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## Character strength and character disorder : an investigation into how personality disorder diagnosis intersects with character strength measurements

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Josh Tecu  
Character Strength & Character  
Disorder: An Investigation into How  
Personality Disorder Diagnosis  
Intersects with Character Strength  
Measurements

## ABSTRACT

On the eve of the release of the *Diagnostic and Statistical Manual 5*, with major revisions planned in its diagnostic approach to personality disorder (PD), qualitative research was conducted via face-to-face interviews to explore the perspective of seasoned mental health clinicians regarding their experience working with personality disordered individuals, and how that experience squared with current debates within personality science and positive psychology. Eight experienced clinicians were asked how they saw PD in regard to character strength, what relationship they imagined existed between the two, and whether they saw them as existing on the same dimensional axis. Participants chose from a list of strengths provided the specific strengths they believed they saw in PD clients they had worked with. Major findings were that clinicians endorsed a dimensional perspective, saw PD features on a continuum with normative personality, and saw strengths in relationship with specific PD diagnosed clients. Combined scores indicate a relationship pattern, with borderline PD overwhelmingly paired with Persistence as a character strength. The research also uncovered controversies within the field regarding utilization of the Axis II due to concerns about stigmatizing clients, and that the diagnosis as presently constructed did not adequately factor in the presence or impact of trauma in the diagnostic formulation.

**CHARACTER STRENGTH & CHARACTER DISORDER:  
AN INVESTIGATION INTO HOW PERSONALITY DISORDER DIAGNOSIS  
INTERSECTS WITH CHARACTER STRENGTH MEASUREMENTS**

**A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements of  
the degree of Master of Social Work**

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**2013**

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## Chapter I

### Introduction

The following exploratory study was inspired by the emerging positive psychology movement, with its focus on the human strength, fulfillment, and flourishing. In particular, it is inspired by leading figures of that movement, Christopher Peterson and Martin Seligman, and their effort to create a “manual of the sanities,” (Easterbrook, 2001, p. 23) to act as a counterweight to the *Diagnostic and Statistical Manual of Disorders (DSM)* and its dominance over the mental health field (APA, 2000). The authors devised their work with the DSM specifically in mind, to redress what they perceived as its limitations for focusing on only “half of the landscape of the human condition” (p. 4). *Character Strengths and Virtues: A Handbook and Classification* (2004) attempts an organizational scheme of human virtues with assessment strategies.

The past concern of psychology with human problems is of course understandable and will not be abandoned anytime in the foreseeable future. Problems always will exist that demand psychological solutions, but psychologists interested in promoting human potential need to pose different question from their predecessors who assumed a disease model of human nature. We disavow the disease model as we approach character, and we are adamant that human strengths are not secondary, derivative, illusory, epiphenomenal, parasitic upon the negative or otherwise suspect. (p. 4)

The present research does not presume that character strengths are “parasitic upon the negative” but seeks to investigate what possible relationship exists within the human personality structure between these two stable “enduring patterns of inner experience and behavior” (APA, 2000, p. 685), namely personality disorder and character strength. The two subjects are not naturally combined in either the classification tools being investigated, Peterson and Seligman’s or the DSM, but the two lend themselves to comparison because they are non-episodic, “permanent” personality formations. Personality Disorder (PD) is currently defined by the DSM-IV-TR (APA, 2000) as: “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (p. 685). Character is defined by Peterson and Seligman (2004) as “moral excellence” (p. 8) and seen as a collective amassment of “positive traits” (p.11) that are “stable and general but also shaped by the individual’s setting and thus capable of change” (p.10).

The upcoming release of the DSM-5 will include a re-conceptualization of PD, in part using dimensional personality trait scores, in particular a variation on the Five-Factor Model (FFM) of personality of McCrae and Costa (1996) as a criteria of diagnosis. These revisions suggest if nothing else that our understanding of PD is incomplete and ongoing and, further, that current trends of empirical research are pointing toward dimensional, trait-based approaches.

The clinical consequences of these two trait-based approaches, character strength and FFM informed PD, are yet to be determined. However, both the DSM and positive psychology efforts will be incomplete without an attempt at integration between the two.



It is the goal of this proposed research study to contribute to a better understanding of personality and, hopefully, to work beyond a mere personality classification, normal or abnormal, towards a personality *taxonomy*. “A good taxonomy has the benefits of a good theory: It organizes and guides the activity of an entire discipline” (Peterson & Seligman, 2004, p. 6).

While clinical applications are beyond the scope of this research, an improvement in the understanding of PD has the potential of contributing to the goals of social work of providing better aid and care for PD afflicted individuals. Further, if PD can be viewed in terms of potential character strength, it adds to social workers ongoing effort to strengthen and empower clients.

The research question explored in the following study was: In what ways do clinicians conceptualize personality disorder and character strength? Do they see a value in moving towards a theoretical framework that sees PD and character strengths as existing on the same dimensional axis? What are the possible strengths and weaknesses of this approach from a clinical perspective?

## Chapter II

### Literature Review

#### Introduction

At the time of this writing, the mental health community is poised on the verge of a great transition in its diagnostic approach to personality disorder as it moves from the DSM-IV-TR (APA, 2000) to the upcoming DSM-5. According to the most recent proposal (<http://www.dsm5.org/proposedrevision/Pages/PersonalityDisorders.aspx>), the later edition proposes to reduce the distinct categories of PD from ten to six, and to assess these diagnostic categories according to five separate criteria. Of these, the two most significant are Criterion A) which essentially reprises the DSM-IV's older categorical model; and Criterion B) which provides a new trait-based approach that has its roots in contemporary personality science, in particular the Five Factor Model (FFM) of McCrae and Costa (1996). This proposed hybrid, two-step approach of the DSM-5 attempts to straddle an ongoing categorical vs. dimensional debate, with the changes paying tribute to the growing consensus and expanding empirical support of a more trait-based, dimensional approach.

Left out of the ongoing categorical vs. dimensional debate is the strengths perspective, a "generative theory" of social work that over the past two decades has come to stand as a sort of guiding ideal of the profession as it engages in clinical mental health practice. The strengths perspective could be defined as a focus on empowerment, capacity building, solution orienting, asset creating and motivation enhancing to offset a perceived client debilitating "deficit mindset" that is seen as pervading the mental health

field (McMillan, Morris, & Sherraden, 2004). One the strength perspective movement's principal target, often portrayed as the chief tool for reinforcing this very "deficit mindset" the movement condemns, is the DSM itself. While the strengths perspective is rooted in the work of many (see Weick, Rapp, Sullivan, & Kirsthardt, 1989; Kristhardt, 1994; Rapp, 1998; Early & Glenmave, 2000) one of its strongest voices is Dennis Saleebey (1992, 1996), author of one of its most definitive texts, *The Strengths Perspective in Social Work Practice* (1997). To offset what is seen as the DSM's pernicious influence, Saleebey calls for the creation a counter DSM in his essay, *The Diagnostic Strengths Manual?* (2001).

Positive Psychology, another recent movement within the field of mental health, has in essence answered Saleebey's call with the release of Peterson and Seligman's *Character Strengths and Virtues: A Handbook and Classification* (2004), an early attempt to create a comprehensive categorical classification of strengths. While not precisely the same, the goals of Positive Psychology compliment the strength perspective's ideals in their effort to correct mainstream psychology's emphasis on pathology by focusing on our capacity for health, fulfillment, and happiness, especially as obtained through the power of individual character strength and virtues. For the proponents of Positive Psychology, this cause is often best advanced by investigating human strengths with empirically validated research (e.g., Ong & Van Dulmen, 2007; Seligman, Steen, Park & Peterson, 2005). While character strengths and personality traits are often defined slightly differently, in truth the two concepts are difficult to tease apart. "Character strengths are conceptually quite similar to similar to personality traits" (Nofle, Schnikter, & Robins, 2011, p. 207). "They [both] exist in degrees and can be

measured in individual differences” (Peterson and Seligman, 2004, p. 603). Robert McCrae, one of the principal authors of Five Factor Model (FFM) of personality, usefully embeds the two concepts: “Psychological well-being is strongly influenced by personality traits, and traits themselves are quite stable over long periods of time” (2011, p. 193). Nofle, et al (2011) even contends that trait models like the FFM are in truth measuring positive character strengths within the factors themselves, a high score for each factor—Extraversion, Agreeableness, Conscientiousness, Emotional Stability, and Openness to Experience—being itself a socially desirable net positive.

For the purposes of the present research, we will demonstrate that there exists a rich and growing literature of empirical and theoretical research that demonstrates that personality trait models such as McCrae and Costa’s FFM can powerfully capture and describe both the constructs of character strength and of personality disorder. While none of the overlapping measurements are perfect or complete between the three domains—character strengths, PD, or normative personality—there exists enough shared commonality among these constructs to support the implication that they exist on one shared personality trait continuum. Further, we will argue that, aside from being empirically supported, there are advantages in the clinical and social justice domains in conceiving of a broad-band, dimensional approach, i.e., that it addresses the very concerns of the strengths based perspective that Seleebey gives voice to by challenging a deficit mindset in social work. Lastly, aside from the virtues of accuracy, empirical validation, and client empowerment, we suggest that a broad-band model of human personality provides numerous advantages in that way we *conceive* of human personality, one which offers potential benefits in multiple domains including research, education,

public policy, social justice and clinical intervention. For example, such a model suggests research into the possible relationship—perhaps even a compensatory relationship—between maladaptive and adaptive personality constructs, i.e., personality disorders and character strengths. To what degree is a disordered personality construct adaptive? To what degree is a “strength” socially constructed or contextually based? To what degree do deficits play a role in the construction of our strengths and vice versa? Attempts to answer such questions will continued to be hampered as long as a gap remains within the literature of psychology and social work of exploring the possible connection between character strength and personality disorder.

Within the following lit review chapter, section two will provide some of the history of personality science, from its origins in classical antiquity to the contemporary DSM-IV-TR. Section three will deal with current trait-based approach to personality science, including the FFM or “Big Five” trait model of personality and its ability to capture PD and character strength constructs. Section four will explore the ongoing categorical vs. dimensional debate, and the utility of the proposed DSM-5 model. Section five will expand on the strengths perspective critique of the DSM, approach. Section six will explore Positive Psychology’s contribution through Peterson and Seligman’s classification system of strengths by investigating the empirical research done on it. Section seven will offer concluding remarks.

### **Personality Science, Personality Disorder and the DSM**

The history of personality classification is long, diverse and, alas, not always worthy of celebration in light of social work values. Ancient classifications include the

four temperaments of Hippocrates that sprang from imbalances in his theorized four humours of the body: phlegm, blood, yellow and black bile (Jouann, 1999). The Greek zodiac, still retained in common practice today, could also be seen as system of encoding personalities through astrological means, i.e., as a way of determining not only what will happen to a person but what kind of person one fundamentally *is* (Snodgrass, 1997). Many other systems, across the globe and throughout the ancient and feudal periods, were conceived for sorting and classifying types of essential human identity and patterns of behavior. Racial, ethnic, and tribal codifications of human identity into fixed hierarchies of lesser and greater, most notoriously in the white supremacy notions that fueled Western Imperialism, could be seen as another such system (Painter, 2010). The Calvinist tradition of the chosen elect and the sinful rest could be seen as yet another (Dakin, 1946).

Added to this project, constructions of fundamentally aberrant personality types were conceived. Though not seen as precisely mentally ill, such types were seen as at odds with healthy functions, abnormal, disordered—not sick so much as wrong. In the modern era, German psychiatrist Julius Koch (1889) postulated the existence of the “psychopathically inferior” personality that he theorized was the product of inherited degeneration. Emil Kraepelin (1904), the great founder of modern scientific psychiatry and pioneer of the precise, descriptive categorical style now so evident in the latest DSM editions, later expanded to seven types the list of “psychopathic personalities” that included the “excitable”; the “irresolute”; the “eccentric”; the “wastrels” who seek out pleasure, gambling and alcohol; and “querulants” who were quarrelsome.

Kraepelin's classification is foreign to today's concept of personality disorder, and as such it may provide a useful illustration of the essential subjectivity and innate bias necessarily embedded in a project involving humans attempting to classify the personal essence of other humans. Among many lingering questions: are not all of the above "disorders" labels for characteristics found throughout the population as a whole and, indeed, within every one of us? Who has not been at times a wastrel, excitable, or quarrelsome? At what point do we say that these qualities define a person? As the personality researchers Krueger and Eaton (2010) recently put it, "The concept of disorder involves value judgments and is therefore inherently a matter of societal and professional opinion" (p. 103). Or, put even more pungently, the historian of psychiatry Edward Shorter wrote recently in *The New York Times* (December 2, 2012), "Personality disorder exists not as natural phenomenon but as cultural phenomenon." Further, "each culture compiles a list of the personality traits it dislikes, or that are harmful to the further flourishing of things; and in [Kraepelin's] Imperial Germany being querulous by challenging authority or being irresolute by not seeing France as the enemy were viewed as disorders."

Allport and Odbert (1936), the two great pioneers of the lexicon of personality science, attempted to steer the field away from such evaluative moral judgments, bemoaning the historical tendency Shorter observed above "of each social epoch to characterize human qualities in the light of standards and interests peculiar to the times." Yet, while they urged researchers to constrain themselves to descriptive traits alone, freed from evaluative questions of social desirability or undesirability, the authors reveal clearly that the subject of their study, *personality*, was in truth the very same as

*character*, the latter merely seen through the prism of morality. “Character is personality evaluated, and personality is character devaluated” (Allport, 1937, p. 52).

The current classification system that has arguably the greatest influence on clinical interpretation of personality is the *Diagnostic and Statistical Manual of Mental Disorders*. While the original DSM came out in 1952, by the 1970s a neo-Krapelian revolution in psychiatry shifted the emphasis to reliability of classification, with the narrative paragraphs of the DSM-II giving way to the explicit criterion lists of DSM-III and beyond (APA, 2012a). The current edition, the DSM-IV-TR (4<sup>th</sup> ed.; APA, 2000) labels 10 putatively categorical form of personality pathology, conceptualized as qualitatively different from most other mental disorders and placed on a separate axis (Axis II) “to ensure that clinicians would consider their potential presence, even when the symptoms of another major mental disorder were prominent in the clinical picture” (Krueger & Eaton, 2010).

