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COMMENTARY

If an Entrepreneur Founded the *DSM–5* Alternative Model of Personality Disorder: When Axis II Meets Disruptive Innovation: Comment on Widiger and Hines (2022)

Jennifer L. Tackett[1], Kathleen W. Reardon[2], Melissa Kaufman[3], and Ryne A. Sherman[4]
[1] Department of Psychology, Northwestern University
[2] Department of Psychology, Cleveland State University
[3] The Garage, Northwestern University
[4] Hogan Assessments, Tulsa, Oklahoma, United States

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Personality disorder (PD) researchers proposed a highly innovative "paradigm-shifting" revamp for the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (APA, 2013). Yet, 10 years later, Widiger and Hines (2022) summarize a developmental process plagued by disagreement and stagnation, with little evidence of the field having reaped the desired benefits of this diagnostic revolution. In this commentary, we draw on principles from entrepreneurial creation, operation, and success—positioning the PD scientists in the role of "disruptive innovator"—and summarize key principles from the entrepreneurial process that may be relevant in understanding the challenges and failures of the PD revolution to date.

Keywords: entrepreneurialism, taxonomy, classification, personality disorders

> "Entrepreneurs are everywhere. . . .my definition of a startup: a human institution designed to create new products and services under conditions of extreme uncertainty."
>
> — Eric Ries, *The Lean Startup* (2011, p. 8)

Revamping personality disorders (PDs) in the *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (*DSM–5*; APA, 2013) is an inherently disruptive and innovative process with the potential for significant impact, but it has been plagued with infighting, bureaucracy, and near-total stagnation. Widiger and Hines (2022) offer a brief review of the many challenges that have stymied this process while also pointing to many remaining issues in need of resolution a full 10 years after the alternative model of personality disorder (AMPD) was brought to the field. How are we to understand the incredibly slow nature of this process and its as-yet limited ability to effect change in the primary way that personality pathology is diagnosed in the *DSM–5* system?

In this commentary, we propose that stakeholders look at the process from a different vantage point: that of an entrepreneur. As Widiger and Hines note, transforming the classification of PDs in the *DSM* system was meant to provide a "paradigm shift"—a level of scientific innovation not seen before in major psychiatric taxonomies (Skodol et al., 2013). We argue that this type of "paradigm shift" represents a truly entrepreneurial endeavor, and to better understand the barriers and pitfalls of the PD revolution to date, we turn to the entrepreneurial process.

Much of modern entrepreneurship draws on the *lean startup* process (Ries, 2011), which argues for accelerating production, maximizing assessment and assembly of a viable product, and developing a fast-paced iterative cycle to scale a start-up from nothing to a rapid growth successful venture. Although the *DSM* is far from a start-up enterprise, the revisioning of PDs is/was certainly characterized by unprecedented creativity and innovation with the goals of creating a viable and useful final product. Pulling from key principles in the lean startup model (Ries, 2011), we seek to illustrate this point by asking the following: What insights can we glean from the start-up process and successful entrepreneurial ventures?

Lesson 1: Iterating Through the Build-Measure-Learn Feedback Loop

In the lean startup process, a core concept is continuous iteration through the build-measure-learn feedback loop (Ries, 2011). In this feedback loop, there is a focus on investing the minimum amount of effort and the least amount of development time to

Jennifer L. Tackett https://orcid.org/0000-0002-5084-3511
Correspondence concerning this article should be addressed to Jennifer L. Tackett, Department of Psychology, Northwestern University, 2029 Sheridan Road, Evanston, IL 60208, United States. Email: Jennifer.tackett@northwestern.edu

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create a basic system that generates useful data from which to learn and quickly revamp the product to start the loop again. Successful entrepreneurs tend to be high in personality traits prone to curiosity, imagination, and problem-solving (Tackett & Kaufman, 2020), which serve them well in moving quickly and strategically through this loop. We would expect the personalities of research scientists to fall similarly, so what is the difference between the psychiatric workgroup members and successful entrepreneurs?

