factor analysis, we are obtaining a hierarchical structure in both adult and adolescent samples with superordinate configurational dimensions of internalizing, externalizing, and borderline spectrum pathology. We have just begun analyzing these data, but nested within the internalizing and externalizing spectra are highly recognizable personality disorders. For example, in preliminary analyses, the adult internalizing spectrum appears to include depressive, anxious, dependent, and schizoid personality disorders. The externalizing dimension includes paranoid, narcissistic, and psychopathic personality disorders. What is potentially exciting about this hierarchical structure is its relation both to trait dimensions identified by Krueger and others and more traditional personality disorder diagnoses, although it suggests what may be a more empirically grounded hierarchical structure than the personality disorder “clusters” in DSM-IV.

### Applying Trait Models of Personality Structure to Clinical Practice

Although we have suggested that trait models can be derived from factor analysis of clinician reports just as they can from self- or other lay informant-report measures, to what extent trait models alone can provide adequate guidance for clinical work is unclear. Clinicians do not find Axis II of DSM-IV particularly helpful clinically, but recent data suggest that they find trait models such as the FFM and Cloninger’s (Cloninger & Svrakic, 1994) seven-factor model even less clinically informative (First, Spitzer, & Skodol, 2005). From a clinical perspective, neither traditional DSM diagnosis nor traditional trait description appears adequate to guide clinical practice. Clinicians do not tend to find it useful to ask questions of the form “Does the patient cross the threshold for avoidant personality disorder?” or “How high is the patient on neuroticism?” Rather, clinicians tend to ask questions of the form “Under what circumstances do which cognitive, affective, motivational, and behavioral patterns and their interactions get triggered in ways that lead to distress for the patient or those around him?”

As argued above, this is a functional question, and questions of function tend to be the focus of clinical work. Both the DSM and trait traditions share the problem for which Mischel (1968) years ago criticized trait theories and has articulated more accurately since (e.g., Mischel & Shoda, 1985).
1995), namely, the failure to specify the eliciting conditions for personality processes (Westen, 1995, 1996, in press). Consider the following item from the SWAP-II: "When distressed, perception of reality can become grossly impaired (e.g., thinking may seem delusional)." Thought disorder is not well represented in five-factor space, and even Axis II is limited in addressing disordered thinking that emerges only under certain circumstances. We suspect, for example, that much of the "comorbidity" found between borderline and paranoid personality disorders reflects the failure to distinguish the chronic suspiciousness of the paranoid patient (well indexed by the Big Four or Big Five facet of mistrust) from the contingent malevolent expectations of the borderline patient (which has no counterpart in any trait model). The contingency of malevolence in patients with borderline personality disorder has been documented empirically by its differential elicitation by stimuli with different affective "pulls" (Westen, Lohr, et al., 1990).

There is no inherent reason item sets used to derive trait structures cannot include eliciting conditions (e.g., the item from the SWAP-200, cited earlier, that includes the qualifier "when distressed"). Such qualifiers are not, however, consistent with a lexical approach to deriving items from everyday language, if the goal is to represent traits adjectivally, because single-word descriptors (adjectives) by definition cannot easily express context or qualification. Regardless of the item set, however, an important challenge ahead for taxonomists using factor analysis to derive clinically useful trait constructs will be to find ways to avoid the loss of resolution vis-à-vis eliciting conditions and qualifiers that comes with factor-analytic aggregation. For example, factor analysis is likely to group together aggression differentially expressed toward one sex or the other, subordinates, peers, and authority figures under the broader rubric of "hostility" or "aggression," but this loses precisely the distinctions that are likely to be clinically useful. Trait descriptions using the SWAP are not immune to this criticism, which we have attempted to address, as in the case study above, by providing a narrative description using items written in everyday clinical language along with a trait profile. However, a more elegant mathematical way of preserving some of the complexity of idiographic description that does not wash out the activating conditions as systematically as factor analysis tends to do would certainly be a welcome development.

Aside from their relative inattention to context or activating conditions, widely used trait models generally fail to addresses internal psychological processes in a way that clinicians find useful. Many psychological processes (mental states and their conditional transformations) that can be captured by an instrument such as the SWAP (designed for clinically experienced observers) are difficult to represent using more common self-report trait measures. Consider the following psychological processes and the SWAP-II items designed to assess them:
• Cognitive style: “Tends to perceive things in global and impressionistic ways (e.g., misses details, glosses over inconsistencies, mispronounces names).”