Among the changes proposed for the upcoming DSM-5 PD criteria (APA, 2012b) will be a reduction of the personality disorder categories, down from ten to six: 1) Antisocial, 2) Avoidant, 3) Borderline, 4) Narcissistic, 5) Obsessive-Compulsive, and 6) Schizotypal. Discarded will be the old DSM-IV’s Paranoid, Schizoid, Histrionic and Dependent personality disorders. These categories will be assessed according to five proposed criteria. Criterion A. involves impairment of self and interpersonal functioning tailored to each PD, and corresponds closely with the DSM-IV’s older model. Criterion B. provides the newer, trait-based approach that has its roots in the five-factor model. Criterion C. assesses stability of symptoms across time and situation. Criterion D. attempts to discriminate culturally or developmentally normative features of personality



from pathological ones. Finally, Criterion E. attempts to rule out possible medical or substance-related causes for personality factors.

Yet a fundamental question persists within the field of psychopathology of whether PD lies on a continuum with normal personality traits or whether PD is a distinct type, apart from normative personality. This question has taken on heightened significance with the imminent publication of the DSM-5. The problems of categorical classifications of PD as exemplified by the DSM-IV-TR and the newly proposed DSM-5 Criterion A. approach are by now well established. Among these are: 1) The high rates of co-occurrence of the various defined disorders and their ongoing boundary and definitional issues (Krueger & Tackett, 2003; Widiger & Clark, 2000). 2) The arbitrary nature of symptom cutoffs (Huprich & Bornstein, 2007; Widiger & Clark, 2000). 3) The temporal instability of symptoms, which calls into question the very “enduring pattern of inner experience” (APA, 2000, p. 685) that is the DSM’s supposed hallmark of the diagnosis (Lenzenweger, Johnson, & Willet, 2004; Skodol, 2008).

### **The FFM (and other models) to map PD and Character Strength**

It is a premise of the research that the values and commitments of social work would be better upheld if there existed a map or framework that conceptualized strengths and pathologies with equal vigor and understanding, as well as a shared tool of measurement that garnered descriptive informational understanding of both parts of what research suggests is a shared personality continuum. With such a broadband scale in existence, a better understanding of how strengths and deficits are inter-related might be

possible. Yet to know how best to conceptualize human personality in such a way, it is helpful to have a broad theoretical perspective. Five-Factor Theory (FFT) provides one.

While numerous alternative versions of dimensional personality trait models have been proposed over the last half-century, probably the most predominant form currently is the Five Factor Model (FFM) of general personality functioning (McCrae & Costa, 2008), otherwise known as the Big Five structure. Within the past few decades it has emerged as the consensually accepted taxonomy of personality traits (Goldberg, 1993; McCrae & John, 1992). The “Big Five” refers to the five broad, independent traits, bipolar domains including Extraversion (vs. introversion), Agreeableness (vs. antagonism), Conscientiousness (vs. disinhibition), Emotional Stability (vs. neuroticism), and Openness to Experience (vs. closedness). Decades of research have lent support to the predictive validity, temporal stability, heritability, and cross-cultural universality of the Big Five (John et al. 2008).

FFT uses a systems theoretical approach to make sense of findings from trait research (McCrae & Costa, 1996, 2008). The basic model, shown in Figure 1.1, makes a crucial distinction between *basic tendencies* of personality trait factors, which the FFM asserts are exclusively biologically based; *characteristic adaptations*, which would include habits, attitudes, roles, and relationship style; and *self-concept*, the self-schemas and personal myths that are the outgrowth of characteristic adaptations.

That FFT traits are exclusively biologically based, completely insulated from direct input from the social environment, is a somewhat radical position. It does, however, have support in well-established findings. Bouchard and Loehlin’s (2001) research supports traits have a genetic basis but are not influenced by the shared

environment, including shared parenting, schools, and neighborhoods. Further, the findings of McCrae et al. (2005) seem to support that the view that the same personality traits, with the same structure, are found in widely divergent cultures across the globe. Yang, McCrae, and Costa (1998), even seems to go so far as to suggest that the various events and upheavals of history have little lasting impact on trait levels. Lastly, Terracciano et al. (2005), asserts that, while traits can and do change, they are highly stable across long periods in adulthood, despite the vicissitudes of life circumstances.

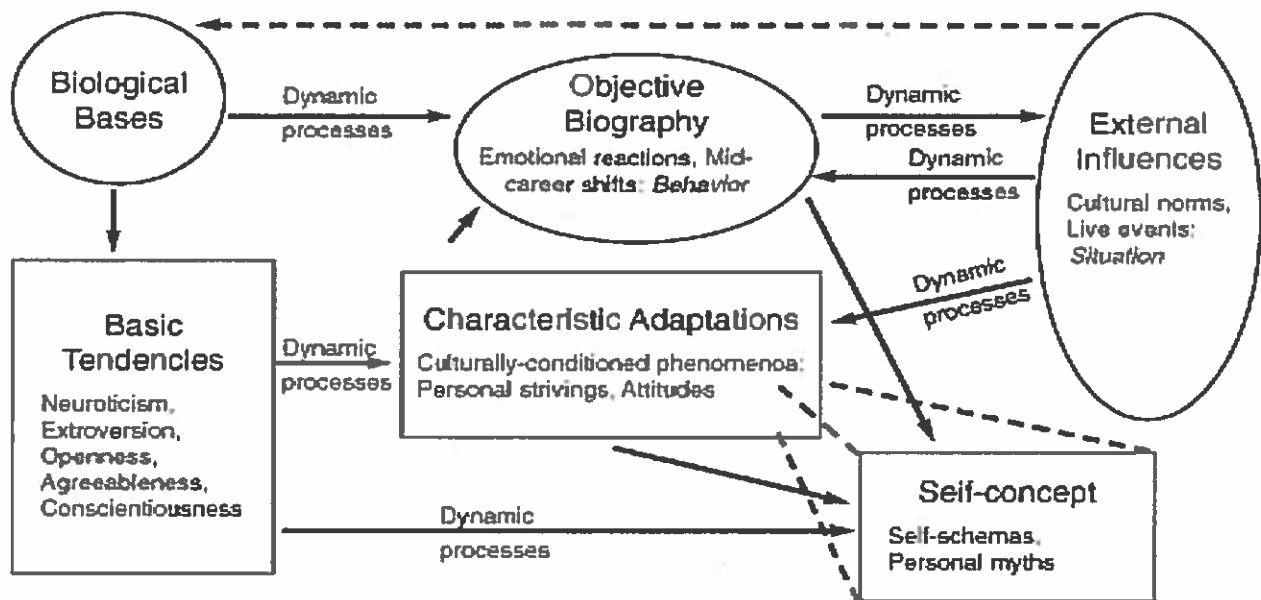


Figure 1.1 The personality system described by the Five-Factor Theory. Boxes indicate core components, ellipses are peripheral components. Arrows show the theorized direction of causal processes. Adapted from McCrae, 2011.

Yet, while McCrae and Costa’s “biological only” perspective of traits in Five-Factor Theory may be supported with robust findings, it could reasonably be argued that, while not wrong, it is at present oversimplified. As McCrae himself admits (2011), the current FFM model does not fully capture the full dimensions of a human being,

“Personality is far more complex than that” (p. 198). Moreover, later research (Roberts &

Mroczek, 2008) powerfully challenges the notion of personality traits as being static entities, unchanging over time. Rather, traits not only can be demonstrated to typically change over time in normative way, they are also often the “true targets” of mental health interventions, including pharmacological ones (Hellerstein, Kocsis, Chapman, Stewart, & Harrison, 2000). Nor does it account for the particular personality constructions—or “characteristic adaptations,” as McCrae phrases it—that FFT theorizes are direct outgrowths of broad trait factors. Such characteristic adaptations are the true subject of the current research, and evidence supports its conceptualization as a category containing both personality disorder and character strength constructs.

Although the FFM includes content that appears to live up to Allport and Odbert’s (1936) conception of a descriptive-only, non-evaluative personality psychology, McCrae and Costa’s system is also clearly evaluative as it relates to character. In general, all of the Big Five traits listed above are socially desirable. A recent literature review of the FFM (Ozer & Benet-Martinez, 2006) examined real world consequential relations of the Big Five found that higher trait levels were positively related to good outcomes at almost levels: happiness; physical and psychological health; spirituality; quality of relationships with peers, family, and romantic others; occupational choice, satisfaction, and performance; community involvement at a social institutional level and reduced criminal activity.

Further, a recent study by Cawley, Martin, and Johnson (2000) employed the lexical approach to explore the concepts of virtue and character into the scientific study of personality for the purpose of creating a virtues scale. Using self-reports of items based on 140 virtue terms, the researchers were able to extrapolate four factors: Empathy

(e.g., concern, understanding, considerate, friendly), Order (e.g., discipline, serious, decent, deliberate), Resourcefulness (e.g., purposeful, perseverance, confidence, sagacity), and Serenity (e.g., meek, forbearance, forgiveness, peacefulness). Most importantly for our consideration of the character evaluative features of the FFM, scales constructed to measure Cawley et al.'s virtue dimensions were reliably associated with FFM dimensions. The findings demonstrate empirical correspondences between their own virtue scale (VS) and the five factors, with correlations ranging from .45 to .63, with the correlations especially high with the factors of Agreeableness and Conscientiousness. These sizable correlations strongly suggest the FFM captures many aspects of good character.

However, as will be echoed in the findings specifically designed to test Peterson and Seligman's (2004) classification below, Cawley's four factors overlapped with the FFM taxonomy but was not fully captured by it and there was no simple one-to-one correspondence of the dimensions of the VS and FFM. Cawley et al.'s difficulties with establishing a clearly identified, conceptually and empirically validated taxonomy of virtues—one that is grounded in trait theory and yet adds information beyond existing trait measurements—prefigured the very same difficulties Peterson and Seligman would encounter with their later Virtue in Action (VIA) system.

Aside from research literature in support of the validity of the FFM as a measure of normal personality (John, Naumann, & Soto, 2008), and of good character (Cawley et al, 2000), there is also considerable research supporting the FFM's utility at capturing personality pathology as defined by the DSM-IV-TR (2000). Saulsam and Page (2004) provided findings suggesting that PD could be understood as maladaptive variants of

FFM traits. While Samuel and Widiger (2008) provide a comprehensive met-analytic review of the FFM and its relationship to personality disorder as defined by the DSM-IV-TR, then extended their work with a facet-level analysis to provide a more specific and nuanced description, finding that the personality profiles generated by the FFM were generally congruent at the facet level with hypothesized FFM translations of DSM-IV PD, although notable exceptions did occur.

Most recently, this dimensional theory, hypothesizing that personality disorder characteristics are matters of degree rather than of kind, was tested using item response theory analyses comparing scales from two personality pathology instruments with scales from an FFM instrument designed to assess normal range personality to look for possible overlap in coverage (Samuel, Simms, Clark, Livesley, & Widiger, 2010). The researchers used a first sample 920 adult individuals from British Columbia (63% female, mean age 33.6, race unmentioned) and a second sample of 680 college students in Kentucky (62%, mean age 19.8, 85% Caucasian, 10% African American, 5% other ethnic group). The first group was given the Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley & Jackson, 2010) and an instrument designed to assess normal range personality, the NEO Personality Inventory–Revised (NEO PI-R; Costa & McCrae, 1992). The second group completed the Schedule for Nonadaptive and Adaptive Personality (SNAP; Clark, 1993; Clark, Simms, Wu, & Casillas, 2010) and the NEO PI-R as well to fulfill course credit.

As mentioned above, the NEO PI-R is a measure of the FFM containing 240 items rated on a 5-point Likert (*agree-disagree*) scale. Data is scored into five broad domain scales—neuroticism, extraversion, openness, agreeableness, conscientiousness—

assessed by six underlying facet scales. Of the two instruments for measure of personality pathology, DAPP-BQ is an containing 560 statements, also rated on a 5-point Likert (*agree-disagree*) scale, which scores data into 18 scales of disorder symptomatology. The SNAP-2 is a 390-item instrument using a True-False format, data scored into 12 lower-order trait scales of disorder symptomatology. The researchers compared the personality instruments using item response theory (IRT), a psychometric approach for evaluating psychological assessment instruments (Emberson & Reise, 2000). IRT can be used to compare the amount of information that existing instruments provide at different levels of a latent trait (Reise & Henson, 2000). An assumption underlying IRT analysis is that the items being analyzed form a unidimensional latent construct, and that the items shares dominant factor in common so as to demonstrate unidimensionality. Mindful of this concern, researchers sorted scales and items from the DAPP-BQ, SNAP, and NEO PI-R into four higher order domains: emotional instability, antagonism, introversion, and constraint. Researchers removed items when unidimensionality were not clearly evidenced.

The results of the IRT analysis seem to demonstrate the validity of the researchers hypothesis that the scales for both general and pathological personality can be combined onto a common metric. Data from the three instruments were reduced into item information curves (IICs) to provide overall estimate of measurement precision, averaging the IICs to control for various scale lengths of the different measurement instruments, termed “mean information curves” (MICs). The results curves illustrated the amount of information in each respective scale on a given trait, and the overlap between them. The results also seemed to support the view that the separate instrument appeared

to be assessing a shared latent construct. For example, when NEO PI-R items assessing extraversion were pooled with SNAP scales of exhibitionism and detachment, the results demonstrated essential unidimensionality, suggesting a shared latent construct that the current study labeled introversion. Comparable findings also supported the three other unidimensional domain constructs of emotional instability, antagonism, and constraint. Most importantly for the current study, their work application of the IRT perspective supported the hypothesis that maladaptive traits were extreme versions of general personality structure.