Widiger and Hines (2022) describe the developmental process of *DSM–5* as generating important and necessary critical feedback (Skodol, 2012). We might argue that the *DSM–5* workgroup did not sufficiently progress through the "measure" and "learn" stages of the lean startup loop, much less engage in iterative cycles to continuously improve the product in a short time frame. One clear issue in the group's inability to complete this feedback loop, as Widiger and Hines discuss, concerns the many remaining questions over how and what to even measure (particularly for Criterion A). Taken a step further, this implies that the initial "build" was problematic—at least for some critical components of the AMPD model (e.g., the level of personality functioning, or LPF, criterion). Based on what is built, and known (e.g., the dimensional trait model), and taking the existing evidence summarized by Widiger and Hines, a push toward a new build-measure-learn feedback loop is clearly needed. With the advent and broad adoption of data collection through online panels, it is possible to collect large and targeted data sets in a short time frame; entrepreneurs know to leverage the power of modern technological advances to gather feedback and implement changes quickly and highlights another area where AMPD progress could accelerate iteration through this loop.

Despite what appears as stagnation in many respects, it is clear from Widiger and Hines' review that indeed sizable literature on AMPD's "minimum viable product" has amassed. There are also certain themes that emerge—repetitive questions regarding the overlap between measures of LPF and trait neuroticism—alongside the progress made on neuroticism-focused clinical interventions, as Widiger and Hines note. What might a new "build" of the LPF look like? It seems reasonable to turn toward more basic assessments of neuroticism to evaluate alongside these newer proposals and to consider what can be done quickly and efficiently, consistent with the build-measure-learn loop. As it stands now, the costs of laborious assessment methods (e.g., clinician interviews) seem to outweigh the benefits, especially for constructs with limited evidence of clinical utility, such as the LPF.

One example of a blunt-force approach could involve pitting "thin-slice" assessments (Ambady & Rule, 2007) of general impairment or distress against the more extensive measurements that have been studied. Thin-slice assessments are quick and easy to obtain, and ample evidence suggests that they can accurately capture variance in even difficult-to-measure psychological constructs including childhood neuroticism (Tackett et al., 2016), pathological personality traits (Friedman et al., 2007), callous-unemotional traits (Tackett et al., 2017), and even clinical impairment (Slepian et al., 2014). A thin-slice measure of the LPF would be quick and easy to introduce into a fast-moving iterative build-learn-measure model and offers advantages more consistent with the entrepreneurial process.

Lesson 2: The Need to Leap

> . . . entrepreneurs can fall victim to analysis paralysis, endlessly refining their plans. In this case, talking to customers, reading research reports, and whiteboard strategizing are all equally unhelpful. (Reis, *The Lean Startup*, 2011, p. 91)

Reis described the "analysis paralysis" of budding start-up founders, and it is easy to see the parallels with the development process and subsequent academic discussion over the PD model makeover as described by Widiger and Hines (2022) and amply documented elsewhere (Livesley, 2012; Skodol, 2012; Verheul, 2012). It is shocking to read about the lack of progress over so much time and clear that in industrial settings—particularly the high-stakes start-up world—this level of analysis paralysis would prove fatal. Why is it that the PD scientific experts have had such difficulty with this fundamental step of entrepreneurial success, the need to leap?

In our own research, we have been attempting to break down the key ingredients of a successful entrepreneurial venture by looking at the personalities of successful founders (Tackett & Kaufman, 2020). Using the Hogan Personality Inventory (Hogan & Hogan, 2007), we have been examining the people who are able to make it big in this very challenging environment. One of the most notable findings from this study is that successful entrepreneurs (defined as original founders who scaled a venture up from nothing to millions of dollars in revenue or millions of users) tend to be *very* low on the personality trait of prudence. Akin to the personality trait of conscientiousness, high prudence individuals tend to prefer structure and order, be very detail-oriented, and be drawn to protocols and standards—characteristics that likely serve research scientists well in many regards. Low prudence individuals, on the other hand, think fast and move faster, are not bound by preexisting rules or structures, and thrive in environments marked by uncertainty and disorder (Rauch & Frese, 2007; Stewart & Roth, 2001). Academic settings likely draw on more prudent approaches, with deliberation, research, and caution, but this results in a very different pace and performance expectation than would typically be demanded in an industry setting.

