Personality Disorders: Theory, Research, and Treatment

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COMMENTARY

Personality Disorders Are Dead; Long Live the Interpersonal Disorders: Comment on Widiger and Hines (2022)

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Widiger and Hines raise a number of significant concerns with the alternative model of personality disorders (AMPD). This places the major class of psychiatric difficulties represented by the personality disorders in a precarious position because the model used in previous editions of the *Diagnostic and Statistical Manual of Mental Disorders* and currently reprinted in Section II is moribund if not dead, and with the AMPD's significant problems, their future is unclear. Although we agree that Widiger and Hines' criticisms have merit, they are not the whole picture. We review additional relevant research that supports the contention that what differentiates personality disorders from other psychopathology is the self and interpersonal dysfunction, as Criterion A of the AMPD currently states. We emphasize the importance of drawing a distinction between the conceptual model and its operationalization. We argue that paradoxically, to save personality disorders, we need to do away with them and replace them with the "interpersonal disorders." There is strong theory, empirical research, and ethical arguments in favor of this conceptual reframing.

Keywords: personality pathology, personality disorders, alternative model for personality disorder, interpersonal dysfunction

Leading up to the publication of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM–5*; American Psychiatric Association, 2013), there was widespread excitement in the personality disorders (PD) research community. The forthcoming revision promised to bring much-needed revolutionary change in the way PDs were defined and diagnosed. The reason a change to the *DSM*'s description of PDs is so monumental is that it has an outsized influence on the science of psychopathology. In effect, to change the pages of the *DSM* is to change the way we think about and study psychiatric phenomena; it reflects and furthers a fieldwide conceptual change. Arguably, although the *DSM* offers a diagnostic system, the scientific impact is considerably larger than any impact on practice. The alternative model of personality disorders (AMPD) holds a unique position in the *DSM*'s history, in that it is a large-scale change to a whole class of disorders, it was hotly debated leading up to publication of *DSM–5*, and it has continued to be a source of debate and research generativity in the years since. However, as Widiger and Hines (2022) noted, it is now time to take stock to determine what, if anything, we have learned from the follow-up to publication of the AMPD and consider the next steps for PD in the *DSM*. Our read is that on balance, Widiger and Hines strike a pessimistic note about what the AMPD has accomplished. Regretfully, we are inclined to agree; progress since the publication of *DSM–5* has been limited and disappointing. At the same time, despite several clear points of agreement with their perspective, we have a different take on the state of the science and where we should go next as a field. We welcome the opportunity to engage them and the broader field in this discussion.

What Are We Talking About?

The *DSM* confounds a conceptual model and a diagnostic system for practice. Perhaps this is necessary, but it creates a great deal of confusion because it is often unclear whether we are debating fundamental issues of conceptualizing psychopathology or practical decisions of how we should determine caseness in applied settings. By point of comparison, take hypertension as a diagnosis. Nobody disputes that blood pressure falls along a continuum and is probabilistically associated with an array of negative outcomes when it is too high or low, and all agree that a diagnostic cutoff is a practical necessity. But nobody confuses the threshold as the phenomenon, and though a shift from systolic/diastolic reading of >140/90 to >130/80 as the hypertension threshold

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might generate some grumbles about being overly conservative, it does not lead to heated debates about the meaning and measure of blood pressure.

The *DSM*'s confounds are reflected in the ambiguity of Widiger and Hines' arguments. For instance, debating the construct validity of the AMPD would seem to be a matter of theory or conceptualization, but whether specific profiles of traits should be given diagnostic labels seems to be more of an applied question, and questions of overlap between Criteria A and B might be either. Reasonable people could see each of these examples as conceptual issues, practical issues, or both, so it is often unclear at what level an argument is being made. More importantly, due to the impact of the *DSM*, this confound between definition and diagnosis has led to life or death debates over the nature of PD instead of fieldwide compromise on a practically useful diagnostic system. Because of this, we have often found, for example, complaints about the unwieldiness of the AMPD in practice to miss the point. As Widiger and Hines note, it is not clear that official criteria sets or diagnostic frameworks are given much consideration, if any, in practice. Thus, what we are really talking about is the nature of PD and how we should think about it, and not merely discussing the mundane details of diagnostic algorithms.