Empirically supporting the above author's argument is Glover, Crego and Widiger's (2012) study into the clinical utility of the FFM, in particular its ability to recover the DSM-IV-TR personality disorders. The researchers first argue for the necessity of an FFM specific for personality disorders, i.e., with an instrument of measurement designed for description of abnormal variants of otherwise normal personality traits. Earlier research (Rottman, Ahn, Sanislow & Kim, 2003) using a more neutral, normative-based version of the FFM, the Five Factor Model Rating Form (FFMRF; Mullins-Sweatt, Jamerson, Samuel, Olson, & Widiger, 2006) produced findings which suggested the trait-based approach alone was more ambiguous than using diagnostic information alone and produced far less correct identification of DSM-IV-TR personality disorders (47% to 82%, respectively). The authors of the more recent study (Glover, et al., 2012) criticize that study as flawed, arguing that, not only is a abnormal variant personality disorder FFM needed for accurate identification, but that diagnostic information should not have been excluded from the trait-based method, and, indeed, the earlier studies methodology stated it would be included. Their study randomly selected



clinicians from the American Psychological Association's Division 42 (independent practice). Each clinician was provided with a description of the study and a material benefit for participants in the form of entry into a lottery for \$250 prize. Clinicians who chose to participate were asked to complete a demographic form, a DSM-IV-TR rating form, and a clinical utility form. They were asked to provide a diagnosis of DSM-IV-TR disorders, five on one side of the form described both in terms of the FFM, five different ones on the other side of the form described in terms of DSM-IV-TR diagnostic criteria. Participants were further asked to rate their familiarity with DSM-IV-TR on a 1-5 Likert scale.

While weighing this battle of two competing studies: Rottman et al. versus Glover et al., the results of which seem to indicate that, for the purposes of obtaining/retrieving a correct DSM diagnosis, a trait model that focuses on maladaptive variants is best. However, this provides with perhaps too narrow a question. If all one wishes to do is label a sickness, than a sickness-only model would seem naturally superior. But treatment does not consist of diagnosis alone. Restricting the measure of clinical utility only in terms of accuracy of diagnosis—"accuracy" here existing within the set framework of the DSM—entirely leaves out the question of therapeutic action. A strength-based perspective argues that a broader focus that harnesses and makes use of client strength is advantageous.

In sum, there is strong evidence to support the Five-Factor Model (FFM) as a comprehensive model of personality traits, capable on some level of capturing both personality disorder constructs and positive character virtues. The question remains, however, does the FFM taxonomy capture all the important personality content needed to

fully reveal both aspects adequately? While such a potential far-reach model would be useful for the enterprise of descriptive psychology, it might also have far reaching uses for clinical care. McCrae (2011) makes mention of how such an understanding may help to “optimize fit” of therapeutic approaches to client type. Beyond that, there is the potential of empowerment through diagnosis of strength as argued by Dennis Saleebey’s “Axis VI” (2001, 2005) that will be discussed below.

### **Toward a Dimensional-only model?**

The above comments highlight an ongoing “categorical-dimensional debate” in developing an understanding of personality structure and psychopathology that has only taken on heightened significance with the approaching DSM-5 revisions. This debate could be further conceptualized as whether to define PD as qualitative or quantitatively different from normal personality, i.e., or whether PD is a matter of degree or of distinct kind.

Widiger and Tull (2007) lean heavily on the dimensional/quantitative side of the issue, arguing that:

An FFM dimensional model of personality disorder would describe abnormal functioning with the same model and language used to describe general personality structure. It would transfer to the psychiatric nomenclature a wealth of knowledge concerning the origins, development, and stability of the dispositions that underlie personality disorder; it would bring with it well-validated and researched instruments and methods of assessment; it would facilitate the development of a more truly universal diagnostic system; and it would represent a

significant step toward a rapprochement and integration of psychiatry with psychology. (p. 81)

Personality researchers Kruger and Eaton (2010) advocate strongly for the inclusion of a dimensional personality trait model for psychopathology manuals such as the upcoming DSM-5, arguing that the upcoming revision would best serve as a “bridge” to a more “structurally valid,” “comprehensive” and “numerical taxonomic” system (p. 110). The original authors of the FFM, Costa and McCrae (2010), in a commentary to Kruger and Eaton’s article within the same journal, take this argument even farther, advocating for an exclusively trait-based model, a fully dimensional DSM-6. These authors join an extensive and growing call among researchers to reconceptualize PD in terms of trait dimensions (e.g., Clark, 2007; Widiger, Livesley, & Clark, 2009; Frances, 1993; Livesley, Jang, & Vernon, 1998; Trull & Durrett, 2005; Widiger & Samuel, 2005).

Krueger and Eaton (2010) argue that the “extensive research literature on dimensional personality traits” have “contributed unequivocal conceptual clarity” to our understanding of personality, and “would have similar utility if applied to psychopathology” (p. 98). An official American Psychiatric Association-National Institute of Mental Health meeting on PDs to prepare for the DSM-5 (Widiger et al., 2005b) identified a new model for the organization of personality pathology. Labeled the Pathological Five Model (PFM), it identifies five trait groups as the domain-level structure of personality pathology: 1) Antagonism, 2) Disinhibition, 3) Negative Emotionality, 4) Introversion, and 5) Peculiarity. The similarities to the older FFM are obvious, with the domains “generally understood as maladaptive and extreme variants of the domains of the FFM” (Kruger & Eaton, 2010, p. 99). Further, the PFM model leads

directly, if not quite identically to the development of the Personality Inventory of the DSM-5 (PID-5; Krueger et al., 2012).

The PID-5, the current chosen tool for assessing the proposed DSM-5 trait model, is a 220-item questionnaire with a 4-point response scale. The results conform to a hierarchical Personality Inventory model (Krueger et al., 2012), composed of five higher order domains, (1) Negative Affectivity, (2) Detachment, (3) Disinhibition, (4) Antagonism, and (6) Psychoticism, which in turn encompass 25 lower order traits that can be broken up into facet clusters that correspond to the higher order domains. PD diagnosis, under this model, would be obtained by a list of elevated pathological traits that are proposed as criteria for the six retained DSM-5 PDs. For example, the diagnosis of Schizotypal PD could be determined by elevated scores in Eccentricity, Perceptual Dysregulation and Unusual Beliefs and Experience (all three of which are parts of the higher order domain of Psychoticism), as well as elevated scores in Suspiciousness, Withdrawal, and Restricted Affectivity.

Hopwood, Thomas, Markon, Wright and Krueger (2012) provide some of the first empirical testing of the model. They recently evaluated the proposed DSM-V hybrid model for its validity, in particular its new Criterion B of personality traits descriptive of the disorder as measured by the Personality Inventory of DSM-5 (Krueger et al., 2012), the assessment instrument that operationalizes the currently proposed model. The model was tested on a large undergraduate sample ( $N = 808$ ) from a public university completing self-report questionnaires online for course credit. The average age was 19.92 (range = 18-40), 71% female, and 84% Caucasian. In addition, the researchers wished to explore how well the new DSM-5 trait model captured the older DSM-IV personality

disorders, and so had participants take the Personality Diagnostic Questionnaire 4+ (PDQ-4+; Hyler, 1994) as well, a 99-item true-false instrument whose content maps correspond directly to the criteria for DSM-IV PDs. The researches used hierarchical regression models to examine the adequacy of the DSM-5 proposed traits, taking indexed PD scales and regressing them on separate blocks of proposed and non-proposed traits to evaluate how well the proposed traits capture the diagnostic type and provide incremental information for it. Their overall results showed strong convergence of the traits with the PD they were supposed to indicate, providing strong support for the DSM-V model in general, and particularly support its Criterion B. approach of trait-based, incremental values as indicators of personality pathology. The newer, smaller list of distinct PD categories reduced the problem of diagnostic overlap that was persistent criticism of the older model. The trait-based approach was found to provide significant incremental information for depicting the six proposed PDs and usefully converged the specified traits with their index disorders and criterion validity. The findings of Hopwood, et al, lend support to the proposed DSM-5 model's implementation.

The above researchers further lend their voice to the view that the DSM-5 hybrid model is likely an intermediary step towards ultimately replacing the old PD constructs with an exclusively trait-based, dimensional model. They cite numerous studies establishing that dimensional models are more likely to stand up to formal tests of psychometric adequacy than are categorical ones (Bastiaansen, Rossi, Schotte, & De Fruyt, 2011; Krueger & Markon, 2006; Markon, Chmielewski, & Miller, 2011). They propose that it might be less complex to simply abandon PD categories entirely and focus instead on general severity and pathological extremity of personality traits. The function

of the hybrid model, in their view, may lie primarily as a means for clinicians to become accustomed to a newer, more efficient system.

Apropos to the current study, the above researchers do posit a potential limitation in the DSM-5 model's focus on pathological rather than normative traits, excluding the possibility of using the DSM-5 to describe people in general, let alone assessing the possible presence of adaptive character strength. The proposed DSM-5 model restricts its field of vision only to those features of personality that are dysfunctional.

Douglas Samuel (2011) makes a strong and compelling case that the DSM-V's proposed dimensional trait model, a "unipolar" model restricted to descriptions of maladaptive functioning only and excluding normal personality, misses a "momentous opportunity to translate basic science into clinical practice by integrating well-established findings from normal personality research into the psychiatric nomenclature" (p. 390). He laments this choice because it is inconsistent with previously published trait research, precludes the possibility of integrating normal and adaptive traits, and fails to capture the range of personality pathology comprehensively. On the latter point, he argues that an integrative, "bipolar" model resembling the FFM is preferable in that, by its very construction, it acknowledges that maladaptivity exists at both ends of the personality trait spectrum. This "full-spectrum" approach would measure extremity on both ends as maladaptive, with cutpoints along the scale that would "prompt the assessment of several narrow traits that [would] more clearly define the specific and maladaptive aspects of that pole" (p. 394). Samuel argues for "tailored testing" that would seek detailed assessment only provided for those individuals for whom it is relevant, and only those who could

demonstrate clinically significant evidence of impairment in functioning would earn diagnosis.

### **The Strengths Perspective**

As social work theorist Mel Gray (2011) recently observed, the strengths perspective in social work has its philosophical roots in the Aristotle's *eudaimonia*, the teleological theory of human flourishing. Aristotle argues in his *Nicomachean Ethics* (2011) that people reach their innate potential through exercise of their capabilities and the pursuit and perfection of their virtues. In this, we have the essence of humanism, rejecting the notion of morality and virtue as merely obedience rules and duties (deontology), the compounding result of environment (consequentialism), or of maximizing the good (utilitarianism). It rests on the belief that all humans have innate capacities that drive them towards their own particular flourishing. But, as philosophers Rasmussen and Den Uyl observe, "Eudaimonia consists of a person taking charge of their own life.... If a person is to flourish, he must *direct himself*" (1991, p. 63, italics in original).

In a direct descent from this philosophical tradition, social work has seen over the past two decades the emergence of the strengths perspective. "Social workers have been encouraged to refashion themselves into strengths-based, solution-focused, capacity building, asset creating, motivation enhancing, [and] empowerment specialists" (McMillen et al., 2004, p. 317). While the strengths perspective has many originators (see Early & Glenmayer, 2000; Kristhardt, 1994; Rapp, 1998; Weick, Rapp, Sullivan, &

Kirsthardt, 1989) one of its strongest voices is Dennis Saleebey (1992, 1996), author its definitive text, *The Strengths Perspective in Social Work Practice* (1997).

Saleebey poignantly gave voice to his dissatisfaction with the newly released DSM-IV's limitations in his essay, *The Diagnostic Strengths Manual?* (2001), wherein he decries the DSM-IV's "lexicon of deficit" that he argues enfeebles the sense of self, weakens communal understandings, enforces the development of a new social hierarchy, and comes to label and expanding range of behaviors, emotions and mental states as "deficiencies requiring medication, sequestering, treatment and, in some cases, imprisonment" (p. 183). He argues that the "diagnostic habit" the DSM model enforces "make it virtually impossible to consider or make an accounting of the assets, talents, capacities, knowledge, survival skills, personal virtues" that a person might possess. "To ignore these things is to disregard the most important resources in helping a person recover."

Saleebey later expanded on these ideas in his essay, *Balancing Act: Assessing Strengths in Mental Health Practice* (2005). In it, he attacked the continued "growth of the medical-psychiatric/pharmaceutical/insurance cartel" and the ever expanding reach of the DSM as a socially constructed worldview with hegemony over other discourses (p. 23). The DSM's "increasingly luxuriant language of deficit, pathology, frailty and infirmity" was particularly pernicious because a diagnosis of mental illness, once applied, "often suffuse[s] deeply into one's identity, becoming part of the package we think of as personality" (p. 24). This tendency has grown, according to Saleebey, with each subsequent edition of the DSM, as the earlier versions psychodynamic/psychoanalytic perspective shifted in DSM-III towards a more precise, descriptive, categorical style in



the hopes of making the diagnosis of mental diseases as exact and definitive as physical ones. Ignored in this campaign for an ever-sharper diagnostic precision is the power of the words themselves to cause a “major existential transformation” of person into pathology through the “symbolic bondage of the label they bear” (p. 26).

Compounding this problem of “medical hexing” (Weil, 1995) with pessimistic and pejorative diagnostic labels is the almost complete asymmetry in the power and prestige of pathology language compared to strength and empowerment language. “The language of strengths is ordinary,” Saleebey writes (2005), while the “medico/psychiatric argot” of mental health language is perceived, in contrast, as extraordinary, technical, authoritative, and vested with the objectivity of science and therefore truth. Sybil and Steven Wolin (1997) eloquently gave voice to this asymmetry when they noted that clinicians “grope for words and fear sounding unschooled and naïve when they replace pathology terminology with the more mundane vocabulary of resourcefulness, hope, creativity competence and the like.” This tendency could only be corrected, they argued, by “offering a systematic, developmental vocabulary of strengths that can stand up to pathology terminology that is the standard in our field.” Saleebey himself proposed the introduction of an “Axis VI” into the DSM that would oblige clinicians to “make a strict accounting of the merits and strengths of clients” (2001). He later expanded this concept (2005), proposing an entire “diagnostic strengths manual” that was “as definite, categorical, and hefty as the DSM.” Such a tool might, he conceived, might provide a counter-axes “gnosis” that included: Axis I: Life goals and dreams, Axis II: Core gifts and abilities, Axis III: Physical gifts and abilities, Axis IV: Psychosocial and environmental supports, and Axis V: Family, culture and community gifts. Yet even

Saleebey himself seemed to doubt the possibility that his concept could be embraced, introducing it with “apologies to skilled ironists” (2005) and conceding that the proposal seemed “a tad precious” (2001). Yet Saleebey’s proposal essentially anticipates the very work Peterson and Seligman would publish with *Character Strengths and Virtues: A Handbook and Classification* (2004).