It is easy to see how low prudence tendencies likely help entrepreneurs thrive in high-risk, ambiguous environments, where the need for substantial innovation and change are critical to success. It is also easy to read the description of the AMPD developmental progress by Widiger and Hines and see very little evidence for this kind of low prudence energy in the process. Although proposing the AMPD does represent a revolution in PD diagnosis, subsequent revision processes have rested on that initial disruption and are potentially missing opportunities for further refinement and radical change. Indeed, our work has shown that low prudence is most likely a "necessary" component of true revolutionary innovation. An outside consultant approaching the AMPD "start-up" would likely encourage consideration of how to insert low prudence energy into all stages of the process (e.g., bring in major players with the ability to *leap*, i.e., push the boundaries) as well as turning attention to how the implicit values of the "original founding team" (the long-standing administrative structure of the *DSM*) are being transmitted indirectly over time and introducing systemic barriers to actual progress. Successful entrepreneurs also tend to score very low on the Motives, Values, Preferences

Inventory (Hogan & Hogan, 2010) Security and Tradition scales (Tackett & Kaufman, 2020), and a founder's values are indirectly transmitted into all aspects of the company culture and environment. To *leap*, the broader culture and environment must be examined regarding the extent to which they facilitate a true entrepreneurial leap or, more likely in this case, the extent to which they hinder it.

Lesson 3: Knowing Your Market

Another core tenet of the lean startup process is ensuring that the product has identified a target customer and that it is optimally designed to meet an underserved need of the customer by adding value (Ries, 2011). If we consider this for a moment in the context of the AMPD, it becomes clear that there are likely two important target audiences: clinicians and patients. Although Widiger and Hines (2022) discuss the importance of evaluating whether *DSM–5* AMPD offers incremental validity and clinical utility compared with the *DSM-IV* model, they also suggest that work to date has focused on a narrow conception of utility (Milinkovic & Tiliopoulos, 2020). Clinical utility has been demonstrated through case reports and clinician surveys (Bach et al., 2015; Morey et al., 2014; Pincus et al., 2016), but there are several remaining unanswered questions from the perspective of both consumer bases, clinicians and patients. Research from the perspective of clinician users (Heltne et al., 2021; Milinkovic & Tiliopoulos, 2020; Morey et al., 2014) suggests that many clinicians do see utility in a dimensional approach and report that their clients may feel more seen and understood as a result—an entrepreneur would attempt to accelerate this progress by continuing to focus on asking targeted questions about the consumer experience, including barriers to adoption, willingness to employ this approach, or patient experiences in receiving diagnostic information and treatment recommendations.

Although clinicians suggest that the AMPD may improve things for their clients, little research to date has investigated clinical utility as measured via patient perceptions. That is, patients as customers could provide direct feedback about the product being offered, especially around topics such as whether they find their diagnosis informative and useful. Patients may also be able to provide indirect feedback on the AMPD through such indicators as the impact of diagnosis on patient experience and symptoms or response to treatment that is individualized using the AMPD diagnostic criteria. A frequent admonition from the lean startup model encourages entrepreneurs to ensure they are soliciting feedback from the target market—asking the wrong groups risks iterating in the wrong direction. In this way, insular, researcher-only discussions about the validity and utility of the AMPD may risk pointing the iteration process down ineffectual paths. It is critical that the feedback and iteration processes are prioritizing solving the problems of the customers who will benefit from the AMPD, namely, clinicians and patients.

