Bridging the implementation gap in dimensional personality models†

COMMENTARY

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SUMMARY

Natoli et al present a comprehensive higher level framework aligning dimensional personality pathology assessment with treatment delivery through a hierarchical model. Their approach integrates common therapeutic factors with trait-specific interventions, offering a promising pathway for clinical implementation. Despite strong evidence supporting the superiority of dimensional models and the field's shift towards dimensional classification, they remain largely unused in clinical practice after a decade, despite evidence of clinical utility and learnability. Although the authors' framework demonstrates how dimensional approaches could work in practice, particularly through matching severity to treatment intensity and traits to specific interventions, healthcare systems require evidence of improved clinical outcomes before undertaking systemic change. Without controlled trials demonstrating enhanced treatment effectiveness, dimensional models risk remaining theoretically superior but practically unused. While healthcare systems remain tethered to categorical diagnostic approaches, the authors' framework offers a practical pathway for implementing dimensional models – one that now requires testing in real-world settings.

KEYWORDS

Diagnosis and classification; evidence-based mental health; mental health services; service development; psychotherapy.

Natoli et al (2005, this issue) provide a compelling framework to advance the long overdue transition to dimensional models of personality pathology. Their emphasis on aligning assessment hierarchies with intervention approaches offers a promising pathway in the march towards the adoption of a dimensional model. Since Galen's application of Hippocratic humours and Theophrastus's character types, debate has endured between dimensional and categorical characterisations of personality pathology. As Natoli et al note, there is now little doubt about the dimensional model's superiority, and although voices long expressed that 'the time had come' for change before DSM-5's release (Clark 2007; Widiger 2006, 2007), the voice of a vocal minority has since evolved into broad field consensus (Hopwood 2018a). ICD-11's adoption of a dimensional framework as the primary model represents a decisive shift in 'official' adoptions, although vestiges of categorical thinking remain in its retention of the borderline patten specifier (Mulder 2023). The field now faces a new challenge: moving from empirical and theoretical superiority to practical implementation. Natoli et al's multidimensional framework offers valuable insights into this transition, yet the field continues without the critical need for evidence that this approach leads to measurably better patient outcomes and healthcare efficiencies.

The paradox of non-adoption

Natoli et al, outline both the established limitations of categorical approaches and the evidence supporting the utility of dimensional models. Yet this evidence highlights a stark reality: despite a strong evidence-base (Hopwood 2018a) and demonstrated clinical utility (Bach 2022), implementation remains severely limited. DSM-5's alternative model for personality disorders (AMPD) is now over a decade old, yet remains largely unknown to clinicians in practice, absent from most post-graduate training curricula and disconnected from government and insurance remuneration schemes. This is particularly perplexing as dimensional approaches are readily learnable, with both undergraduate and professional graduate students demonstrating high inter-rater reliability and score equivalence with expert ratings (Few 2013; Zimmermann 2014; Garcia 2018; Morey 2018; Garner 2022). Further, clinicians rate dimensional approaches more useful for treatment formulation and communication, with an overall preference for dimensional approaches. Perhaps some resistance lies in these same studies finding that some form of hybrid approach is still preferred, suggesting something alluring about a qualitative label (Bernstein 2007; Morey 2014, 2020). The gap between evidence and practice extends from theoretical and empirical challenges to institutional inertia – layers of bureaucracy, entrenched billing systems and decades of categorical treatment approaches create substantial barriers to adoption (Brown 2023).

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Natoli et al's proposed hierarchical framework may address several of these barriers by matching common factors to severity assessment and treatment intensity. Although this approach aligns with existing practices and provides the qualitative labels needed by clinicians and institutions – particularly given that personality disorder severity appears to be the primary prognostic indicator (Crawford 2011) – it raises complex questions about treatment targets. Evidence suggests that severity (personality functioning) changes over the course of therapy whereas personality style may be much slower to change, suggesting that individuals 'stay essentially who they are' (Natoli 2005) while developing more adaptive environmental interactions. This suggests a need to develop more adaptive manifestations of high traits while potentially 'taking the edge off' these extremes. Previous work suggests that personality functioning is the more malleable and important target (Wright 2016), yet individual cases may require a focus on reducing trait elevations when adaptive manifestations at certain extremes prove unrealistic.

A step forwards on a much-needed track

The proposal for modularised treatments for specific trait and impairment combinations is well-reasoned, building on existing evidence-based approaches (Hopwood 2018b; Ruggero 2019). This initial emphasis on guidelines was necessary – developing treatments before establishing stable models risks wasting resources and potentially discouraging clinicians back to categorical approaches. However, with more mature dimensional models now available, the field must shift focus towards practical implementation. The treatment of Morris in Natoli et al's case vignette is a nice illustration and guidance for future research to follow, and I hope the challenge of real-world evidence is accepted soon.

Changes to diagnostic systems must demonstrate improved patient outcomes to justify the disruption to healthcare systems (Lahey 2021; Zimmerman 2022). Although initial frameworks could serve as scaffolding for building this evidence base, we still lack the randomised controlled trials across multiple sites that would demonstrate superior outcomes compared with existing approaches (Zimmerman 2022). Larger scale trials also meet another barrier, as standardisation becomes more challenging when moving away from categorical diagnosis-specific protocols towards personalised approaches based on trait profiles (Krueger 2014; Waugh 2017). This is not to say that treatment approaches should not be individualised, and there are respectable arguments for the perils of providing this type of 'cookie-cutter' treatment; however, standardisation to some degree underpins reliable clinical trial data.

Demonstrable outcomes could manifest as shorter treatment durations, better recovery rates, lower readmission rates or – perhaps most compelling to institutions – reduced healthcare costs. To achieve this, we will likely need to see broader systemic changes. Training programmes should integrate dimensional approaches into their core curricula, moving beyond brief introductions to provide sustained practical experience (Zimmermann 2014; Monaghan 2023). This will mean that the next generation of clinicians will be familiar and confident enough with these models to integrate them into their practice.

To further reduce the implementation hurdle, treatment protocols could integrate dimensional-based frameworks with existing evidence-based treatments to draw on existing institutional knowledge, confidence and resources (e.g. cognitive–behavioural therapy, dialectical behaviour therapy, interpersonal psychotherapy). The psychodynamic tradition's emphasis on modelling adaptive interpersonal styles might be particularly relevant for certain trait profiles. Active work on the clinical demonstration is progressing within the Hierarchical Taxonomy of Psychopathology framework (Ruggero 2019). Data gained from these approaches might provide enough evidence to convince larger healthcare systems to change – if these approaches are indeed superior in practice.

Conclusions

The field has moved beyond debating the theoretical superiority of dimensional models; the next challenge is demonstrating their practical advantage in improving patient care. This requires a coordinated effort: developing standardised yet flexible treatment protocols, conducting rigorous clinical trials and creating implementation frameworks that healthcare systems can readily adopt. Natoli et al's clear framework and detailed case vignette represent important steps towards this goal, providing concrete guidance for implementing dimensional approaches in clinical practice. Psychiatry as a field now needs to extend this work to provide clear evidence that these models can provide better treatment outcomes if they are ever to see the light of day in mainstream practice.

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Declaration of interest

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