Personality Disorders: Theory, Research, and Treatment

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COMMENTARY

Progress But No Cigar: Comment on Bach and Tracy (2022)

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The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* alternative model of personality disorder (AMPD) introduced innovations that are likely to be enduring features of a scientific classification of personality disorder: (a) an explicit definition of personality disorder, (b) a description of levels of severity, (c) a dimensional model of individual differences, and (d) the important principle that classifications should use and be consistent with the findings of normal personality science. Bach and Tracy's review of evidence of the clinical utility of the alternative model compared with traditional typal diagnoses clearly demonstrates that dimensional classification does not adversely affect clinical utility. Based on this evidence, they propose that the AMPD minus the hybrid component be adopted as the *Diagnostic and Statistical Manual of Mental Disorders* classification of personality disorder. It is argued that the recommendation is premature because evidence of clinical utility is insufficient in the absence of evidence of construct validity. The rest of the commentary explores the conceptual and methodological problems arising from the way the AMPD's innovative features are translated into a diagnostic classification.

Keywords: classification, definition of personality disorder, levels of severity, alternative model of personality disorder

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Although this 10th-anniversary review of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM–5*) alternative model of personality disorder (AMPD) by Bach and Tracy focuses on clinical utility, it needs to be viewed from a wider perspective. The *DSM–5* personality disorder (PD) proposal was a disappointment and an advance. A disappointment because it missed the opportunity to highlight PDs by pioneering a new approach to classification that also applied to other areas of psychopathology. Progress in the decades preceding publication created the conditions for change: Most experts thought that change was necessary, robust evidence indicated the changes needed, and the conceptual foundations for an innovative system were in place. Rather than meeting the opportunity, *DSM–5* was a confusing framework that evoked strong criticism even from those seeking change. Nevertheless, the proposal was also an advance. It abandoned tradition in favor of evidence and incorporated such innovations as an explicit definition of PD, assessment of severity, and dimensional classification. Even more significant was implicit acknowledgment that classifications should incorporate the findings of normal personality science, a reversal of the previous tendency to rely exclusively on an inappropriate version of the medical model. Bach and Tracy consider that the evidence of clinical utility is now sufficient to warrant the AMPD's adoption as the primary classification of PD. Wisely, they recommend abandoning the "hybrid" model. Although the "hybrid" model was presented as facilitating transition to dimensional classification, it was largely a Hail Mary attempt to retain categorical diagnosis despite the evidence. This commentary addresses two issues: whether evidence of clinical utility is sufficient to warrant the AMPD becoming the "official" *DSM* classification and whether the Level of Personality Functioning Scale (LPFS) and maladaptive personality trait model provide an adequate classification of PD.

Is Evidence of Clinical Utility Sufficient?

Bach and Tracy strengthen their recommendation by adopting a broad interpretation of utility that incorporates validity. However, other authors consider it crucial to distinguish the two (Kendell & Jablensky, 2003), although they note their close relationship (First et al., 2004). Utility is concerned with the practical aspects of a classification—ease of use and value in assessing patients, establishing prognosis, and planning treatment. These features are constrained by a system's validity but distinct from it: a system with good construct validity could have limited utility and vice versa. This distinction is important when evaluating the reviewers' recommendation because despite adopting a broad conception of utility, they provide limited evidence of validity offering instead the narrative that the model is more useful than categorical classification in making clinical decisions, overall assessment, clinician and patient acceptance, ease of learning, and treatment planning.

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However, the notion that these findings justify the AMPD becoming the official *DSM* classification is an overreach given that they rest solely on evidence of the practical aspects of utility based largely on comparisons with the *DSM–5* categorical system—a low bar to clear given the limitations of categorical diagnosis. More convincing would be evidence that it performs better than *International Classification of Diseases, 11th Revision*, a more straightforward dimensional system. But even this would be insufficient without evidence of validity. The rest of this commentary argues that although the AMPD incorporates features necessary for any scientific classification, it requires substantial revision and rethinking.