• Affect regulation: “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).”

To what extent such processes could be captured by self-reports is unknown, but we suspect the fact that these processes are largely not available to introspection (i.e., they are implicit rather than explicit) and the fact that they generally have not been captured in over 60 years of objective testing may provide an indication. At the same time, it seems highly unlikely that the traits identified by trait theorists (particularly the Big Four psychopathology traits) that have proven so generative of research, replicable across samples and instruments, and useful for behavior genetic (and, increasingly, genetic and neuroimaging) research could be of little relevance from a clinical standpoint. One potential strategy for integrating traditional trait approaches with more process- and function-oriented clinical language might be to correlate the 200 items of the SWAP with measures of the Big Four or Big Five. Thus, one might begin to translate the empirical lexicon of the FFM or Big Four psychopathology traits into a more clinically rich language.

In any case, it seems likely that the most important hurdle to be faced by trait researchers whose goal is to replace traditional personality disorder diagnoses with factor-analytically derived traits in DSM-V will be to demonstrate not their empirical strengths, which are considerable, but their clinical utility. The DSM is intended as a manual for clinicians as well as researchers. However, over the past 25 years, revisions have tended to focus on increasing its utility for research purposes (e.g., identifying diagnostic criteria that may be readily assessed by structured interview and hence useful in identifying “clean” diagnostic groups), with the assumption that such changes will “trickle down” to clinical practice in the form of better re-
search evidence. As the manual has become more unmanageable, however, with its explosion of diagnostic categories and laundry-list criterion sets that lack any grounding in functional or causal relations that are helpful in human categorization (see Kim & Ahn, 2002; Westen & Bradley, 2005), it may have become less rather than more relevant to clinical practice. Thus, it seems likely that the revision process for DSM-V may take more seriously questions of clinical utility (First et al., 2004).

**Conclusions**

We conclude with one final thought regarding the relation between personality and psychopathology. A prime characteristic of the approaches to personality that emerged from the clinic during the past century, beginning with the theories advanced by Freud to explain and guide clinical observation and intervention, was that they were personality theories, not just models (in the more narrow sense). Thus, not only did they describe domains on which individuals differed, but they also specified functional relations among mental processes and behavior and implicit and explicit rules that could guide interpretation and clinical understanding of a given patient.

Consider, for example, the case of a young woman interviewed by one of us at a clinical case conference some time ago (Westen, 1995). The patient had been orphaned until her 10th year and, like many such children, had grown up to have difficulty forming attachments as a young adult. She spoke in clipped sentences, offering as few words as possible. Indeed, this had made her a very frustrating patient on the inpatient unit where she was being briefly treated. About 10 minutes into the interview, the interviewer asked her if she also spoke to herself in clipped sentences—that is, in her own mind. The patient was initially startled by the question, having never thought about her own mental processes this way. After some reflection, she acknowledged that this was indeed the case and became engaged in the first genuine dialogue in which she engaged during her hospitalization. What became clear to her over the next few minutes was how she used this strategy to avoid painful thoughts, particularly about herself. If she avoided reflection, she avoided the object of reflection.

The interviewer had never asked a patient this question before. So, what suggested that this might be a fruitful line of inquiry? What guided the interviewer was a dynamic theory of affect regulation, which suggested that the patient’s clipped way of speaking could be a way of protecting herself interpersonally, protecting herself intrapsychically, or both. By exploring the meaning to her of letting her thoughts flow without rigidly controlling them, he and the patient learned something very important that might not be readily captured by adjectival descriptions such as “introverted” or
“taciturn” that are no doubt accurate descriptors of her behavior but do not offer enough help in understanding who she is—that is, her personality.

Our point is that a clinically useful theory of personality and psychopathology must lead both to accurate predictions and to interpretive understanding. In this respect, empiricist and hermeneutic philosophies of science are less contradictory than complementary, as each offers one way of using—and testing—a theory (Westen & Gabbard, 1999; Westen & Weinberger, in press). Although clinical observation is far less useful than more systematic empirical methods in deciding among competing hypotheses, an adequate theory of personality cannot choose between utility for prediction and utility for interpretive understanding. All of our structures of empirical inquiry are essential in hypothesis testing and in model generation, but they do not guarantee that we test the right hypotheses or that the hypotheses we test are the ones most useful for clinical practice. As we move into an era in which personality once again assumes its place as central to the understanding of psychopathology, we may find that clinical approaches to personality are not only clinically useful but also theoretically indispensable.