An Alternative Perspective on the Empirical Research Relevant to the AMPD

The fully dimensional constructs in the AMPD have been highlighted as a radical shift in the *DSM*. At the same time, it is largely a noncontroversial move—few among those who favor traditional diagnoses believe they represent true discrete categories, just as few among the proponents of dimensions dismiss the need for diagnostic thresholds for practical use. Indeed, the Section II PD model has effectively died, as evidenced by very little research on constructs beyond borderline PD, antisocial behavior, and narcissism (even then the latter two owe their longevity to broader interest in psychopathy, to externalizing behavior, and to personality science as opposed to the *DSM*'s operationalizations). The really controversial aspect of the AMPD was the Faustian bargain of wedding Criterion A, which is rooted in contemporary psychodynamic theory, with Criterion B, which is rooted in quantitative personality trait research. Thus, the AMPD is something of a Frankenstein's monster, a contention that is supported by how much it tends to alarm and horrify many in the field. This issue is the core of Widiger and Hines' critique of the AMPD. They summarize a good deal of research relevant to the AMPD that has emerged since publication of the *DSM–5* and conclude or imply that Criterion A lacks discriminant validity, it likely does not define the core of PD, and therefore is not necessary.

Although we believe Widiger and Hines' characterization of the research relevant to the AMPD is accurate, it is selective, and we do not think their conclusions are the only reasonable ones to draw. We view the evidence as largely supporting the conceptual underpinnings of the AMPD but not the specifics of its operationalization. Especially given the reliance on self-report in the AMPD research, it is premature to write off the Criterion A constructs rather than the currently available measures. Starting with whether the levels of personality functioning is a unitary construct, this seems mostly to be a question tied to a specific measure (Level of Personality Functioning Scale–Self-Report; LPFS; Morey, 2017) as opposed to a general criticism because other measures (General Assessment of Personality Disorder; Livesley, 2006; Severity Indices of Personality Problems; Verheul et al., 2008) seem to show greater differentiation among the same constructs. If Criterion A is to be judged by the merits and demerits of one self-report measure, so should Criterion B be judged solely by the performance of the Personality Inventory for *DSM–5* (PID-5; Krueger et al., 2012). But the remainder of the article would suggest that Widiger and Hines do not hold the trait model to that standard.

As Widiger and Hines note, there is a high degree of overlap in content and external correlates between measures of Criteria A and B. They compare this with the high degree of comorbidity (i.e., lack of discriminant validity) among the Section II diagnoses. However, this is fundamentally different. Criteria A and B generally, and for specific diagnoses, are intended to be shared features. For instance, posttraumatic stress disorder and pervasive depressive disorder, to name a couple of similarly structured diagnoses, each have a Criterion A that is definitional of the disorder followed by further criteria that clarify the diagnostic presentation. In the case of persistent depressive disorder, Criterion A refers to the experience of low mood or anhedonia, whereas Criterion B references additional features (e.g., neurovegetative symptoms and hopelessness). As with the AMPD, it would be illogical to assume that there would not be substantial empirical overlap between the features in Criteria A and B. Criterion A is intended to be definitional and therefore shared across individuals with the same diagnosis. One could argue that if Criteria A and B were not substantially correlated, it would be a major problem.