### **Positive Psychology, CS&V and the VIA empirical research**

While the above research supports that the FFM, or variants of it built on Five-Factor Theory, has utility for capturing maladaptive PD constructs, there is *also* growing evidence supporting that the FFM can capture strengths and virtues as well. The evidence, however, is scant, preliminary on often contradictory, especially in comparison to that gathered on the maladaptive side of the personality continuum. This imbalance in the amount of research data perhaps underscores Saleebey’s indictment of the field referenced above (2005), supporting his argument of psychology’s ever-expanding “lexicon of deficit” (Saleebey, 2001). Positive psychology, however, is a relatively new movement, and the system of categorizing strengths and virtues created by Peterson and Seligman’s (2004) is, by their admission, only an early effort in ongoing project. So, while a broad model based on FFT could potentially be used to adequately and descriptively capture character strengths as well as character disorder, placing both constructs on the same dimensional continuum, it is perhaps not surprising that the strength constructs of the continuum remain comparatively so little explored.

While Peterson and Seligman (2004) derived their list of 24 strengths and six virtues from a review of philosophical, spiritual and psychological literature, they

explicitly acknowledge their systems' connection to the FFM in their conceptualization of the virtues (Chapter 3). And, indeed, there is evidence to support Peterson and Seligman's positive traits are closely related to the factors of the FFM.

Haslam, Bain, and Neal (2004) attempted to explore the implicit structure of positive characteristics by taking up Peterson and Seligman's (2004) VIA. The researches demonstrated substantial correspondence in the associations of VIA and FFM variables, but only in the realm of "semantic similarity" and "patterns of perceived association." The implicit structure of character traits was examined with two studies of undergraduates. Study one was designed to assess the robustness of the implicit structure across methodological variations. Participants (190 Australian undergrads, 153 female, mean age 22 years, ethnically diverse) were randomly assigned to one of four conditions, representing combinations of two methods of judging associations (sorting vs. rating) and two forms of association (semantic similarity vs. covariation). In each condition, participants completed a questionnaire asking them to make judgments about 42 positive characteristics (24 terms were Peterson and Seligman's strengths, 18 terms standing for more established systems of personality description). The researchers second study tested the robustness of the findings of study one. Participants (100 Australian undergraduates, 58 female, mean age 19.1 years, ethnically diverse) were randomly assigned to complete one of the sorting tasks identical to the first study but in groups of 2 to 6 in a laboratory setting.

The findings obtained an implicit structure of the characteristics that was highly consistent and replicable across methodological variations. The virtue, trait, and value classifications all demonstrated a capacity to illuminate this implicit structure, indicating

that they occupied a largely shared domain. Several of the proposed virtue groupings formed coherent groups that marked poles on dimensions. The domain of strengths was shown to substantially overlap the trait and value domains.

[I]t seems inappropriate to conceptualize strengths as psychologically distinct constructs from traits and values or to classify them without some consideration of well-established trait and value taxonomies. Concepts of “strength,” “virtue,” and “character” offer new theoretical perspectives on the study of personality, but our findings imply that strengths can be conceptualized and studied in much the same ways as traits and values. (p.539-540)

While the findings of Haslam et al., is promising in support of seeing Peterson and Seligman’s VIA system as linked to normative trait theory like the FFM, the limitations of the study are clear. Their research measures only the shared conceptions of lay people, focusing on the “lexical” approach that holds sway over so much research into personality structure, “which assumes that salient aspects of personality are encoded in natural language” (p. 532). Grounding a scientific taxonomy of personality only in the superficial resemblance of terms within one language is likely not deep enough to capture the true shape of psychological structure or dynamics of personality.

To address how issues of culture impacts measurements of positive psychology, Park, Peterson and Seligman (2006) conducted a web-based study of 117,676 adults from around the world. Findings seemed to indicate that, except for religiousness, there were no substantial differences of character strengths profiles as a function of regions within the U.S., or between nations. Through a comparison of 54 nations and the 50 U.S. states,

the profiles of character strength overwhelmingly converged both within in the U.S. and compared with the profiles of the other nations. While it is perhaps premature to declare this as absolute proof of the universality of human nature and character, the findings do suggest the validity of using findings personality studies conducted in other cultures as being applicable to our own.

Craig MacDonald, Miles Bore and Don Monro (2008) usefully investigated the validity of Peterson and Seligman's classification system of 24 character strengths by examining the relationship between the strengths themselves and their six higher order "virtue" domains, as well as investigating how those 24 character strengths relate to the FFM model. Sampling 123 first year psychology students enrolled in an Australian university (28 males, 86 female, 9 not indicating gender; age range 18-57, with a mean of 21.51). All participants were given course credit for volunteering. To measure the 24 character strengths, researchers used Peterson and Seligman's (2004) Virtues in Action Scale (VIA), given self-report test using a five-point Likert scale (from "very much like me" to "very much unlike me"), featuring 213 items compile pseudo-randomly. The measure of the FFM was Goldberg's (1999) Big Five scale obtained from the International Personality Item Pool (IPIP, 2001) website. This measure has 20 self-report items per scale with a four-point Likert scale ("definitely false"/"false on the whole"/"true on the whole"/"definitely true"). Participants were randomly given one of four differently ordered questionnaire booklets and instructed to answer the questions in the order they appeared. Using a second order Principal Components factor analysis, the researchers found that the 24 character strengths did not produce a factor structure

consistent with the six higher order virtues, that is the 24 strengths did not produce a clean six component solution but instead were well represented by a four factor solution.

In short, Peterson and Seligman's classification conceptual structure did not fare well when tested. This is perhaps unsurprising, given that the categories that make up their system were obtained through surveys of centuries of religious and philosophical literature, parsing what strengths and virtues the authors found to be ubiquitous and sorting them into a theoretical relationship guided by intuition rather than through empirically grounded data. Nor were Peterson and Seligman's six virtue domains tightly empirically correlated with the five factors of the FFM. Again, this is unsurprising in that, while the authors acknowledge some correspondence between their own classification system and the FFM, they make plain that these links are conceptual only. For example, FFM Conscientiousness might be conceptually paired as related to VIA Temperance, they were not specifically designed to be the same.

Furnham and Lester (2011) also investigated the factor structure of Peterson and Seligman's Virtue in Action Inventory of Strengths (VIA) against a FFT devised measure of personality, the Abbreviated Big Five (McManus, Smithers, Partridge, Keeling, & Fleming, 2003). The Abbreviated Big Five is a 15-item questionnaire measuring the FFT traits described above, and has good evidence of reliability and validity. Using a sample of 366 participants (233 female; 136 from the U.S., 172 British; and 60 from other European countries; age range 17-27, median age 19) the researchers had them take a questionnaire rating character strengths and the Abbreviated Big Five.

Not surprisingly, Furnham and Lester's found that the Abbreviated Big Five results did not factor totally in the six virtues specified by Peterson and Seligman. They

were, however, interpretable in terms of that theory. Only modest empirical support was gained by the factor analysis of the self-ratings for support of the 24 strengths in the six virtues. Of the personality factors measured, many were shown to powerfully related. In the correlational analysis between the virtues and personality variables ( $N = 365$ , correlation  $r > .12$  are significant at  $p < .05$ ), Agreeableness was most powerfully related to Humanity (46). In addition, Conscientiousness related to Courage (19) and Temperance (16). Of the 24 strengths, Conscientiousness was related to perseverance, dignity, honesty and industry. Extroversion was the trait most overall strongly and consistently related to virtues, showing strong positive correlations with Wisdom (27), Transcendence (25), Fun Loving (16), Courage (13) and a strong negative correlation with Temperance (-25). These findings, like those of MacDonald et al. (2007) and Haslam et al. (2004) listed above, suggest that further work needs to be done both conceptually and empirically on Peterson and Seligman's classification.

Noftle, Schnitker, and Robins (2011) recently investigated and largely corroborated the above researchers conclusions about the core validity problems of the VIA structure. In an attempt to disentangle the relationship between character strengths and personality, they tested how the VIA scales predicted well-being beyond the Big Five dimensions and vice versa. Study 1 assessed three "proxy" indicators of well-being: "time perspective," "proneness to regret" and "mindfulness." Study 2 assessed two direct measurements of well-being: Pavot and Diener's (1993) Satisfaction with Life scale and Desalvo et al.'s (2006) single-item measure of physical health. The researchers performed a series of hierarchical linear regressions on each of the well-being variables, entering the character strengths and the Big Five dimensions. Overall, they found that

character strength and personality traits had relatively similar predictive abilities for measures of well-being. However, the VIA system did not predict substantially better. They concluded that the empirical structure of VIA had yet to be replicated and thus validated; there was much conceptual and empirical overlap; while the strengths were predictive of well-being, but was sometimes entirely redundant of the traits.

While validity evidence challenges the current structure of Peterson and Seligman's VIA system of strengths, this is not surprising in a field that is yet so new, a factor that the Nofle et al. acknowledge (p. 223). Still, as the above research demonstrates, there is by now ample evidence that VIA strength constructs—even as they are now imperfectly defined—are well represented in Big Five trait models and thus warrants the continued research perspective of positive psychology that holds strength as universal virtues that can be empirically and quantitatively studied.

## **Conclusion**

Aidan Wright (2011) recently attempted to reconcile the ongoing categorical-dimensional debate of personality science, illuminating is a broader conceptual question of whether to define and describe personality pathology as a *quantitatively* extreme expression on the outer edges of a normal personality continuum, or PD as *qualitatively* distinct typologies with different processes.

Wright insists there's ongoing problems with Widiger's continuum approach, and he outlines five of them: 1) the trait models might not be able to fully capture intra-individual PD structure; 2) statistical extremity does not ipso facto determine whether an individual's behavior will be expressed extremely; 3) personality operates on multiple



levels, as does the meaning of behavior; 4) it's not clear when and where problematic functioning will occur on broad dimensions, as this often depends on an individual's construal of meaning of situations and events; 5) it does not seem like the majority of variance of PD, especially in regard to its most aberrant aspects (e.g., self-mutilation or suicidal ideation) can be adequately captured by trait models. In short, while trait models like the FFM can be shown to be related to PD, they do not fully explain it and instead offer only overly simple caricatures. Further, while it can be shown for example that Narcissistic PD individuals score high for extraversion, the reverse can be shown to be true: that all high-score extraverts are narcissistic.

Wright proposes a new analogy to help reconcile the ongoing debate of categorical vs. dimensional, qualitative vs. quantitative, degree vs. kind. He posits that the relationship PD and normative personality is properly understood as being similar to the relationship of water, ice, and steam, i.e., that while temperature of water is perfectly continuous and easily measure quantitatively, at different points along the continuum dramatic shifts occur in the structure, pattern of interaction, appearance, and form. In sum, that PD is not made of categorically different substance from normative personality, but could be defined by qualitatively different processes.

Wright insists that what is needed are not static trait conceptualizations of personality, but dynamic models that also include the *when* (temporal sequences), *how* (mental representations of the self and environment), and the *why* (internally experienced drives). He argues that older theoretical traditions such as object-relations and more contemporary social-cognitive theory allow for models of personality as an ensemble of structures and processes that better capture PD distinctions. In short, Wright comes down

in support of the DSM-5's proposed revisions for PD diagnosis, with its hybrid, two-step approach that combines discrimination between normal and disordered personality functioning globally with a separate description of content areas of dysfunction. He approves that much of the language is process based, used to define deficits of self-identity and interpersonal relatedness that are, he argues, the defining difference between maladaptive and adaptive functioning. He also approves of the DSM-5's proposed specialized, non-normative, maladaptive trait model as better suited to making finer qualitative distinctions with process and functioning factors. However, he does not challenge Widiger's earlier argument that maladaptive processes are embedded within normal traits, that they are deviations and distortions of normal functioning. His contention instead is that trait models do not well articulate the jump between normal and abnormal functioning and do not adequately describe the relationships of the patterns between them.

It is the premise of the proposed research that upholds both Wright's argument for the utility of normative trait models like the FFM for capturing a broad dimension of personality and his critique that they are at present inadequate for fully describing the relationship between maladaptive and adaptive personality constructs. It is a further premise that some of this inadequacy may stem from a trait model that does not also include positive, one might even say "hyper-adaptive" functioning as Peterson and Seligman attempted to categorize as character strengths. The absence of a personality model that includes positive strengths and virtues denies the possibility of examining a compensatory relationship. One possible theoretical framework to inform this investigation may lie in opponent process theory (OPT). While the concept has its roots

in the physiologist Ewald Hering's (1868) investigation into color vision, the OPT model was expanded by Richard Solomon a century later to investigate motivation, emotion and addictive behavior (Solomon & Corbit, 1974). The theory, as it regards to emotion, has been pithily defined Joachim I. Krueger (2012) as, "Each emotion, once triggered, eventually brings along its opposite. Where there is despair, there shall also be hope."

An Opponent Process approach furthers the critique that Wright levels at the lack of dynamic understanding of trait only models to understand maladaptive processes could be equally brought to bear on the positive, "hyper-adaptive" processes of character strength. As a parallel to Wright's critique of trait captures of PD, the "jump" between normal and positive strengths functioning are do not adequately described, and the relationships of the patterns between them is only dimly understood, never mind an understanding of the possible relationship between maladaptive and hyper-adaptive functioning.

In conclusion, the literature supports the possibility of a dimensional model that conceptualizes a human personality through traits that ranges all the way from pathological extremity through normal, healthy functioning and on to superior extremity of excellence. Further, that current trait models as they now exist, while they can map and describe strengths and disorders, suffer ongoing problems of structural validity, an essential factor of any diagnostic system. Lastly, we argue that treatment does not consist of diagnosis alone and that social work's strength based perspective urges us towards that a broader focus that harnesses client strengths.

## Chapter III

### Methodology

In this chapter the proposed methods of research, including sampling strategy and mechanism for protection of the rights of human subjects, sampling and data collection are described.

#### **Research Purpose**

The purpose of this research study was to examine personality disorders (PD) as currently defined by the DSM-IV-TR (APA, 2000) and examine how they intersect with the positive psychology movement's view of character strength as conceptualized Peterson and Seligman's *Character Strengths and Virtues: A Handbook and Classification* (2004). The research question it was designed to explore was: In what ways do clinicians conceptualize personality disorder and character strength? Do they see a value in moving towards a theoretical framework that sees PD and character strengths as existing on the same dimensional axis? What are the possible strengths and weaknesses of this approach from a clinical perspective?