Along these lines, Widiger and Hines lament the dearth of treatment applications for the AMPD and note that most efforts to date have been focused nearly exclusively on the trait domain of negative affectivity. Although they mention the availability of "speculations and suggestions" (p. xx), there are few concrete ideas in this review or in the broader literature about how exactly to move forward. The AMPD's purported potential for clinical application is one of its touted strengths (Hopwood et al., 2018); can we leverage feedback from the target market here as well? What are the barriers to treatment development, evaluation, and implementation within the AMPD framework? How can researchers in this area move more quickly through the uncertainty inherent in developing a new model to ensure whether the model is meeting the needs of its intended consumers (that is, improve our ability to identify and treat PDs to reduce the mental health burden on patients and their families)?

Lesson 4: The Need to Pivot

An important way that entrepreneurs track their success is by measuring concrete indicators about what is going well and, just as importantly, what is not working—in the start-up world, a pivot refers to a drastic change in the direction of a business when you realize the current products or services are not meeting the needs of the market. Thinking about the AMPD, it is not immediately clear what evidence would be necessary for the field to say that the current iteration of the AMPD is not meeting its stated goals and push for a pivot to a new way of thinking. How is the AMPD currently being evaluated and against what specific, measurable benchmarks? By whom? As Widiger and Hines note, by this time, there are several demonstrations in the literature that Criterion A shows poor incremental validity over Criterion B and that its relationship with other variables of interest may be the result of measurement factors. Similarly, Widiger and Hines point out that removing focus on self-interpersonal impairments would aid harmonization with the International Classification of Diseases, *Eleventh Revision*, model of PD, suggesting that we may not benefit from retaining Criterion A at all. When does this evidence rise to the level of prompting action?

There is a lot of uncertainty inherent in deciding when to make a major change to approach, and successful start-ups use various strategies to help them weather this uncertainty and continue to push for progress. Specifically, entrepreneurs are typically low on values such as tradition and security and low on personality traits such as prudence, meaning they feel much less tied to conventionality or the need to seek extensive consensus or feedback when making major decisions (Rauch & Frese, 2007; Tackett & Kaufman, 2020). These characteristics free entrepreneurs up to pivot when needed; this does not seem to be the case for researchers interested in PD assessment (at least at the operational level of the workgroup). In the way that even seasoned clinicians seek consultation with colleagues, or a patients' other treatment providers when feeling "stuck" in treatment, it may make sense to seek consultation from experts to devise a systematic way to evaluate the AMPD against its stated goals and make decisions accordingly. That is, feedback from seasoned entrepreneurs in industry settings may aid in evaluating the evidence base from a different perspective and help researchers establish a more productive build-measure-learn loop, a stronger minimum viable product, and, ultimately, a tool that better serves the customer base(s).

Conclusion

In the high-stakes and fast-moving start-up world, it seems clear that the paradigm shift planned for PDs in *DSM–5* would have been designated a "failed venture" years ago. We try to offer some practical suggestions and constructive reframing from an entrepreneurial perspective. If we were consulting on this project from an

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entrepreneurial lens, we would ask for a clear delineation of the build-measure-learn feedback loop, including the integration of resource-efficient "new builds" of Criterion A (e.g., thin-slice assessments). We encourage more work on getting the minimum viable product in front of users/customers and more time spent on customer discovery, followed by the use of online panels to collect market feedback within a broader and more efficient iterative process. We would encourage examination of where the sources of entrepreneurial energy lie in the current team (e.g., low prudence) and consider strategies for leveraging that energy or bringing new team members in to provide it. Finally, an analysis of the broader value-based structure of the American Psychological Association and the *DSM* leadership team could inform existing barriers to execution and implementation and ideally offer insights regarding more productive pathways to move forward.

Though the vision for the PD paradigm shift in *DSM–5* may not have been fully realized, the model should nonetheless be recognized for what it is: disruptive innovation in psychiatric taxonomy. Rather than see these revolutionary ideas languish further, we point to the need for an injection of entrepreneurial energy into the project. Pulling some tools from the entrepreneurial toolbox may offer a much-needed shake-up to the foundation of tradition and security and open up avenues to true innovation and change that will ultimately move us much faster to a place of serving our customers—the patients, clients, and clinicians who need a classification system that works.

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