However, we do think it is fair to ask whether there is too much redundancy among the criteria of the AMPD. But by the same token, it is also fair to expand this question beyond the overlap between Criteria A and B. In fact, because the AMPD uses maladaptive traits they show low discriminability not only with Criterion A but also among themselves. Exact values vary across samples of course, but to illustrate with a recent study that included both community and clinical samples, the median correlation among PID-5 trait domains was r = .41 (range: .31–.50) and r = .60 (range: .27–.79) in each sample, respectively (Ringwald, Hallquist, et al., 2021). This degree of overlap has implications for studying unique associations among traits and outcomes, and frequently the finding is little in the way of unique associations when traits are entered simultaneously as predictors in a multiple regression (Ringwald, Hallquist, et al., 2021; Ringwald, Hopwood, et al., 2021). Though these unique associations often exhibit the expected pattern of associations, the associations are often low and at times nonsignificant (Sleep et al., 2018). Indeed, in the studies cited earlier (Ringwald, Hallquist, et al., 2021; Ringwald, Hopwood, et al., 2021; Sleep et al., 2018), it is the shared variance that is the real powerhouse behind the R^2 in predicting various outcomes, as we have shown in our work using latent variable modeling to isolate this shared variability among the traits. Taking these types of results at face value, it is hard to argue that the AMPD traits improve discriminability over the Section II diagnoses, at least in any unqualified way.

It stands to reason that this high degree of overlap among the AMPD traits is due to their shared maladaptivity, presumably what Criterion A was intended to capture. By embedding

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maladaptivity in the AMPD traits, the typically higher empirical discrimination among basic personality traits relative to maladaptive trait measures is clouded by the shared impairments and thereby artificially creates higher overlap between Criteria A and B as operationalized in various measures, and also among themselves. Morey et al. (2022) recently illustrated this nicely by showing the pattern of correlations among the basic traits and AMPD traits in three samples in raw form and after partialing out the LPFS. The residual associations were much more discriminable. This is a challenging issue because conceptually the goal of the AMPD was to separate what is the core dysfunction of PD from the style in which it manifests, but empirically this has proven difficult, especially when considering measures such as the LPFS and PID-5. It is also understandable that a diagnostic manual would want to directly list maladaptive manifestations of traits. The main point here is that dropping Criterion A creates conceptual problems because there is then no defining feature to explain the high degree of empirical overlap among the traits.

Widiger and Hines also review research that shows strong correlations among clinical syndromes and self-report Criterion A measures, suggesting Criterion A does not differentiate PDs from other classes of disorders. They neglect research using other measures that do show self and interpersonal impairments are excellent discriminators among patients diagnosed with PD as opposed to other diagnoses (Beeney et al., 2019). More importantly, they neglect the enormous body of research on the association between traits and clinical syndromes (e.g., major depressive disorder, anxiety disorders). Indeed, the relationship between personality traits and PDs is not privileged. Arguably, the associations between basic personality traits and clinical syndromes are stronger than the association between personality traits and the Section II PD constructs. To illustrate, we compare effect sizes from Kotov et al. (2010), a meta-analysis of the association between personality traits and anxiety, depressive, and substance use disorders, with effect sizes from Samuel and Widiger (2008), a meta-analysis of the five-factor model traits and *DSM-IV-TR* PDs. Kotov and colleagues report that across all diagnostic groups, the mean effect size for neuroticism was r = .64 (converted from Cohen's d = 1.65 using Ruscio, 2008). This eclipses the mean association between neuroticism and PDs reported in Samuel and Widiger (r = .31) and even exceeds the largest associations with individual PD diagnoses (borderline PD r = .54; avoidant PD r = .52). This is all the more remarkable, given that many of the Samuel and Widiger samples were largely monomethod (i.e., both self-report) associations, whereas Kotov et al. were most frequently hetero-method (i.e., self-report with interview).[1] One might argue that neuroticism is an exceptional marker for distress and that the clinical syndromes are mostly distilled instantiations of distress as well. However, even with other traits we see symptom syndromes often exceed the associations with PDs. For instance, the associations with extraversion and dysthymia (r = −.59) and social phobia (r = −.55) were both larger than any single PD association. The mean effect for conscientiousness across diagnostic groups in the study by Kotov et al. (r = −.45) was also three times the mean association of PDs in Samuel and Widiger (r = −.13).