The literature regarding the validity and value of dimensional models for capturing and conceptualizing personality disorder and character strength, and of postulating a relationship between them, will always be incomplete if it does not explore more deeply the question of clinical utility and therapeutic action: how real-world clinicians work with, understand and relate to real-world clients challenged and empowered by characterological disorders and strengths. Theoretical and empirical research alone likely provides too narrow a window into this subject. As has been

demonstrated in Chapter 2 above, highly refined instruments can be designed to measure personality, capture maladaptive and hyper-adaptive positive features and constructs, and describe a relationship between them and between normative personality traits. Yet it is possible that a crucial element of real-world complexity may be lost if personality science remains hermetically sealed off from the subjective experience of clinicians working in the field. Among other dangers is the risk of a self-confirming statistical tautology, of a personality science incapable of recognizing or addressing what it cannot at present measure. For a deeper and more complex understanding, the researcher felt a qualitative exploration of subjective understanding of mental health clinicians working in the field of personality disorder was necessary.

While clinical applications are beyond the scope of this research, an improvement in the understanding of PD has the potential of contributing to the goals of social work of providing better aid and care for PD afflicted individuals. Further, if PD can be viewed in terms of potential character strength, it adds to social workers ongoing effort to strengthen and empower clients. The study could potentially have an impact in furthering awareness of the mission of the positive psychology movement, and contribute a link to connecting the work of that movement into the clinical domain. Strength-based therapeutic interventions could potentially be greatly improved with a more rigorous classification of what exactly we mean by “strength” and a broader understanding of how “disordered” elements of personality are related to “non-disordered” strengths and virtues. This research has the potential to benefit clinical work by attempting to connect these two modes of thought.

## **Research Design**

Within the literature cited in Chapter 2, the primary design of past research of the dimensional models was through quantitative methods with data typically gained through questionnaires. In order to contribute to a better understanding of personality disorder and character strength, the current research used a qualitative study to investigate the unique insights and understanding of experienced mental health clinicians by conducting semi-structured interviews that used open-ended questions that allowed for nuance and subjectivity in answers. These elements, subjectivity and nuance, seem essential and fitting if research is to address the problematic critiques of the PD diagnosis—subjectivity, poor diagnostic reliability and frequent overlap—that the literature review outlines. In other words, the very topics of the research, personality disorder and character strength, exist in the realm of subjectivity, and thus subjective opinion is perhaps the natural point from which research should extend.

Beyond the simple culling of subjective opinion, however, the interview questions were designed to encourage and elicit opinions around possible relationships mental health clinicians saw between specific personality disorder and specific character strength. In some questions these possible relationships were asked after directly and overtly, in others the structure of the question encouraged thought along these lines and left space for participant's own free subjective associations and feelings on the topic. In the final question, participants were asked to choose from a list of specific character strengths culled from Peterson and Seligman's (2004) classification. While this method may be subject to the same limitations discussed in the literature of Haslam, Bain, and

Neal's (2004) "lexical" approach "which assumes that salient aspects of personality are encoded in natural language" (p. 532) it diverges in that it seeks to compare and draw connection between two unlike categories that, while mutually subjective and prone to human bias, are rarely seen as being directly related. It is an inquiry into the possibility of such a direct relationship that this qualitative study seeks to explore.

### **Sample**

As noted regarding the research literature, the primary sample for most previous research regarding the dimensional models made use of undergraduate students (Furnham & Lester, 2011; Haslam, Bain, & Neal, 2004; Hopwood, Thomas, Markon, Wright & Krueger, 2012; MacDonald, Miles & Monroe, 2008; Samuel, Simms, Clark, Livesley, & Widiger, 2010), used presumably selected due to their convenience to the researchers. In contrast the current research conducted interviews with experienced mental health clinicians who have worked with PD diagnosed clients. Participants were all professional mental health therapists within the United States with a minimum of five years experience as practicing clinicians. They all had experience working clinically as mental health therapists, and that experience included working individually with adult PD diagnosed clients. They were all both willing and able to discuss their clinical work with individual PD cases while maintaining their client's confidentiality. Lastly, all participants were able to speak English fluently as it was the only language the researcher spoke. The specific age, sex, gender, race, ethnicity, sexual orientation, religious beliefs or political orientation of participants were beyond the scope of the proposed research and were not used as criteria for exclusion. While diversity of population demographics

were desired and sought after aspect of the study, the primary factors for participant selection was clinical experience and conceptual insight into the topics being discussed. The original goal sample size was 10-15 experienced clinicians in the treatment of personality disorder.

There was a separate criterion for the clinical cases that were the *topic* of the interview questions. In the initial research design, PD cases discussed had to involve adults who were given at least one Axis II personality disorder diagnosis that the clinician being interviewed had to agree with this PD diagnosis. That is, they believe that the diagnosis was valid and the client's symptoms fit the criteria as established by the DSM-IV (APA, 2000). In practice, this proved to be more difficult than expected in the field as some participants proved resistant, reluctant or in general ambiguous about the use of Axis II PD diagnosis.

### **Recruitment, Ethics and Safeguards**

After receiving signed and written approval by Humans Subjects Review Committee (Appendix E) for the application for research, the recruitment phase was begun. The primary means of recruitment for participants of the study was done through the researcher's own contacts within the clinical community of western Massachusetts. The approach used was a snowball and purposive sampling, i.e., asking clinicians the researcher knew for information to help locate other clinicians they felt could fit criteria and could be helpful. Initial sampling was first attempted by using the community clinician referral list of the agency where the researcher was then interning, the University of Massachusetts Amherst Center for Counseling and Psychological Health



(CCPH), which made available the public contact information of those clinicians with experience and expertise in working with personality disorders after permission was gained by the director of the agency the use of the referral list for those purposes. Potential participant clinicians all received a recruitment email describing the purpose of the study, attached to which were the letter of informed consent for them to sign, the list of interview questions, and a list of character strengths (Appendices A, B, and C) taken from Peterson and Seligman's (2004) classification.

All interviews were conducted face-to-face in settings that the participating clinician and the researcher agreed was comfortable and private enough to ensure confidentiality of the case material being discussed, usually within the clinicians office, although one at their private home and one in the researcher's office. All interviews were recorded with a digital audio recorder that was clearly visible and not concealed. All participants were given a hard copy of the letter of informed consent to sign immediately prior to the interview that included a release to make such recording (Appendix A).

The digital audio files were all saved in MP3 format to a password protected computer hard drive, after which the original recording files on the recorder were destroyed. All audio recordings were transcribed into text format in Microsoft Word by the researcher.

Confidentiality was maintained and no identifiable information of the participants or their clients was shared with outside sources. All identifying information was removed from the data before it was shared with the researcher's advisor, Joanne Corbin, MSS, PhD. All data in the form of electronic files has been secured with a password protected computer, while physical notes are stored in a locked drawer. Should any future

presentation and publications stemming from the present research be issued, no participants will be identified. All participants were given and signed an informed consent document outlining research procedures. The signed copies of these documents have been stored in a sealed envelope along with the rest of hard copy notes in a locked drawer. All data and releases will be kept secure for three years as required by Federal regulations, after which time they will be destroyed.

### **Data Collection**

Eight face-to-face interviews were recorded, spanning from 21 to 48 minutes in length. All interviews followed with a specific set of questions submitted to participants in advance via email (Appendix D), but with a semi-structured format that allowed for follow-up questions, illustrations and anecdotes that both participants and researcher felt worthy and relevant. Participants discussed specific PD diagnosed clients they had worked with in the past while maintaining client confidentiality, including selecting specific character strengths they would assign to these clients. The only specific demographic information sought was the clinician participants' educational and professional training and background, licensure status, theoretical orientation and experience working with PD diagnosed clients. While excluding wider demographic data was necessarily a limitation of the study, the findings cited in Chapter 2 above (McCrae et al., 2005; Park, Peterson & Seligman, 2006; Terracciano et al., 2005; Yang, McCrae, & Costa, 1998) lend empirical support to the validity of using findings of personality studies conducted in diverse regions, cultures, countries, age groups, and timelines as being applicable to each other.

The chosen form of data collection for this study was short interviews with guided questions. The questions were answered verbally and recorded by a Sony IC Recorder and the audio files copied to a computer. All interviews were transcribed by the researcher into text format in Microsoft Word. The final question of the interview was to ask about specific PD clients that have met the above mentioned criteria and what possible top character strengths they imagine these clients may have had. Participants were asked to select from a list presented to them of character strengths taken directly from Peterson and Seligman's (2004) classification schema (Appendix C).

In addition, participants were asked more generalized, open-ended questions that gave them a chance to add further thoughts and opinions regarding the perceived relationship between character strength and personality disorder. The questions were sent via email to the participants in advance (see Appendix B for a complete list of interview questions) so that they might reflect on them in anticipation of the interview.

The audio recordings of participants' open-ended, semi-structured interviews were analyzed qualitatively to search for common themes and content. John Seidel's (1998) description of qualitative data analysis (QDA) process, summarized as "noticing, collecting and thinking" were applied to interview transcriptions. Once data collection had been completed, the researcher reviewed and sorted the answers to specific questions together. Patterns were analyzed, themes identified, as well as major points of conflicting opinion. As data was sorted, sub-categories of data were uncovered within question groupings, and specific quotes and sections of dialogue between the researcher and participants were chosen to express the nuances of opinion or of clinical insight. Lastly,

data were compared to the literature cited in chapter two to add further context to the findings.

To minimize the possibility of bias within the research, all data was specifically grounded in the precise words of the interviewed participants. While the impact of subjective interpretation and bias-of-emphasis remains a factor inherent in the qualitative research design even among the most reflexive researcher, a concerted effort was made to restrain interpretation to the specific words of transcribed interview content. Yet, despite these restrictions, it is a premise of the research that the contribution of real-world clinicians in the field of personality disorder treatment will contribute rich information and useful exploratory finding in what are the formative stages of an emerging field of social work.

## Chapter IV

### Findings

Through the process of face-to-face, in person interviews, ranging from twenty-one to forty-eight minutes in length, from March 22 to April 19, 2013, eight seasoned mental health clinicians working in Western Massachusetts shared about their experience working with personality disordered individuals. They offered their perspectives gained from that work and explored how those fit with their conceptualization of character strength, and how they saw strengths and disorders relating to each other. Below are themes that arose from these interviews. Most of the statements are taken as direct quotes from the participants.

#### **Demographics**

Of the eight individuals selected to participate in this study, five were female, three male, seven Caucasian, one non-native of the U.S. from Latin America with English as a second language, all mental health clinicians living and working in the Western Massachusetts region of the United States. Six of the eight were licensed clinical social workers that had earned an MSW. Among those, one was close to achieving her PhD in social work. The other two were board certified psychiatric MDs, one who had let his license lapse into inactive status since retiring. Professional experience as licensed clinicians ranged from seven to thirty years. All participants had worked as clinicians in more than one setting, inpatient and outpatient, private practice, community clinic, hospital, short term and long term care.

Theoretical orientation tended towards primarily a psychodynamic point of view, informed and supported by other techniques and treatment models such as DBT, EMDR, Somatic Experiencing, Control Mastery theory, Motivational Interviewing, Relational theory and Mindfulness based practices. All endorsed adopting an eclectic view of theoretical orientation rather than adhering strictly to one specific theory model.

All participants had experience working with personality disordered individuals, although some were reluctant or resistant to assigning that diagnosis to clients. Even among those who were resistant or prone to eschew Axis II diagnosis, all seemed to agree that DSM-IV descriptive categories did capture and adequately describe specific clients in their care. In this way, it could be said that their resistance to Axis II diagnosis was more concerned with the social consequences of diagnostic stigma rather than resistance to the premise of the existence of personality disorder as such. Participants had worked therapeutically with personality disordered individuals in a variety of settings, and their experience included both long-term and short-term care, but case examples presented in the finding tended to privilege longer-term therapeutic relationships.

## **Analysis**

The purpose of this research study was to examine personality disorders (PD) as currently defined by the DSM-IV-TR (APA, 2000) and examine how they intersect with the positive psychology movement's view of character strength as conceptualized in Peterson and Seligman's *Character Strengths and Virtues: A Handbook and Classification* (2004). The research question I wished to explore was: In what ways do clinicians conceptualize personality disorder and character strength? Do they see a value

in moving towards a theoretical framework that sees PD and character strengths as existing on the same dimensional axis? What are the possible strengths and weaknesses of this approach from a clinical perspective?

The major findings of the research are discussed below, broken into the primary themes emerging from a careful analysis of the data.

### **Clinical experience with PD = Borderline PD**

A finding suggested by this research is that talk about Axis II with mental health clinicians is almost invariably to talk about borderline personality disorder (BPD) to the virtual exclusion of all other personality disorder diagnoses. All eight participants mentioned “borderline” specifically in their interview answers, despite the fact that the word does not appear in any of the interview questions. Three participants [4, 5, 7] made mention of *any other* DSM-IV personality disorder diagnosis. This finding that mental health clinicians make a natural and almost interchangeable association between “personality disorder” and “borderline” is supported by well-established data that indicates BPD is the most highly treated of all personality disorders (Ansell, et al, 2007). BPD patients require the most hospitalizations of all PD diagnosed individuals and are as group characterized by significantly greater psychiatric treatment utilization both inpatient and outpatient than other personality disorders. This statistical data is reflected in the findings of the present qualitative research study. Either when asked directly or spontaneously offered, participants within the present study indicated that borderline diagnosed patient featured predominantly in their own clinical experience with PD, and it is from that association that their responses should best be understood.

### **BPD = Persistence**

Most participants, with nothing more than the prompt of the words “persistently characterologically challenged” and “Axis II” in question one, spontaneously offered their own sense of what strength they would be likely to find in such a person. To an almost uncanny degree [Participants 1, 2, 3, 4, 5, 6, 7 and 8], this took the form of some version of “Persistence,” “Perseverance,” “Strong-willed,” or possessing a tenacious “belief that regardless of how badly it feels at that particular moment, that it could be better.” However, some participants [3, 4] did acknowledge that this impression was derived from clients *who had stayed in therapy*, a likely important factor that shaped their impression. Additional spontaneously offered strengths classically found in Axis II clients included being hard working, engaging, and having a sense self-advocacy [Participant 1], a “genuine desire for connection” [Participant 4], “Protectiveness” and fierce (though fickle) “Loyalty” [Participant 5], “Courage” [Participant 7], and “Resilience” [Participant 8]. These answers were further reiterated and supported by participants’ response to question eight where they were instructed to choose specific strengths off a list provided.

