of personality functioning and of personality traits (Skodol et al., 2015), to address the myriad shortcomings of traditional categorical constructs of PD, as enumerated by Hopwood. The majority of personality experts, while appreciating that personality pathology was fundamentally dimensional in nature, favoured a hybrid dimensional–categorical model as an intermediate step in the transition from categorical to dimensional diagnosis in the DSM (Bernstein et al., 2007). A vanguard of eventual Work Group members developed an initial hybrid model, which was published at about the same time as the Work Group convened (Krueger et al., 2007).

A pathological, rather than a normative, trait model was developed since the DSM is a classification of psychopathology. The model was refined iteratively in samples of community members with a history of mental health treatment (Krueger et al., 2012). The resulting model includes five broad trait domains—negative affectivity, detachment, antagonism, disinhibition, and psychoticism—corresponding to the pathological poles of four of the five domains of the Five Factor Model: neuroticism, low extraversion, low agreeableness, and low conscientiousness. Each of the five trait domains subsumes from three to eight more narrow trait facets, based on the community surveys. The trait model included in the final Alternative DSM-5 Model for Personality Disorders (AMPD), Hopwood agrees, can be used effectively to capture the relatively stable aspects of personality pathology.

For the more dynamic component of the AMPD, a literature review was conducted to discern aspects of personality pathology with specificity for PDs, concurrent and predictive validity, and rater reliability (Bender et al., 2011). Since personality traits predispose to both PDs and other type of psychopathology (e.g. Kotov et al., 2017), the AMPD required a component which would help distinguish PDs. Four elements of personality functioning stood out with respect to specificity and reliability: identity, self-direction, empathy, and intimacy. These were incorporated into a 5-point severity scale of impairment in personality functioning, the Level of Personality Functioning Scale (LPFS). Secondary data analyses of over 1750 patients and community members showed that increasing levels of impairment on the LPFS predicted a PD diagnosis, its severity, and its complexity (Morey et al., 2011).

Hybrid dimensional categories were eventually constructed to represent six specific PDs and a residual category of personality disorder-trait specified (PD-TS) for all other PD presentations. Criterion A consists of moderate or greater impairment in personality functioning, represented by two or more disorder-specific characteristic impairments. Criterion B consists of a required minimum number (and sometimes configuration) of pathological personality traits. Traits assignments and diagnostic thresholds were empirically based (Morey et al., 2013; Morey et al., 2016; Morey & Skodol, 2013).

Numerous studies have documented the clinical significance of personality traits and impairments in personality functioning with respect to the prediction of important life outcomes (Morey et al., 2012; Ozer & Benet-Martinez, 2006; Roberts et al., 2007; Skodol, 2018) and to the planning and outcome of treatment (Bender et al., 2011; Morey et al., 2014). Thus, one might conclude that trait profiles and levels of impairment in personality functioning serve Kendell and Jablensky's purposes of 'diagnosis' as described earlier and ought to be incorporated into clinical practice. Although PDs may be fundamentally interpersonal, other models for the development of inflexible and maladaptive ways of perceiving, thinking, and relating exist, such as conflict and defence in the psychodynamic model (Bender & Skodol, 2007) or disturbed attachment in the social cognitive model (Herpertz & Bertsch, 2015). One advantage of the DSM-5 AMPD is that it is integrative and can be understood and assessed according to the core principles of several prevailing models of personality and PD (Waugh et al., 2017). Thus, diagnosis might be standardized according to the AMPD, and formulation might be individualized according to the assessor and his or her theoretical understanding of personality pathology development and its treatment.

Moving Toward an Integrative Understanding of Personality Disorder: It's About Time

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Abstract: This commentary makes three key points in response to Hopwood's target article. First, we propose that it is time for clinical personality research to move forward by investigating the unique descriptive information and dynamics of the alternative DSM-5 trait model. Second, we argue that it is time to integrate clinical trait and dynamic models directly, without relying on categorical PDs as intermediaries. Finally, we wholeheartedly support Hopwood's call for increased dialogue and collaboration between basic and clinical personality psychologists. © 2018 European Association of Personality Psychology

In a stimulating target article, Hopwood emphasizes three key points. First, it is time for research on categorical and dimensional models of personality disorder (PD) to go beyond simply mapping traits onto categorical PDs. Second, interpersonal theory provides a framework for understanding the within-situation dynamics that underlie maladaptive PD behaviours. Third, it is time to reintegrate basic and clinical personality psychology. In this commentary, we propose

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taking each of the first two points a step further. We wholeheartedly agree with the third point and provide some additional, anecdotal evidence to support it.