Broadening the lens beyond individual diagnoses, the accumulating literature on the quantitative structure of psychopathology including both clinical syndromes and PDs as indicators reveals a five-factor structure that is easily recognizable as maladaptive variants of the big-five personality traits (Ringwald, Forbes, et al., 2021; Wright & Simms, 2015). This of course is the model adopted by the Hierarchical Taxonomy of Psychopathology (HiTOP; Kotov et al., 2021), and the obvious match to the structure of major personality traits led Widiger et al. (2019) to conclude that "the structure of general personality provides a fundamental base for the HiTOP dimensional model of psychopathology."

In summary, the argument that the PDs should be defined by a trait model because it has higher discriminant validity falls apart in the face of the broader evidence. Also, because personality traits show just as strong, if not stronger, associations with clinical syndromes as they do with Section II PDs, it leaves unclear what it is about personality that separates these classes of disorders, at least empirically. That is not to say that a personality trait structural model or an extension such as HiTOP lacks value—rather, it is destined for a higher calling, providing the structure for all (or most) of psychopathology, not just the PDs. Therefore, one might go so far as to argue that the Criterion B trait model is a worse candidate for retention in a revised model of PDs in the *DSM*, because at least Criterion A attempts to define what is unique to PDs and is supported by nonself-report research (Beeney et al., 2019), whereas the accumulated trait research unambiguously shows that they do not.

It's Time to Replace PDs With Interpersonal Disorders

The Section II PD model is effectively dead, and the AMPD as operationalized has significant problems. Furthermore, because personality is related to nearly all psychopathology, "personality" is hardly the most distinguishing feature of these disorders. So, what is the way forward for the real and significant pathology traditionally identified as PDs? The time has come to do away with the PD chapter of diagnostic nomenclatures and reincarnate them as the interpersonal disorders. This is not a new proposition (Hopwood et al., 2013), and a full treatise of the rationale is not possible due to the space limits of this commentary. Therefore, we make three points in favor of replacing the PDs with an interpersonal disorder chapter in the *DSM*: one theoretical, one empirical, and one ethical.

First, there is voluminous theoretical literature highlighting the interpersonal nature of the traditional PD constructs (Benjamin, 2002; Hopwood et al., 2013). For example, even when the most notable features are not explicitly interpersonal (e.g., affective dysregulation, self-harm in borderline PD), their focus and function are typically interpersonal in nature (e.g., distress due to and efforts to avoid perceived abandonment). Contemporary integrative interpersonal theory (CIIT) provides an empirically supported structural model along with dynamic process

[1] For Samuel and Widiger (2008), we counted three of 18 samples (or 16.7%) to be nonself-report. Kotov et al. (2010) coded the assessment method for psychopathology using the following rubric 1 = *Structured Clinical Interview for DSM*, 2 = *fully structured interview*, 3 = *informal diagnosis*, and 4 = *other*. They do not define *other*. Nevertheless, if one takes 1 to 3 as diagnosis by method other than self-report, then 82.2% are hetero-method. If one argues that fully structured interviews are largely self-report, then 52.5% are hetero-method. Thus, the majority, even with a conservative approach to counting, are hetero-method in Kotov et al. (2010).

concepts that accord with the self and interpersonal domains of functioning in Criterion A and that views these domains as inexorably intertwined (Wright et al., in press).

Second, many studies link the PDs with the interpersonal domains of CIIT (Wilson et al., 2017), and when considering the structural research on psychopathology, the interpersonal spectra of antagonism and detachment only emerged when studies started including the PDs (Wright & Simms, 2015). Ringwald, Forbes, et al.'s (2021) recent meta-analysis shows that the highest loadings on each of these spectra are exclusively from PD diagnoses. This includes obsessive-compulsive PD, which has a split loading on these two spectra. This may be the clearest evidence that when considering all domains of psychopathology the PDs primarily reflect interpersonal dysfunction, even though other disorders will at times result in interpersonal problems and PDs will at times result in noninterpersonal problems.

