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The Alternative Model of Personality Disorder Is Inadequate for Capturing Obsessive-Compulsive Personality Disorder

Douglas B. Samuel, Caroline E. Balling, and Meredith A. Bucher
Department of Psychological Sciences, Purdue University

The alternative model of personality disorder (AMPD) included in Section III of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5)* reconceptualized personality pathology in terms of pathological traits and impairments in functioning. For example, the construct of obsessive-compulsive personality disorder (OCPD) was reconceptualized via the traits of rigid perfectionism as well as at least 2 of perseveration, intimacy avoidance, and restricted affectivity. We review the literature to summarize how effectively the legacy construct of OCPD is captured by the AMPD. We conclude that although the trait of rigid perfectionism is highly related to scores on OCPD measures, the AMPD as a whole fails to adequately account for the broader features of the legacy OCPD construct. Specifically, the AMPD trait model lacks a number of traits, such as workaholism, excessive deliberation, and moral scrupulousness, which are necessary for a fulsome dimensional trait system. These limitations in the inclusion of important traits stem from the AMPD's development process that left out crucial content. We outline how the AMPD could be improved in its ability to account for problems of overcontrolled behavior.

Keywords: OCPD, compulsivity, overcontrol, perfectionism, workaholism

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Obsessive-compulsive personality disorder (OCPD) has a lengthy history that traces its origins to Freud's (1908) description of the "anal" character traits of orderliness, parsimony, and obstinacy (Costa et al., 2005). It has been included in all previous editions of the American Psychiatric Association's diagnostic manual, albeit with some notable variation across iterations (Samuel & Widiger, 2010). Within the fourth and fifth editions of the *Diagnostic and Statistical Manual* (*DSM*; American Psychiatric Association, 2013), OCPD is defined as a "pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency" (p. 678). OCPD is one of, if not the, most prevalent PDs with rates in the general population of at least 2% (Torgersen, 2009) and possibly as high as 8% (Grant et al., 2004). Functionally, OCPD links with significant occupational stress and work addiction that leads to burnout, depression, physical health concerns, and relationship disruptions (Atroszko et al., 2020). OCPD has the highest economic disease burden of all PDs in terms of direct medical costs and productivity losses (Soeteman, Hakkaart-van Roijen, et al., 2008) and among the highest burdens in terms of quality of life (Soeteman, Verheul, et al., 2008). Given these factors, it is crucial that diagnostic models adopting a dimensional trait approach ensure their comprehensiveness by fully capturing the features of OCPD.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM–5*) retained the categorical model of PDs from the *DSM–IV* (American Psychiatric Association, 2000) but also added an alternative model of personality disorder (AMPD) within Section III. The AMPD adopted a hybrid approach with a set of 25 dimensional traits, sorted into five broad domains (Criterion B) and four indicators of difficulties in self and interpersonal functioning (Criterion A). Six of the legacy PD constructs, including OCPD, were redefined in terms of specific combinations of those traits, plus functional impairment. For OCPD, this included impairment in at least two areas of self/interpersonal functioning, the presence of the trait rigid perfectionism, and at least two of the other three traits assigned: perseveration, intimacy avoidance, and restricted affectivity. Only two studies to date have examined an OCPD-specific operationalization of Criterion A (Liggett, Carmichael, et al., 2017; Liggett & Sellbom, 2018). These studies have shown reasonable convergence of OCPD impairment with measures of legacy OCPD, but questions remain about the ability to discriminate from other PDs. Thus, our review focuses on the Criterion B traits of the AMPD.

The *DSM–5* workgroup nominated 37 traits for the AMPD, 11 of which were assigned to OCPD. After factor analyzing self-report scales, these 37 traits were reduced to the final set of 25 that appear in the *DSM–5* (Krueger et al., 2012). As Crego et al. (2016) helpfully detailed, the *DSM–5* development process unduly affected the traits assigned to OCPD. Specifically, several traits that had been assigned to OCPD were deleted from the model, and others were unassigned based on empirical studies (i.e., Hopwood et al., 2012). This resulted in only two traits, rigid perfectionism

Douglas B. Samuel https://orcid.org/0000-0003-3592-1523
Caroline E. Balling https://orcid.org/0000-0001-6522-1996
Meredith A. Bucher https://orcid.org/0000-0001-7279-8136
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Correspondence concerning this article should be addressed to Douglas B. Samuel, Department of Psychological Sciences, Purdue University, West Lafayette, IN 47907, United States. Email: dbsamuel@purdue.edu

and perseveration, being deemed indicative of OCPD. At a later date, the traits of restricted affectivity and intimacy avoidance were assigned, yielding the final model in *DSM–5*. The present review recapitulates the performance of these AMPD traits for capturing OCPD.