Mapping Traits onto Categorical PDs: Time to Move On

As Hopwood discusses in the first third of the target article, much recent research has focused on empirically mapping the dimensional, Alternative DSM-5 Model for Personality Disorders onto the more traditional, categorical model of PDs retained from DSM-IV's Axis II. We agree with Hopwood that this research is approaching the limits of its usefulness. The limitations of the categorical, DSM-IV PDs have been well known for many years: in one study, 74% of PD experts agreed that the categorical approach should be replaced and 80% believed that personality disorders are extreme variants of normal personality (Bernstein et al., 2007). High PD co-morbidity, heterogeneity within diagnoses, and a paucity of empirical support plague the categorical diagnostic structure. Proponents of the categorical model have defended its clinical utility. However, a trait-based approach also offers advantages to clinicians. Effective intervention techniques can focus on problematic patterns, such as the specific facet traits of emotional lability or rigid perfectionism, rather than a broad diagnostic category. Additionally, the alternative model encourages clinicians to assess any patient for maladaptive traits that may impact the course of a clinical disorder or complicate treatment.

Growing empirical support for dimensional models of personality pathology suggests that it is time to break through the traction of DSM-IV diagnoses and shift research attention to DSM-5 trait domains and facets (Waugh et al., 2017). These DSM-5 traits can be used to recover much (but not all) of the descriptive content from the DSM-IV PDs. Further progress toward describing patterns of PD behaviour will not come from documenting these associations in ever greater detail. Instead, Hopwood argues that progress will come from better understanding the within-situation and within-person dynamics that underlie pathological traits. We agree that this is one important way to move PD research forward. However, we also propose an additional way to move forward: rather than further documenting how the DSM-5 traits *overlap* with the traditional PD categories, it is time to start empirically investigating what is *unique* about the trait model. What new descriptive information do the DSM-5 traits provide? And how can clinicians make best use of this additional information? For example, do the DSM-5 traits facilitate treatment of cases traditionally classified as personality disorder not otherwise specified (PDNOS)? As clinicians and researchers increasingly shift their focus to the alternative trait model, we believe that there is still much to learn about the value added by this model's greater diagnostic coverage and flexibility.

Using Interpersonal Theory to Understand PD Processes: Time to Cut Out the Middleman

In the remaining two thirds of the target article, Hopwood describes how interpersonal theory can be used to understand the within-situation dynamics that underlie PD. Specifically, for each of four categorical PDs, he describes a prototypical dynamic sequence: the actor misperceives a key feature of their interpersonal situation, which activates negative affect and motives, which produces maladaptive behaviour; in response, the partner perceives the actor's behaviour as inappropriate, which activates negative affect and motives in the partner, which produces interpersonal behaviour that reinforces the actor's initial misperception.

We agree that interpersonal theory, and especially this recursive sequence of interpersonal perception, motivation, affect, and behaviour, provides a useful lens for understanding the dynamics by which PD behaviour is maintained and reinforced. However, we propose taking this idea further by applying it directly to the DSM-5 traits, rather than the traditional PD categories. Versions of three DSM-5 traits are already incorporated, more or less directly, into the sequence that Hopwood describes: DSM-5 detachment is similar to low dominance/agency, DSM-5 antagonism is similar to low warmth/communion, and negative affectivity is similar to negative valence (see Hopwood's figure 1). How might the two remaining DSM-5 traits, disinhibition and psychoticism, influence interpersonal perceptions, motives, affect, or behaviour? For example, how might a highly disinhibited individual's orientation toward immediate gratification affect their regulation of interpersonal motives and behaviour? How might a highly psychotic individual's odd perceptions or beliefs affect their interpersonal behaviour, as well as their partner's response? More generally, we propose that the interpersonal dynamics model elaborated by Hopwood and the DSM-5 trait model have both reached a point where they can be integrated directly with each other, without needing to use the traditional PD categories as an intermediary. Promising research along these lines is now underway (e.g. Wright, Pincus, Hopwood, Thomas, Markon, & Krueger, 2012), but much work remains to be done.

Integrating Basic and Clinical Personality Psychology: Going Back to the Future

Throughout the target article, Hopwood laments the historical division between basic and clinical personality psychologists and calls for further dialogue and collaboration. Indeed, our own personal history illustrates this division and its unfortunate implications. Our psychology department at a small liberal arts college historically included a single personality/clinical psychologist. About a decade ago, this single position was split into a separate personality psychologist and clinical psychologist (the two of us). Despite working side by side in a small department for years, and despite our shared interest in dimensional personality models, this commentary represents the first scholarly collaboration between the two of us! However, as consensus around trait models of normal and abnormal personality continues to grow, we are optimistic about the prospects for future collaborations--between the two of us and between basic and clinical personality psychologists more broadly.

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