Finally, diagnosing a patient's personality as disordered is arguably ethically problematic. In no other area of medicine, including psychiatry, do we diagnose the whole person as the problem instead of a specific domain of functioning (Wright & Hopwood, in press). By shifting to formally labeling and conceptualizing the PDs as the interpersonal disorders, we can focus the diagnosis on the domain of and processes of dysfunction (Wright et al., in press) and end this ethically problematic practice of diagnosing the person as the disorder.

Some may argue that content traditionally covered by the legacy Section II PD diagnoses is not primarily interpersonal in nature (e.g., the disinhibition of antisocial PD, the peculiarity of thought, and behavior of schizotypal PD). We agree and do not wish to argue that every last legacy PD feature is or must be recast as primarily interpersonal. Rather, as the *DSM–5* already cross-lists schizotypal PD in the thought disorder section, it and other features may be better placed in other sections organized around thought disorder or disinhibition and so forth. Indeed, this reorganization would seem to be a fundamental implication of the HiTOP model.

Conclusion

Widiger and Hines raise a number of significant concerns with the AMPD. Although these are fair critiques, they are not the whole picture, and considering additional research leads us to drastically different conclusions than they arrive at. We believe, consistent with CIIT, that what differentiates the PDs from other psychopathology is the self and interpersonal dysfunction, as Criterion A currently states. There is strong theory, empirical research, and ethical arguments in favor of this conceptual definition. A distinct, but related, issue is whether the current AMPD operationalization of this core dysfunction has proved useful diagnostically. On the latter, we do not see the AMPD or a strictly trait-based approach as being capable of reviving the PDs. However, we do believe reanimating them as interpersonal disorders would. Paradoxically, to save PDs, we need to do away with them.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, fifth ed. (DSM-5)*.

Beeney, J. E., Lazarus, S. A., Hallquist, M. N., Stepp, S. D., Wright, A. G. C., Scott, L. N., Giertych, R. A., & Pilkonis, P. A. (2019). Detecting the presence of a personality disorder using interpersonal and self-dysfunction. *Journal of Personality Disorders*, *33*(2), 229–248. https://doi.org/10.1521/pedi_2018_32_345

Benjamin, L. S. (2002). *Interpersonal diagnosis and treatment of personality disorders*. Guilford Press.

Hopwood, C. J., Wright, A. G. C., Ansell, E. B., & Pincus, A. L. (2013). The interpersonal core of personality pathology. *Journal of Personality Disorders*, *27*(3), 270–295. https://doi.org/10.1521/pedi.2013.27.3.270

Kotov, R., Gamez, W., Schmidt, F., & Watson, D. (2010). Linking "big" personality traits to anxiety, depressive, and substance use disorders: A meta-analysis. *Psychological Bulletin*, *136*(5), 768–821. https://doi.org/10.1037/a0020327

Kotov, R., Krueger, R. F., Watson, D., Cicero, D. C., Conway, C. C., DeYoung, C. G., Eaton, N. R., Forbes, M. K., Hallquist, M. N., Latzman, R. D., Mullins-Sweatt, S. N., Ruggero, C. J., Simms, L. J., Waldman, I. D., Waszczuk, M. A., & Wright, A. G. C. (2021). The Hierarchical Taxonomy of Psychopathology (HiTOP): A quantitative nosology based on consensus of evidence. *Annual Review of Clinical Psychology*, *17*, 83–108. https://doi.org/10.1146/annurev-clinpsy-081219-093304

Krueger, R. F., Derringer, J., Markon, K. E., Watson, D., & Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine*, *42*(9), 1879–1890. https://doi.org/10.1017/S0033291711002674

Livesley, W. J. (2006). *General Assessment of Personality Disorder (GAPD)*. Unpublished manuscript, Department of Psychiatry, University of British Columbia, Vancouver, BC, Canada.