### **It’s All Subjective: Any Behavior Can Be seen as Adaptive**

As it turns out, all participants eagerly embraced the idea of character strength being an important part of their clinical focus when attempting to understand and work with their clients, including those diagnosed with Axis II PD. However, the exact understanding of what “strengths” were was open to wide interpretation.



A frequently made comment [Participants 1, 2, 4, 5, 8] was to point out in some form or another that *all* behavior could be seen as either strength or pathology, i.e., that behavior is open to subjective interpretation and is contextually based to the situation. Further, while much of Axis II behavior might indeed be pathological in terms of going against the grain of the social order, and thus maladaptive, that same behavior could be considered adaptive if viewed in terms of *survival*. Participant 1: “Some of the clients have said that, ‘If I wasn’t cutting I’d be dead now. This is how I keep from dying.’” Participant 8: “The way I think about it is that the domain of Axis II is how people figure out how to survive Axis I. So I see it as less of disorder and more of a strength.”

Across interviews, clinicians offered some acknowledgment that even the most aggressive, hostile, destructive and seemingly pathological behavior of their PD clients could and should be interpreted as adaptive on some level.

Researcher: If you don’t mind me saying, when I asked a version of this question before, everything you were saying was like, this is a strength in certain settings and a weakness in others.

Participant 5: Right.

Researcher: You mentioned hostility, which could be seen pejoratively, but also could be seen as vigilance.

Participant 5: Right. And the stance is sort of a “no” stance in a way, a self-protective stance. And there’s strength in that, actually. It’s [considered] a defense for good reason, but there’s also choice in there.

Participant 7 usefully noted:

Participant 7: The word “compensatory” is almost built into the way of understanding the personality disorder itself. For example, the ingratiating quality of a narcissist may not be what *you* mean by compensatory, but it’s compensatory in that it’s countering the internal feeling of worthlessness and distance that’s built into the disorder.

### **Choose Your Continuum: Mature-Immature vs. Normative-Extreme**

A large subset [Participants 2, 3, 4, 6, 7] brought up that even behavior typically pathologized as “disordered” in Axis II presentations is seen within the theoretical framework of classic psychodynamic theory (Mitchell & Black, 1995) as serving as ego syntonic adaptive coping mechanisms, usually framed in the form of “defenses” of greater or lesser maturity.

Participant 3 in particular emphasized the impact of Harvard psychologist George Vaillant on his thinking as a clinician, in particular how he did his clinical assessment of patients and how he understood and conceptualized strengths. Vaillant is most famous for his comprehensive longitudinal research study of, among other things, the maturation of defense mechanisms through the life cycle (Shenk, 2009). Vaillant’s basic theoretical lens seems to be Anna Freud’s ego psychology, seeing defenses as “adaptations,” i.e., unconscious responses to pain, conflict or uncertainty, and in placing those defenses on a hierarchy of “maturity” ranging from psychotic (most primitive) up through immature, neurotic and mature (Mitchell & Black, 1995). Vaillant findings are relevant to present discussion because he did champion the conception of mental health and mental illness as being parts of a shared continuum that he chooses to see not in terms of health or morality, but of maturity-immaturity and subject to change over time with experience and knowledge.

Participant 4 also endorsed her use of the classic ego psychology continuum of mature vs. immature defenses to understand her clients, and emphasized this theoretical viewpoint in helping with her ability to see a common humanity between them.

Participant 4: My experience when I teach, and even when I was a student, was that whenever we cover a diagnosis everybody is worried, “Oh, am I borderline now?” “Do I have narcissistic personality disorder?”

Researcher: Right [laugh].

Participant 4: So that kind of anxiety that is experienced in the learning process is for me indicative that we are all in there, in one way or another, and when faced with significant stressors we can all regress and we will all use some unconscious defenses that are more primary. Projective identification, for example, I think is very useful. I think we can all go there, depending on circumstances.

Later...

Researcher: Right, so just to repeat back what I think I’ve heard. The question presents a certain continuum of “normative” versus “extreme” personality construction, and I think you’re saying that, well, I tend to use a different scale that is more developmental.

Participant 4: Right. And so I think that when you have people at one end of the extreme, then, okay, how do we help these people to move forward [developmentally], which is different then when somebody functions here and then they regress, can we get them back to there.

Most participants [2, 3, 5, 6, 8] offered some version of Participant 4’s idea that, given the right circumstances, any person could be temporarily stressed to the point of having a PD-type presentation. As Participant 2 put it, quoting a clinician friend, “Everyone has borderline personality disorder in a breakup.”

Supporting this view, all participants endorsed the opinion that PD was “better understood as a matter of degree” than of “kind.” Participant 3 asserted that such a view was absolutely necessary for the understanding of “treatment” at all. How could a PD client ever get better if they weren’t on a continuum with more normative personality, especially if that disorder was perceived as being defined by an over-reliance on more “primitive” and “immature” ego defenses? Maturity, after all, is usually seen as factor existing within the continuum of a lifespan, and typically improving with age.

Participant 7 challenged the very idea of the question, “I mean [laughs], on the one hand you can’t have a psychopathology that doesn’t have building blocks that exist in the normal range. I mean, what would that be?”

### **The Question of Stigma**

The findings of the current research revealed strong feelings of ambiguity among interviewed clinicians regarding the way personality is currently defined within the DSM, and the way to which this diagnosis is used and viewed within the mental health community. As mentioned above, “Axis II” was mentioned by participants almost interchangeably with borderline PD diagnosis, and it with that association that, specifically in regard to BPD, that most of the comments should be understood. In addition, though not directly asked, many participants felt compelled to offer their private opinion that they found borderline PD and Axis II in general had become too pejorative as a diagnostic label and led to stigma and reductive thinking within the mental health community. Participant 1: “Unfortunately, as you know, that borderline diagnosis has got to go because it’s too pejorative.” Participant 2: “I’m not sure what to think about this, but I *do* have big problems with the DSM approach currently, that it is too pejorative, and this seems like maybe an improvement.”

Participant 4: Well, I think especially for Axis II diagnosis, I know for myself as a clinician, I struggle with giving an Axis II diagnosis because it carries such a stigma and pejorative notions. And as long as you’re the provider, and have established a relationship and the situation is indeed workable, then that may be okay [to give that diagnosis]. But if they’re ever transferring to someone else, I think the label can perhaps get in the way of another clinician with perhaps seeing the client’s strengths.

## The DSM: Pro or Con?

Despite the widespread disappointment with the current DSM model of PD, most participants, with the exception of Participant 8, were resistant to the idea of dispensing with the current DSM categories entirely and replacing them with personality trait scores alone. Most answers congregated towards the issue of the utility of the categories in helping with description, assessment, case formulation and treatment planning.

Participant 4: I think [the categories] help me diagnostically to be organized. If I think about somebody as a borderline diagnosis, then that is going to exclude certain features that would belong, for example, to narcissism. And while there may be some flavor of narcissism present, for example the narcissistic rage, but the category is very different. So I think there is something useful in the categories, but again, any extremes loses something of the human essence.

Participant 6: It's helpful to have the categories to inform how you might want to interact with a person. That is one thing I rely on. When I start seeing those features of the category, then I know I have to shift gears in how I relate and understand them.

Participants 1 and 6 also added that diagnostic categories were clinically useful and needed to be maintained. Participant 3 further argued that such DSM categories are useful in general with regard to psychopharmacology because, "sometimes you need categories to make a decision about what you're going to do with medicine." Participant 7 noted suspected flaws he foresaw in the FFM model: "Well, I think you would have such a long list of traits so that it would be practically unwieldy, and then also the risk would be to lose the theoretical underpinnings, which is *already* happening in the DSM." Only Participant 8 seemed to see no downside to an exclusively trait-score-continuum model that dispensed with diagnostic categories entirely.

Of them all, Participant 7 went the farthest in his defense of the current DSM model of describing and categorizing personality disorder.

Participant 7: On the other hand, strictly saying that [all psychopathology has building blocks within the normal range] would miss the point that there are elements [within that diagnosis] that are distinct, for example the incredibly intense inability to be separated or alone that I just mentioned, that deflates the integrity that you have for yourself, so that you're disintegrating. That's the really extreme form of borderline experience. I mean, it's built on the ability to feel disassembled and even that you're *dying*, that's a feeling that is built into all of us, but it's such an extremely abnormal way to feel that I'm not sure that it's helpful to say that it grows out of a way that you and I experience a little bit and not a lot. Because I don't experience that at all.

The theme that all behavior could be subjectively viewed as "strength" in one context but pathology in another, occurred in every interview, yet Participant 7 went the farthest in asserting that, while "compensatory," it would be a mistake to lose sight of the classic view of personality disorder as an impairment of healthy personality functioning.

Participant 7: The broad statement I'm making is the fundamental problem facing the person with significant Axis II, especially the deep-seated narcissistic and borderline, is that those diagnoses prevent the natural experience and expression of many of these things [items on the character strength list], though I'm not going to say all of them. They're deprived in a certain way of the ability to fully experience it in the way that an un-affected person would, that it's so distorted by the underlying tensions of the illness.

### **Strength Axis is a Good Idea**

Many participants [2, 3, 8] endorsed the inclusion of an Axis VI for client's strengths that Dennis Saleebey (2001) called for. Participant 3 made reference to, "at one point, there was even going to be Axis VI with defense mechanisms," a plan he tacitly endorsed as supporting his chosen way of working. Participants 5 and 7 could see the possible utility of such an addition, but had concerns that it could simply devolve into another meaningless formality, of which they both felt there was more than enough in the current system of case conceptualization. Participant 5: "Well, I always want there to be more things, but I want them to *count*, which they [often] don't." Later, she added, "I

guess if it's just going to be a descriptor, than I don't know if it's useful. It just takes more clinician time." Participant 7 rather comically offered:

Let's put it this way: I'd rather have *that* as an Axis V than the current one, which assigns some sort of fucking arbitrary number that nobody ever really thinks about in any serious way as opposed to telling me something meaningful about the person.

Of all the participants, only Participant 1 openly resisted the idea of adding a formal axis devoted to strengths, mostly due to sentiments corroborating with Participant 5 that it would be just more work and likely not prove to be meaningful or useful.

### **BPD = Impairment in Relationships, Attachment and Love**

Participant 7 went the farthest in elaborating on what he saw has the fundamental impairment of Axis II, in particular cluster B borderline and narcissistic personality disorder: the disturbance in the ability to give and receive love.

Participant 7: To me the very definition of the character disorder, accurately diagnosed, prevents these strengths from really realistically occurring. That's the problem, especially in significantly narcissist and borderline [personalities]. Okay, take "Love." The central challenge of a borderline patient is the inability to attach and feel secure in an attachment. So how do you love if that's the case? Love isn't the love we would see in a healthy person so tested. Love is an area for conflict.

Later...

Participant 7: Love is significantly impaired by the diagnosis. Let's see, which ones wouldn't be impaired? A dependent personality can love, but it's a love that often has pathological qualities to it.

Researcher: In a way I think that's an interesting thing you've said. Of all the features, you could say that, while the word "love" doesn't appear much in the DSM, in some ways it kind of defines the Axis in a lot of ways.

Participant 7: I think it does. Certainly though attachment theory and that kind of way of looking at it, I think love is way up there. Are you capable of giving and receiving love?

Researcher: And if the answer is no – I’m sorry to interrupt – but in a way I think you’ve seized on the compensatory strength, which would be persistence against the current of the rest of society.

Participant 7: Exactly, exactly. There aren’t any satisfying attachments but you keep trying and you keep searching.

Other participants, while straining to frame personality disordered behavior in terms of strength, felt compelled to acknowledge that in the realm of love and attachment it would be hard not to see certain presentations as impairments or pathological deformations. However, most framed this as the direct result of attachment failure and past trauma, frequently developmental trauma:

Participant 4: And I think that in environments that are very invalidating, then the person, or the child, gets confused and it’s not really clear, “Who am I?” And “Why are others responding in this way?” And the methods of compensating are then different.

### **Would 100 Narcissists Have the Same Strengths?**

A question that lingered over the research project was: *Would one hundred people with the same PD diagnosis have the same character strengths?* This was a question that the researcher did not include on the official list of submitted questions but which began to be asked at interview three onward as it became apparent that the “compensatory relationship” question was phrased too generally and was garnering/eliciting responses that were too broad and unfocussed to be used very productively for the purposes of the research. (Most participants’ answers offered some version of “sure” or “of course” without it leading to any specific or precise illustration.) Unfortunately for the purposes



of research, because the question was asked informally each time and therefore was not scripted and submitted consistently to each participant, the amount of control on the data collection process was reduced. Three separate versions of the question are submitted below.

Asked in Interview #3:

Researcher: So, this isn't a printed question, but since it keeps coming up I'm just going to ask it off the record, as it were. Part of what I'm hoping to explore [with this research project] is.... Here would be an example: let's say I had a hundred people who were accurately diagnosed with narcissistic personality disorder. Do you imagine that those people – and there's a big challenge that exists to the design of the diagnostic criteria of that disorder, but that aside, let's say it's designed perfectly – do you think [these 100 narcissistic personality disordered people] would have similar strengths?

Asked in Interview #4:

Researcher: So this is a big hypothetical. Let's say I had two hundred clients diagnosed with narcissistic personality disorder, and I was able to identify their character strengths on some kind of measuring tool – which in fact these guys [pointing to Peterson and Seligman's strength list] – do you think I would have similar clusters of strengths?

Asked in Interview #7:

Researcher: What if I could get two hundred people who were accurately diagnoses with narcissistic personality disorder, and if I were to test them for what their character strengths — and these guys [Peterson and Seligman] have created such tests – would I find similar strengths, do you imagine?