NOTES

1. In keeping with psychoanalytic parlance, we use the terms personality, character, personality structure, character structure, and personality organization interchangeably to describe the patterned organization of personality processes.

2. Factor analysis of items (for simplicity, assuming the items assess the domains of personality relatively comprehensively) typically reveals trait dimensions that cut across domains rather than segregates them.

3. Kernberg tied this continuum to developmental fixations and regressions, which is probably not an optimal way of characterizing the relation between development and psychopathology. He also initially did not distinguish episodic psychosis (e.g., mania with psychosis in an otherwise relatively high-functioning personality) from chronic psychosis, although he has done so more recently (Kernberg, personal communication to DP; December 2003). Nevertheless, the basic framework he offered is extremely useful from a descriptive and dynamic point of view.

4. To what extent this problem is inherent in the use of factor analysis for taxonomic purposes is unclear. For example, in prior research, we a priori identified multiple clinically relevant subdomains of functioning involved in object relations, such as complexity of representations of people, affect tone of relationship paradigms (the extent to which the person tends to expect and experience relationships to be pleasurable or painful), capacity for emotional investment in relationships (ability to care about another person), self-esteem, and dominant interpersonal concerns (Westen, 1991b). Each of these dimensions, coded from narrative data using a five- or seven-point scale, is associated with predictable correlates. To see if we could reproduce something like this structure factor ana-
lytically, we developed a questionnaire that assessed the same domains of functioning by using many of the descriptors from the narrative coding manual as items. Instead of identifying domains of functioning, however, factor analysis grouped items by type of psychopathology, cutting across domains. For example, a borderline pattern emerged that included items suggesting a tendency toward black-and-white representations, malevolent affect tone, a self-serving approach to emotional investment, self-loathing, and interpersonal themes such as rejection or abandonment. We doubt that a factor analysis of statements from the coding manual of Loevinger’s Sentence Completion Test (Loevinger & Wessler, 1970), which has generated hundreds of studies demonstrating impressive construct validity (Westenberg et al., 1998), would similarly reproduce her dimension of ego development.

5. Although some researchers may be concerned about “contaminating” the diagnostic manual with considerations of clinical utility, we would suggest that if clinicians do not find empirically derived models or diagnoses clinically useful, we should consider their response data and should try, in a nondefensive way, to understand that response. Practitioners in other areas of medicine tend to welcome discoveries from the laboratory, such as new treatments, whereas clinical psychologists and psychiatrists often find academic research academic. One hypothesis, of course, is that the minds of clinicians are simply filled with cognitive biases and “romantic” ideas of knowledge that cloud their thinking (Garb, 2005), and hence what is needed is psychoeducation (or more effective “dissemination,” e.g., of knowledge about new treatments). An alternative (or complementary) hypothesis, however, is that the different observational vantage points of clinicians and researchers might mean that they have something to teach one another. In this respect, we might pause to wonder why clinicians hypothesized the importance of personality (or unconscious processes) in psychopathology for decades, while researchers were asserting, based on the best available evidence, that they could study phenomena such as depression independent of the person who happens to be hosting the symptom. If clinical observation leads to the recognition of functional domains that are inadequately addressed by models of personality structure derived from self-reports, we should welcome their observations and bring them into the research process. Our own view is that experienced clinical observers provide a vast untapped resource for research if we simply quantify their observations using the same psychometric procedures applied for decades to patient self-reports (Westen & Weinberger, 2004, in press).

REFERENCES


Personality Structure as a Context for Psychopathology


Personality Structure as a Context for Psychopathology


Fonagy, P. (2002). Understanding of mental states, mother–infant interaction, and the


Ego Impairment Index across the schizophrenia spectrum. *Journal of Personality Assessment*, 80, 50–57.


sonality feature, and instability of daily negative affect and self-esteem. Journal of Personality, 72, 111–137.


Personality Structure as a Context for Psychopathology


of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. Psychological Bulletin. 130, 633–663.