In a recent review, Zimmermann et al. (2019) counted 237 publications on the AMPD, and many of these provide relevant data as to how successfully it captures OCPD. As such, we can only discuss highlights of this literature in the present review. We organize findings into three main areas. First, we describe the literature that has investigated whether the AMPD trait model contains adequate OCPD content. Second, we describe studies that examined which AMPD traits are most related to OCPD. Third, we discuss the limitations of the current model and specific directions to improve the AMPD conceptualization of OCPD.

Does the AMPD Fully Capture OCPD?

We extend a prior review of this literature (Al-Dajani et al., 2016) in showing that the Personality Inventory for *DSM–5* (PID-5) accounts for only a small portion of the variance in OCPD measures. When entered simultaneously, the AMPD traits accounted for only between 24% (Jopp & South, 2015) and 38% (Hopwood et al., 2012) of the variance in OCPD scores. In almost every study, this percentage was notably lower than all other PDs examined. Liggett, Sellbom, et al. (2017) included multiple measures to create latent variables for the traits and OCPD. They found that the latent constructs shared 53% of the variance. Reichborn-Kjennerud, et al. (2017) examined the question from a genetic perspective in a large twin sample. They found 100% genetic overlapping variance between the PID-5 domains and the other Section III PDs, yet only 43% of the variance was shared for OCPD. Taken together, these results illustrate that the AMPD model simply does not contain all the relevant variance to account for OCPD. This is true both for the five domains and the 25 facets of the AMPD.

How Do Specific AMPD Traits Relate to OCPD?

A great deal of research has examined the relations of individual AMPD domains and facets with measures of OCPD. Ostensibly, these studies have been concerned with examining whether the assigned traits do, in fact, relate to OCPD, or investigating whether there are other traits that might be added to the OCPD description. As revealed in the earlier section, such a goal is circumscribed, given the model as a whole is limited in its coverage of the OCPD construct.

At the domain level, the results have been mixed, with small correlations between OCPD measures and PID-5 domains. For example, Watters et al. (2019) found the highest correlation with OCPD scores was the domain of negative affect in clinical (r = .30) and student (r = .40) samples. The correlations for the domain of disinhibition, which is the domain where nearly all models would conceptually place the majority of OCPD traits, were only .18 and .17. Bach et al. (2016) examined three different short forms across a combined sample of close to 1,400 participants and found that the highest correlations for OCPD were for the domains of psychoticism (rs = .26, .22, and .23) and negative affectivity (rs = .24, .23, and .21). Similarly, Bach et al. (2018) administered the PID-5 and the Structured Clinical Interview for *DSM–5* (SCID-II) to a sample of 226 psychiatric outpatients. The reported correlations of OCPD with the PID-5 domains were .28 (psychoticism), .23 (negative affectivity), .23 (antagonism), .19 (detachment), and .13 (disinhibition). That said, when the domains were entered simultaneously, the domain of disinhibition (b = −.25) had the largest effect. The (slightly) higher correlations observed for negative affectivity and psychoticism may simply reflect the association with distress and lack of discriminant validity in those domains (Crego & Widiger, 2020). The lack of appreciable relations with disinhibition indicates the limited OCPD-relevant content in this domain.

Many studies have examined the specific correlations between AMPD facet scales and markers of OCPD. Nonetheless, the literature can quite easily and clearly be summarized in a more abbreviated format. To put it succinctly, rigid perfectionism is the only AMPD trait that has consistently correlated with OCPD scores with anything more than a modest effect size. Rigid perfectionism was the largest correlate of OCPD in every study reviewed with effect sizes hovering around .50. The three other assigned traits typically had effects closer to .20. Various studies have suggested additional traits—beyond the four assigned—but these have not replicated. For example, Liggett, Sellbom, et al. (2017) found that self-reported Personality Diagnostic Questionnaire, Fourth Edition and SCID-II-PQ measures of OCPD correlated with rigid perfectionism at .54 and .42, respectively. The perseveration scale also correlated highly with the Personality Diagnostic Questionnaire, Fourth Edition (.52) but correlated much lower with the SCID-II-PQ (.32). Overall, Liggett, Sellbom, et al. (2017) found that those two traits as well as intimacy avoidance, offered significant predictive validity for OCPD.