Morey, L. C. (2017). Development and initial evaluation of a self-report form of the DSM-5 Level of Personality Functioning Scale. *Psychological Assessment*, *29*(10), 1302–1308. https://doi.org/10.1037/pas0000450

Morey, L. C., Good, E. W., & Hopwood, C. J. (2022). Global personality dysfunction and the relationship of pathological and normal trait domains in the DSM-5 alternative model for personality disorders. *Journal of Personality*, *90*(1), 34–46. https://doi.org/10.1111/jopy.12560

Ringwald, W. R., Forbes, M. K., & Wright, A. G. C. (2021). Structural evidence for the Hierarchical Taxonomy of Psychopathology (HiTOP) model: A meta-analysis. *Psychological Medicine*. Advance online publication. https://doi.org/10.1017/S0033291721001902

Ringwald, W. R., Hallquist, M. N., Dombrovski, A. Y., & Wright, A. G. C. (2021). Associations between personality (dys)function and general behavioral dysregulation. *Clinical Psychological Science*. Advance online publication. https://doi.org/10.31234/osf.io/28qvd

Ringwald, W. R., Hopwood, C. J., Pilkonis, P. A., & Wright, A. G. C. (2021). Dynamic features of affect and interpersonal behavior in relation to general and specific personality pathology. *Personality Disorder: Theory, Research, and Treatment*, *12*(4), 365–376. https://doi.org/10.1037/per0000469

Ruscio, J. (2008). A probability-based measure of effect size: Robustness to base rates and other factors. *Psychological Methods*, *13*(1), 19–30. https://doi.org/10.1037/1082-989X.13.1.19

Samuel, D. B., & Widiger, T. A. (2008). A meta-analytic review of the relationships between the five-factor model and *DSM–IV*-TR personality disorders: A facet level analysis *Clinical Psychology Review*, *28*(8), 1326–1342. https://doi.org/10.1016/j.cpr.2008.07.002

Sleep, C. E., Hyatt, C. S., Lamkin, J., Maples-Keller, J. L., & Miller, J. D. (2018). Examining the relations among the DSM-5 alternative model of personality, the five-factor model, and externalizing and internalizing behavior. *Personality Disorders: Theory, Research, and Treatment*, *9*(4), 379–384. https://doi.org/10.1037/per0000240

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Verheul, R., Andrea, H., Berghout, C. C., Dolan, C., Busschbach, J. J. V., van der Kroft, P. J., Bateman, A. W., & Fonagy, P. (2008). Severity Indices of Personality Problems (SIPP-118): Development, factor structure, reliability, and validity. *Psychological Assessment*, *20*(1), 23–34. https://doi.org/10.1037/1040-3590.20.1.23

Widiger, T. A., & Hines, A. (2022). The DSM-5 alternative model of personality disorder. *Personality Disorders: Theory, Research, and Treatment*, *13*(4), 347–355. https://doi.org/10.1037/per0000524

Widiger, T. A., Sellbom, M., Chmielewski, M., Clark, L. A., DeYoung, C. G., Kotov, R., Krueger, R. F., Lynam, D. R., Miller, J. D., Mullins-Sweatt, S., Samuel, D. B., South, S. C., Tackett, J. L., Thomas, K. M., Watson, D., & Wright, A. G. C. (2019). Personality in a hierarchical model of psychopathology. *Clinical Psychological Science*, *7*(1), 77–92. https://doi.org/10.1177/2167702618797105

Wilson, S., Stroud, C. B., & Durbin, C. E. (2017). Interpersonal dysfunction in personality disorders: A meta-analytic review. *Psychological Bulletin*, *143*(7), 677–734. https://doi.org/10.1037/bul0000101

Wright, A. G. C., & Hopwood, C. J. (in press). Integrating and differentiating personality and psychopathology. *Personality and Psychopathology*. https://doi.org/10.31234/osf.io/7nk9t

Wright, A. G. C., Pincus, A., & Hopwood, C. J. (in press). Contemporary integrative interpersonal theory: Integrating structure, dynamics, temporal scale, and levels of analysis. *Journal of Abnormal Psychology*. https://doi.org/10.31234/osf.io/fknc8

Wright, A. G. C., & Simms, L. J. (2015). A metastructural model of mental disorders and pathological personality traits. *Psychological Medicine*, *45*(11), 2309–2319. https://doi.org/10.1017/S0033291715000252

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