Of those participants asked this question [3, 4, 7, 8], three hypothesized that they expect no such commonality would be found in the character strengths of people with shared personality disorder diagnosis, while only Participant 8 endorsing a hypothesis that there would be similar strengths found. Interestingly, the majority response seems to contradict the results collected from question eight, in which participants were asked to assign character strengths to a specific PD case they had worked on. Of the eight participants, four chose a client with borderline PD [Participants 1, 2, 3, 6], with two

strongly implying that borderline was the diagnosis [Participants 4, 7], while two abstained from assigning any Axis II PD diagnosis [Participants 5, 8]. And yet, despite the denial of a direct compensatory relationship, all eight participants chose remarkably similar character strengths for their Axis II clients. For example, of the responses, all eight participants chose Persistence as a character strength for their Axis II client, with six of them [Participants 1, 2, 3, 4, 5, 7] selecting it as among their primary, exceptional strengths. Such similarity in response could be seen as strongly suggesting the possibility of a compensatory relationship between deficit and strength, even if the nature of such a relationship is yet dimly understood.

### **Character Strengths Found Within Character Disorder**

Below are the gathered findings: strengths endorsed by the individual participants as representative of their chosen Axis II clients. Among the more distant second selections, Bravery/Courage was selected by three participants [2, 3, 4] as among their client's primary strength, as was Creativity [2, 5, 6]. Humor was selected by two participants [3, 4]. Lastly, among the primary character strengths chosen, single participants endorsed Leadership [Participant 5] and Wisdom [Participant 8]. Some participants [1, 2, 4, 6, 8] made an aside to point out what strengths they felt would be most absent, typically: Temperance, Prudence, and Emotional Regulation.

**SCORE:**

**Participant 1:** *Axis II diagnosis chosen: borderline.*

*PRIMARY: Persistence.*

**Participant 2:** *Axis II diagnosis chosen: borderline.*

*PRIMARY: Bravery, Persistence and Creativity.*

*SECONDARY: Curiosity, Love of Learning, Integrity, Love, Kindness, Social Intelligence, Open Mindedness*

**Participant 3:** *Axis II diagnosis chosen: borderline.*

*PRIMARY: Courage, Persistence and Humor.*

*SECONDARY: Curiosity, Love of Learning, Social Intelligence, Humility, Modesty, Self-Regulation, Hope, and Forgiveness and Mercy*

**Participant 4:** *Axis II diagnosis chosen: strongly implied borderline PD with complex PTSD.*

*PRIMARY: Bravery, Persistence, Humor.*

*SECONDARY: Wisdom.*

**Participant 5:** *Axis II diagnosis chosen: none given.*

*PRIMARY: Persistence, Leadership and Creativity.*

*SECONDARY: Hope.*

**Participant 6:** *Axis II diagnosis chosen: borderline.*

*PRIMARY: Creativity.*

*SECONDARY: Courage, Persistence, Social Intelligence, Humor, and Gratitude*

**Participant 7:** *Axis II diagnosis chosen: implied borderline.*

*PRIMARY: Persistence and Courage.*

*SECONDARY: Kindness, Emotional Intelligence, Humor.*

**Participant 8:** *Axis II diagnosis chosen: declined.*

*PRIMARY: Wisdom.*

*SECONDARY: Perspective, Bravery, Persistence, Humanity, Humor, and Hope.*

## Chapter V

### Discussion

This study aimed to explore the perspective of seasoned mental health clinicians in Western Massachusetts regarding their experience working with personality disordered individuals, and how that experience squared with current debates within personality science and positive psychology. The research question explored was: In what ways do clinicians conceptualize personality disorder and character strength? Do they see a value in moving towards a theoretical framework that sees PD and character strengths as existing on the same dimensional axis? What are the possible strengths and weaknesses of this approach from a clinical perspective?

As discussed in the previous chapter, the principle findings of the research were that: 1. Mental health clinicians associate PD care almost exclusively with BPD. 2. They tended to endorse the view that all behavior can be seen as adaptive and thus the very subject of strength is necessarily subjective. 3. Many leaned toward a hierarchical continuum of mature-immature behavior. 4. Many were averse to the use of Axis II categories out of concern for diagnostic stigma. 5. Despite that, almost all were resistant to dispensing with DSM PD categories altogether, mostly for reasons of clinical utility. 6. The majority endorsed or accepted the inclusion of a strengths axis for client diagnosis. 7. Some saw in BPD presentation as impairment in the capacity for love and attachment. 8. Many did not predict that people with the same PD would have the same character strengths. 9. Despite this, participants overwhelmingly associate BPD with the strength of Persistence.

In the following chapter, the strengths and limitations of the study will be addressed, as well as the implications for future research.

### **Endorsement for a Dimensional Perspective (With Caveats)**

Participants as a rule endorsed the underlying premises of the dimensional perspective of personality science as defined in the literature. From their perspective as clinicians working with PD, for the most part they readily embraced that PD features were matters of “degree rather than of kind.” This clinical intuition is supported by the findings of those researchers (Cawley, et al, 2000; Glover, Crego & Widiger, 2012; Haslam, Bain, & Neal, 2004; John, Naumann, & Soto, 2008; Samuel & Widiger, 2008; Samuel, Simms, Clark, Livesley, & Widiger, 2010; Saulsman and Page, 2004) who have mapped out an overlap between disordered to normative to exceptional personality traits. For the participants interviewed, the idea of PD diagnosed individuals existing on a continuum that included healthy functioning was almost a prerequisite of their therapeutic work. While no interviewed participant endorsed being particularly familiar with either the Five Factor Model, or in the current efforts of researchers to map personality functioning on a dimensional scale, none expressed any doubt that such measurements were possible and that the findings would support a dimensional view.

Further, as revealed in the findings, many participants expressed the opinion that a dimensional view of personality disorder was preferable quite aside from the issues of scientific veracity in that it would help to reduce stigma. Any effort to lower or eliminate stigma around borderline, narcissistic or other personality disorders was seen by many participants as a good in and of itself, and a continuum approach that went so far as to

include client's strengths was seen as better still as it contained the potential of empowering through a diagnosis of strength.

An unexpected outcome of the research was to uncover an entrenched debate within the clinical field about the uses and misuses of the Axis II diagnosis, and the way the current DSM conceptualization does not adequately account for the impact of trauma on the personality presentation, and results in stigma and shaming the negatively impact therapeutic empathy and alliance building. As revealed in the findings, many clinicians confessed to outright reluctance to the employment of the diagnosis.

Whether the Axis II was used or not, participants widely agreed that PD diagnosis continued to be hampered by the problem of subjectivity and stigma illustrated in our brief history of the development of personality science outlined in the review of the literature. While we may no longer use Emil Kraeplin's (1904) "psychopathic personality" labels to reductively label individuals as essentially "excitable" or "irresolute," the current DSM-IV diagnoses of borderline or narcissistic PD was found by many participants to perpetuate the dynamic of stigmatization that Krueger and Eaton (2010) criticized as "inherently a matter of societal and professional opinion," and which Edward Shorter (2012) dismissed as existing "not as natural phenomenon but as cultural phenomenon."

The question of stigma and subjectivity was underscored by the large subset of participants [2, 3, 4, 6, 7] who noted that behavior typically pathologized as "disordered" in Axis II presentations could also be seen as serving as ego-syntonic adaptive coping mechanisms, usually framed in the form of ego defenses of greater or lesser maturity within the theoretical framework of classic psychodynamic theory (Mitchell & Black,

1995). Put more bluntly, all behavior that we could pathologize could also be viewed as an adaptive coping skill to maintain survival and reduce distress. However, while the classic model does perhaps eschew more judgmental hierarchical continuums of “good” and “bad” or “healthy” and “sick,” its hierarchy of “mature” and “immature” certainly reifies certain coping strategies as more developmentally advanced and sophisticated, thus worthy of being fostered within clients.

Within the present research, all participants universally embraced the strengths perspective as advocated by Dennis Saleebey (1992, 1996, 2001, 2005). Most agreed with Saleebey’s criticism of the current DSM and decrying its impact in encouraging a focus of deficit alone. Further, most participants showed interest and tacit if not explicit approval of Seligman and Peterson’s attempt to create a taxonomic classification of character strengths (2004), agreeing with Saleebey’s criticism of asymmetry in pathology vs. empowering language and supporting the advice of Wolin and Wolin (1997) that what’s needed was a “systematic, developmental vocabulary of strengths that can stand up to pathology terminology that is the standard in our field.”

However, despite the widespread criticism of the DSM and its flaws and limitations, almost all participants with the exception of Participant 8 resisted the embrace of dimensional-only model of human personality that dispensed with PD category labels, the position advocated by researchers Widiger and Tull (2007). Most participants found the existing categories usefully descriptive of the symptomatic presentations they encountered and useful in suggesting possible courses of treatment, including, as Participant 3 mentioned, medication treatment. While no participant challenged the specific arguments of Widiger and Tull that dimension-only models would

be a more structurally valid or comprehensive form of modeling, some like Participant 7 suspected such innovations would be unwieldy in practice. It was enough for clinicians to keep in mind that their client's personality was made from "building blocks that exist in the normal range." The insertion of complex personality scales as a necessity for diagnosis was seen as potentially burdensome to their work. The implication suggested by the findings of the present research with respect to the literature, is that the growing call to reconceptualize PD in terms of trait dimensions only (e.g., Clark, 2007; Frances, 1993; Livesley, Jang, & Vernon, 1998; Trull & Durrett, 2005; Widiger, Livesley, & Clark, 2009; Widiger & Samuel, 2005) was likely to emerge more from the domain of researchers than from clinicians, and possibly over the latter's objections.

Lastly, when asked to select from a list of strengths they felt were most strongly representative of an individual Axis II diagnosed client, clear patterns emerge from the findings, with BPD being the only specified diagnosis, and Persistence being far and away the most selected strength, and Bravery and Creativity being the second strengths most selected.

### **New Directions for Research**

Even within the limited scope of the present research, a relationship between character disorder and strength remains an intriguing possibility suggested by the findings. As mentioned above, despite no participants assuming a direct linked relationship in the presence of any specific deficit or strength, almost all participants endorsed the presence of Persistence as a strength prominently featured among their borderline PD diagnosed clients. This finding alone is not sufficient to establish the



presence of a necessarily direct compensatory relationship suggested above. For one, despite Peterson and Seligman's early effort at strength classification (2004), there is no precise, universally established, or internally valid criteria for defining of Persistence as an exceptional trait distinct from what would be found in the general population. As reviewed within the literature, Peterson and Seligman's strengths models did not fare well when tested, either as internally valid or in corresponding with other personality measures (Furnham & Lester, 2011; MacDonald, Bore & Monro, 2008). Their effort at classification is likely only a first step of a much larger and ongoing project and warrants continued research.

Yet despite this need it remains clear both within the empirical research literature and within the present qualitative study that our understanding of character strength remains woefully behind that of sickness.

Within the current research, the answers provided by the participants remain fuzzy and hazily defined when speaking about client strengths. Much of the time it seemed adequate for participants to acknowledge that their PD clients simply *had* strengths, or that their client's pathological behavior could and should be re-framed as *also* being strengths in terms of survival and coping with internal torment. Yet, while it is arguably possible to say that all human behavior is open to subjective interpretation, it remains clear that the existence of objective pathological behavior tends not to be doubted while the existence of objective character strength often is. The presence of suicidal ideation and self-harming behavior, for example, tends to be universally seen a reliable indicator of mental illness, regardless of culture or nation. The participants of the current research, lacking a universal systemic and comprehensive vocabulary and

classification of strengths for their clinical practice, were often left puzzling over the list of character strengths that were culled from Peterson and Seligman's classification (Appendix C). Selecting from a precisely specified strengths list was clearly an unusual activity for them. Most participants were left hemming and hawing before shrugging to endorse an open-ended laundry list of possible strengths. The selection of strengths was not done rigorously. Participants expressed no hesitancy in giving out strengths, and saw no danger in giving out too many strengths or of endorsing the presence a strength that might not be universally corroborated. No participant felt the need for some form of criteria to establish the presence of a strength before endorsing it, being content with their own subjective opinion as clinicians to establish its veracity. In no interview did any participant of the present research theorize as to the etiology of character strength, as to how such strengths come into existence and what they are constructed from. Questions designed to inquire after a suggested possible relationship between strengths and deficits within the psychic structure were often greeted by participants as novel and intriguing ideas, unfamiliar to their usual way of thinking about things. Participants for the most part seemed to be content with simply acknowledging that strengths simply *existed* within their clients and to make an effort to see them. Even among those participants who were the most vocal advocates for an emphasis on strengths in clinical work did not see strengths as something to be rigorously defined or classified, but simply identified and collected.

This somewhat unfocussed approach to strengths is precisely what Peterson and Seligman's efforts (2004) were designed to correct. The findings of the present research suggest that within the field of clinical mental health there is a lack of rigor in the

understanding and application of strength information even among clinicians who expressly favor a strength-based approach. The insertion of strengths language seems to be generally looked on benignly and favorably, but with a lack of intellectual rigor about the point and purpose of such observations, and, more importantly, how it might be employed and utilized for clinical interventions. Without a more substantive understanding of strength, it is possible that “strength-based” efforts can languish as essentially a clinical side-show to the main event of symptom-based interventions, or devolve into mere happy talk without specific, focused clinical purpose.

As reviewed within the literature, Park, Peterson, and Seligman (2006) offered important preliminary findings that suggest there were no substantial differences of character strengths profiles within regions of the U.S. or between nations. While not firmly established, it is possible that character strengths are no more or less culture-bound than mental illness, and, even more likely, no more or less culture-bound than personality disorder. It is possible that a dependable, reliable and measurable classification of strengths can thus be created whose utility and validity is equal to the DSM itself. Further, it may be possible to develop a deeper theoretical taxonomy that may reveal the underlying structure of character strength formation, why appears in some and not others, and how its creation might be fostered in those that lack it. At present, by their own admission, Peterson and Seligman’s classification lacks such a profound understanding (2004, p. 6).

## **Limitations of the Study**

Hindsight grants a better critical perspective on the flaws, weaknesses and limitations on the design of the research study. First, in terms of sheer *amount* of data, the study failed to recruit the original goal sample size of 10-15 experienced clinicians as participants before the constraints of time required the end of the data collection process. An initial over-reliance on cold emails to a community clinician referral list failed to recruit one single participant within the time allotted, and the effort to use such methods used up valuable time. In the end, all participants were recruited through a snowball sampling beginning with the researcher's own personal contacts with experienced clinicians in the region. In hindsight, this recruitment method would have been relied on more strenuously, and more time would be devoted for snowballing referrals to arise and be included.