Similar results have been found for methods beyond self-report. A study of 110 Dutch adults in mental health care showed correlations between the SCID-II OCPD score and PID-5 facets of .47 for rigid perfectionism, .20 for perseveration, .00 for intimacy avoidance, and −.02 for restricted affectivity (Orbons et al., 2019). Overall, though, rigid perfectionism was the only significant predictor when all facets were entered simultaneously in a binomial regression. Morey et al. (2016) examined the interrelations of the AMPD traits and OCPD as rated by practicing clinicians, and they reported correlations of .66 for rigid perfectionism, .32 for perseveration, .29 for restricted affectivity, and .27 for intimacy avoidance.

Limitations of the AMPD Model for Capturing OCPD

As highlighted in the first section, the AMPD model traits have proven repeatedly to be unable to fully account for OCPD, as articulated in *DSM–5*. Further, the traits assigned have—except for rigid perfectionism—been only modestly related to OCPD scores. We echo Crego et al. (2016) in suggesting that this limitation partially stems from the removal of content in the cut down from the AMPD model from 37 to 25 traits. In that process, the entire domain of compulsivity (five facets) was folded into disinhibition and relevant content was mostly removed. Specifically, the previously separate traits of rigidity and perfectionism were collapsed, whereas the trait of orderliness was removed entirely. A survey by Samuel, Lynam, et al. (2012) showed that experts on OCPD were unanimous in seeing these traits as relevant for OCPD. Furthermore, even those 37 traits were impoverished for accounting for OCPD due to the lack of inclusion of workaholism, which is a central criteria for OCPD and included in other major

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trait models (Simms et al., 2013). Of course, International Classification of Diseases, 11th Revision does include more of these traits through the separate domain of anankastia, which more or less mirrors compulsivity (Mulder, 2021). Although we do not agree with separating the opposite poles of a single dimension into two traits (e.g., Samuel, 2011), this arrangement does have the benefit of better emphasizing the content of compulsivity that is relevant to OCPD.

Rojas and Widiger (2017) provided the most systematic evaluation of this question when they looked precisely at the AMPD coverage of the individual *DSM–5* OCPD diagnostic criteria. They showed reasonable coverage of three criteria, yet others such as moral scrupulousness and hoarding were not covered. Further, research by Liggett and Sellbom (2018) demonstrated that the trait of workaholism was clearly necessary to account for OCPD as conceptualized in the *DSM–5*. However, they only examined this one additional trait, and it may well be that additional traits, such as excessive deliberation (Samuel, Riddell, et al., 2012), are also necessary for a fulsome trait model. Finally, the current trait of rigid perfectionism may prove too heterogeneous, given these are separate dimensions in factor analyses of OCPD (Ansell et al., 2008), and many theorists have suggested perfectionism is multidimensional (Ayearst et al., 2012). In sum, although there are limits on what traits any model can reasonably include, the *DSM–5* AMPD falls well short of an adequate array.

The traits assigned to OCPD reflect the poverty of choices available in the model. Perseveration was an unusual choice, as it is not included in historical or current representations of OCPD (Crego et al., 2015). Further, intimacy avoidance and restricted affectivity reflect a historical, but not current, definition of OCPD including emotional coldness. Indeed, the *DSM–III* included the criterion "restricted ability to express warm and tender emotions," yet this was not retained for *DSM–IV*. As such, it is unsurprising that these two traits would not correlate with scales measuring the present conceptualization. In fact, their inclusion actually worsens the representation of OCPD (Miller et al., 2015).

The OCPD construct itself also complicates identifying trait assignments. This construct has shifted considerably across time and iterations of the *DSM* (Samuels & Costa, 2012). Further, OCPD scales are notoriously heterogeneous (Grilo et al., 2001) and often have only modest intercorrelations (Samuel & Widiger, 2010). Given these factors, it is unsurprising that various studies often reach different conclusions about how to account for OCPD within trait models (Samuel & Widiger, 2011). In this regard, the AMPD model would do well to focus more broadly than simply trying to account for OCPD as defined in *DSM–5*. Rather, the AMPD should strive for a complete conceptualization of all the traits that make up problems related to the broader conceptualization of overcontrolled behavior (Lynch, 2018).

Conclusion

In contrast with most other PDs, the AMPD does a poor job of accounting for the historical and current conceptualizations of OCPD. Improvements should come primarily from the addition of necessary traits such as workaholism, but also possibly subdividing existing traits such as rigid perfectionism. Finally, as the field pursues a revised model with a more complete set of compulsivity-related traits, the traits assigned to OCPD should be altered with an eye toward a well-defined phenotype and the number and ratio of traits should target that precisely. The goal for a revised AMPD should be a trait model that includes a robust sampling of traits relevant to overcontrolled behavior, rather than capturing a specific conceptualization of OCPD.

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