From a demographic perspective, the sample of the present study could be criticized for being too racially, ethnically and culturally homogenous. Further, it could be criticized for being too homogenous in terms in theoretical perspective and clinical opinion. For example, of all participants, only one defended with any vigor the DSM's current approach to personality disorder and the way it conceptualizes PD constructs. Considering the sway that the DSM has over the mental health profession, and that it acts as something like the official voice of the American Psychiatric Association (APA), it is easy to suppose that more and better defenders of this official voice could be found. Without adequate defenders for its point of view, the DSM and the APA that produces it, stands in danger of serving merely the role of a straw man in an important argument the

research is intended to explore, with the APA perspective too easily dismissed due to a lack of able defenders representing its position.

Contrary-wise, the scope of the clients discussed by participant mental health clinicians might usefully be narrowed to one diagnosis. As has been already in the findings section, despite interview questions focusing on generic “personality disorder” or “Axis II,” all interview subjects spontaneously focused on borderline personality disorder practically to the exclusion of all others PDs listed in the DSM. Given this unexpected finding, it would likely be better for further research to tailor such a study to this specific diagnosis, and to direct all interview questions to specifically address what all participants seemed to have implicitly concluded: that to talk about PD is to really talk about borderline PD. Further studies regarding work with PD *outside* of the borderline diagnosis would likely require a far more strenuous and lengthy recruiting process as experience with such cases seems to be far rarer.

Further, it now in hindsight seems correct to specifically design the sample to include those clinicians who resist the formal use of Axis II diagnosis or who think it is an incomplete way to assess individual clients, despite the recognition that their clients may technically fit criteria for them. As reviewed above in the current findings, the principal reason for resistance to such a diagnosis seems to be a concern about stigma and a sense that it does not adequately capture or emphasize the impact of trauma as a factor. Yet the current research design did not provide for or define any alternative way of identifying PD outside of the current DSM model.

This leads to perhaps another limitation of the present study: it was designed to explore PD as a construct possibly existing on a dimensional axis with other personality

constructs, rather than as a possible response to trauma. Such etiological questions of PD were left as beyond the scope of this study's original design, however, of the participants interviewed, several [2, 3, 8] saw the presence of trauma as being the key salient factor in understanding PD in general, and borderline PD in particular. Additionally, as Participant 3 observed, the study of trauma is still relatively new in the field of psychology, as is its impact in shaping the human personality. It is possibly more fruitful to look at the environmental, relational and developmental stressors — stressors such as trauma — that *lead to* the creation of character constructs such as strengths and disorders if one is to truly understand and conceptualize the possible relationship between them.

## **Conclusion**

The release of this study coincides at a moment when the entire construction of the Axis II as it currently appears within the DSM-IV is under question, mere weeks before the release of the DSM-5 and its anticipated major revisions. While the present research is limited in scope, the researcher believes its findings add to the growing voice calling into question the implicit design within the Axis II diagnostic model.

Even from this research project's brief and limited survey of clinical opinion, findings suggest that, despite being privileged with its own Axis, the Axis II is often unused by clinicians, or when used is largely confined to only a very few diagnostic presentations, leaving the other nine or so to languish as diagnostic oddities within the literature. Why these other nine are mostly ignored by clinicians in the field is not precisely known, but perhaps due to the reluctance of stigmatize patients or to avoid assuming an "enduring pattern of inner experience" (APA, 2000, pp. 685) when another

Axis I diagnosis might serve just as well to address a client's present distress. Further, simply based on the soon to be reduction in the number of separate Axis II diagnoses from ten to six, the question is raised about the validity of each individual diagnostic label, and of the rationale of clustering such diverse diagnostic presentations into one shared category as an Axis. As Participant 7 said in regard to schizotypal PD, "I wonder about that as an Axis II to begin with." As the review of the literature has demonstrated, researchers have found compelling evidence against the empirical validity of the Axis II, and against the current three-cluster structure (Bastiannson, Rossi, Schotte, De Fruyt, 2011).

It is a hypothesis of the present research that a compensatory relationship is likely to exist between the formation of character strengths and disorder. Just as such compensatory relationships exist throughout the physical and metaphysical universe, for example in the opponent-process theory of Ewald Hering (1868) regarding color, the present research theorizes the possibility of such a relationship occurring in the realm of personality and character formation. The findings of the present study offer teasing preliminary data suggesting the need for future research to explore this theorized relationship further. For example, even using the theoretical frame of classic ego psychology discussed above, where all behavior "compensates" for emotional pain and vulnerability, it is not clear why particular ego defenses occur in compensatory response to specific ego challenges. As relating to the current findings, is it random chance that borderline PD individuals seem to consistently display persistence as a characterological feature? Is it perhaps a necessary outgrowth of the same etiological factors created the personality disorder in the first place? Peterson and Seligman's (2004) attempt at

character strength classification is likely a flawed and incomplete early effort at a project that deserves far more attention, especially if it is to achieve some parity with the literature and research of character disorder.

The questions the present research was designed to address was whether there was potential value in moving towards a theoretical framework that sees PD and character strengths as existing on the same dimensional axis. The principal findings of the research suggest that there is. The review of the literature of personality science strongly supports the view that characterological strength and deficit can properly be understood as existing on the same continuum with normative personality configurations. The research project's sample of clinicians experienced in working with PD revealed a high degree of overlap and similarity in the strengths they selected as associated with individuals sharing the same BPD diagnosis, suggesting the possibility of direct compensatory relationship between the two. These same participants also endorsed within their own clinical judgment the need, validity, and utility of conceiving of client strengths as being part of and entwined with disordered personality presentations, and were intrigued and supportive of efforts to enhance or awareness, understanding and engagement of client's strengths resources within the field of mental health. In conclusion, the present research supports viewing strengths and disorders of personality on the same continuum and supports the trends of current personality science moving in that direction.



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## APPENDIX A: INFORMED CONSENT FORM

Dear Participant,

My name is Josh Tecu and I am a graduate student at the Smith College School for Social Work. As part of my Master's thesis, I am conducting a study on the ways experienced clinicians conceptualize personality disorder and character strength, especially in light of the dimensional trait models expected to be featured in the upcoming DSM-5. This research will be used for my master's thesis and may be used in the future for professional presentations and publications on this topic.

I am contacting you as a professional mental health therapist within the United States, a licensed PhD of Psychiatry or Psychology, PsyD or LCSW or equivalent with a minimum of five years experience as a practicing clinician who has worked with clients with an Axis II diagnosis of personality disorder. In my study I intend to collect data via in-person interviews with licensed mental health clinicians regarding their work of longer than two (2+) months with clients diagnosed with an Axis II personality disorder or clients suspected of having significant personality disordered features. Interviews should take 30-45 minutes, and would be conducted at a time and place convenient for you, and that we both deem comfortable and private enough to ensure confidentiality of the case material being discussed. The only other specific demographic information included in the study will be your, the participant's, general educational and professional training and background, licensure status, theoretical orientation and experience working with PD diagnosed client's. All interviews will be captured by a digital audio recorder and transcribed by myself. In the event that I do hire outside transcribers for help, a signed agreement of confidentiality will be obtained prior to transcription.

The study proposed has been submitted and approved by the Smith College Human Subjects Review Board. While the risks are remote, there remains the possibility of accidental disclosure to me of the identity of clients whose cases we may discuss, or that the discussion of previous case material will elicit strong emotions from you. Please be careful to not disclose any identifying client information. By agreeing to participate in the study, you will be contributing to research that aims to expand and enhance awareness of the strengths perspective and positive psychology. Through participating, you may personally benefit by gaining a broader understanding of how "disordered" elements of personality are related to "non-disordered" strengths and virtues. Although, due to the limited resources of the project,

no material benefit of compensation can be granted for your participation, the donation of your time and clinical insight would be greatly appreciated.

While participation in the study is not anonymous, all efforts will be made to insure to protect the identity of any clients of yours discussed. No identifying client information will be included in the study. All questions regarding case material will be general in nature and should pose no risk to client confidentiality. All data will be presented in the aggregate. All transcriptions will be done by me or by a professional transcriptionist who has signed a pledge of confidentiality. All physical data will be stored in a locked cabinet, and all electronic data in a password-protected file. As required by federal regulations, all research data will be kept secure for three years, after which it will be destroyed. If any data is continued to be used for research purposes beyond that point, I will continue to use the security measure mentioned above and destroy the data when no longer needed.

Your participation in the study is voluntary and you may withdraw from the study or refuse to answer any question or choose to restate an answer at any time during the data collection process up to May 10, 2013. In the event of a withdrawal, all materials pertaining to you will be destroyed immediately. You may contact me, the researcher, at anytime via phone at (413) 586-0331 or email [jtecu@smith.edu](mailto:jtecu@smith.edu) regarding any questions or concerns you have about the research project and your participation in it. Additionally, you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. Please keep a copy of this consent for your own records.

Thank you for your participation in this research project.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICPATE IN THE STUDY.**

Participant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Investigator's Signature \_\_\_\_\_ Date: \_\_\_\_\_

## APPENDIX B: QUESTIONS LIST

I am conducting a study on the ways experienced clinicians conceptualize personality disorder and character strength, especially in light of the dimensional trait models expected to be featured in the upcoming DSM-5. Please weigh these issues as you consider the following questions.

Before beginning the interview, please provide the following basic demographic data:

A.) Educational background.

B.) Professional mental health training:

C.) Licensure Status:

D.) Theoretical orientation:

E.) Experience working with personality disordered clients:

1. In what ways do you see character strengths reflected in your clients?  
Specifically, your most persistently characterologically challenged clients, those who have earned a diagnosis of Axis II personality disorder as defined by the current DSM-IV?
2. Have the PD diagnosed clients you have worked with demonstrated compensatory strengths to offset, manage or compliment their characterological challenges?
3. In what ways do you conceptualize a relationship between PD and character strengths? Do you see characterological strengths and deficits as being interrelated and, if so, how?
4. The Five Factor Model (FFM) conceptualizes human personality on five broad, bipolar trait dimensions: Extraversion (vs. Introversion), Agreeableness (vs. Antagonism), Conscientiousness (vs. Disinhibition), Emotional Stability (vs. Neuroticism), and Openness (vs. Closedness) to Experience. Subsequent models



have attempted to extract from the FFM dimensional system scales that capture personality disorders, while others have been designed to capture character strengths. Do you see a value in moving towards a dimensional framework for the current conceptualization for personality disorder?

5. Are personality disorder characteristics, in your opinion, better understood as matters of degree or of kind? Are such characteristics better understood as of made up extreme variations of otherwise normative personality traits, or should they be seen as distinct constructs separate and apart from healthy personality formation?
6. What would be lost in a trait-only model, in your opinion, if later versions of the DSM were to dispense with the categorical approach for Axis II and replace it with personality trait measurements alone?
7. Should later versions of the DSM include an Axis VI for clients' character strengths? Would there be any possible clinical utility of such strength-based diagnostic information? How might it be used by you in your clinical practice?
8. Considering specific PD diagnosed clients you have worked with in the past, what possible character strengths would be comfortable assigning to them from Peterson & Seligman's list of strengths and virtues [see attached]?

## APPENDIX C: CLASSIFICATION OF CHARACTER STRENGTHS

### **Wisdom and Knowledge** (strengths that involve the acquisition and use of knowledge)

creativity [originality, ingenuity]  
curiosity [interest, novelty-seeking, openness to experience]  
open-mindedness [judgment, critical thinking]  
love of learning  
perspective [wisdom]

### **Courage** (strengths that allow one to accomplish goals in the face of opposition)

bravery [valor]  
persistence [perseverance, industriousness]  
integrity [authenticity, honesty]  
vitality [zest, vigor, energy]

### **Humanity** (strengths of tending and befriending others)

love  
kindness [generosity, nurturance, care, compassion, “niceness”]  
social intelligence [emotional and personal intelligence]

### **Justice** (strengths that build healthy community)

citizenship [social responsibility, loyalty, teamwork]  
fairness  
leadership

### **Temperance** (strengths that protect against excess)

forgiveness and mercy  
humility and modesty  
prudence  
self-regulation [self control]

### **Transcendence** (forge connections to the larger universe and provide meaning)

appreciation of beauty and excellence [awe, wonder, elevation]  
gratitude  
hope [optimism, future-mindedness, future orientation]  
humor [playfulness]  
spirituality [religiousness, faith, purpose]

## APPENDIX D: RECRUITMENT EMAIL

Dear Participant,

My name is Josh Tecu and I am a graduate student at the Smith College School for Social Work. As part of my Master's thesis, I am conducting a study on the ways experienced clinicians conceptualize personality disorder and character strength, especially in light of the dimensional trait models expected to be featured in the upcoming DSM-5. This research will be used for my master's thesis and may be used in the future for professional presentations and publications on this topic.

I am contacting you as a professional mental health therapist within the United States, a licensed PhD of Psychiatry or Psychology, PsyD or LCSW or equivalent with a minimum of five years experience as a practicing clinician who has worked with clients with an Axis II diagnosis of personality disorder. In my study I intend to collect data via in-person interviews with licensed mental health clinicians regarding their work of longer than two (2+) months with clients diagnosed with an Axis II personality disorder or clients suspected of having significant personality disordered features. If you meet these criteria, please contact me via this email or the phone number listed below.

Please see attached a letter of informed consent, which explains in more detail the purpose of the study and the nature of for participation in it. Also attached, please read my list of questions to guide us during any future interview, and of a short list of character strengths taken from Peterson and Seligman's *Character Strengths and Virtues: A Handbook and Classification* (2004).

If you have any questions or concerns regarding participation in the study, please feel free to contact me by email (jtecu@smith.edu) or by phone: 413-586-0331.

Sincerely,

Josh Tecu

Smith College School of Social Work

## APPENDIX E: HUMAN SUBJECTS REVIEW APPROVAL LETTER



School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

March 14, 2013

Joshua Tecu

Dear Josh,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett'.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.  
Acting Chair, Human Subjects Review Committee

CC: Joanne Corbin, Research Advisor