Problems With the Definition of PD

Although the provision of an explicit definition of PD was important, there are major problems with the definition offered. Most previous definitions were relatively ad hoc when what is needed is a principled definition based on explicit rules and principles. Without such a definition, it is difficult to resolve fundamental questions about what constitutes PD and whether some conditions are really variants of other mental disorders (e.g., that borderline PD is really a mood disorder), simply the extremes of normal variation, or merely socially undesirable patterns. In this context, the AMPD definition of PD as self and interpersonal dysfunction is plausible but it is not the principled definition needed. As the original author of this definition, it seems appropriate to acknowledge its deficiencies. This requires providing a little context.

In the decades preceding *DSM–5*, evidence that PD is best represented dimensionally created the diagnostic problem of differentiating disorder from normal variation because extreme trait levels do not necessarily imply dysfunction. This point was recognized by Schneider (1923/1950), who proposed that disorder was extreme variation that caused suffering to oneself or society. However, "suffering" is not helpful in making the distinction because there is no way to specify how much suffering is required to constitute disorder. As the prospects for a dimensional classification increased, problems identifying an alternative to "suffering" led some colleagues and I (Livesley, 1998, 2003; Livesley et al., 1994) to propose defining PD as impairment to the organizing, integrative aspects of personality rather than in terms of maladaptive traits. Although the idea promised to provide the basis for a principled definition, it proved challenging to define impaired personality organization in ways that enabled reliable assessment. Based on functional and evolutionary perspectives on personality, we proposed that PD represented the failure to solve major life tasks related to the construction of a coherent self and the capacity for interpersonal relationships. The definition was also influenced by clinical definitions that largely focused on either chronic interpersonal dysfunction or self-pathology. Unfortunately, this choice was arbitrary—it was based on clinical tradition not principles. Other manifestations of impaired personality organization could have been selected. Indeed, a case could be made for using constructs such as self-coherence and self-actualization that feature in classical theories of personality. The idea was advanced originally to facilitate implementation of dimensional classification with the expectation that it would subsequently be replaced with a nonarbitrary definition. Unfortunately, constructs used in official classifications tend to get ossified and reified.

The definition's arbitrary qualities increased with the AMPD's proposal that self-functioning be assessed in terms of identity and self-direction and interpersonal functioning in terms of empathy and intimacy. The principles used to select these features from the extensive array of self and interpersonal pathology characterizing PD are unclear, and there is no evidence that they provide a comprehensive evaluation of core pathology. Alas, the AMPD's arbitrary qualities are further increased by how identity, self-direction, empathy, and intimacy are defined. Rather than drawing on the personality and philosophical literature, the LPFS's authors seemed to have relied instead on a blend of psychoanalytic ideas, clinical tradition, and common sense. Although the result is plausible as shown by evidence of the clinical utility of Criterion A, there are substantial problems with how these constructs are defined and evaluated.

In the interests of space, I will primarily discuss the definition of identity as "experience of oneself as unique, with clear boundaries between self and others, stability of self-esteem and accuracy of self-appraisal, capacity for, and ability to regulate, a range of emotional experience" (APA, 2013, p. 762). Although these features occur in individuals with PD, the definition shows little resemblance to how identity is defined in the literature. It is generally considered an aspect of the self that denotes a person's place and the features that the individual feels characterize who he or she is (Jorgensen, 2018; Taylor, 1989). Basically, it is the answer to the question "Who am I?" The AMPD definition does not capture these features creating uncertainty about what is actually being assessed. Also, descriptions of the manifestations of "identity" dysfunction are often fuzzy and include features prevalent in individuals without PD raising concerns about overdiagnosis. The definition also includes features unrelated to identity as it is generally conceptualized. For example, why is the "capacity for, and ability to regulate, a range of emotional experience" (APA, 2013, pp. 762) considered part of identity? It seems better understood as a feature of negative affectivity. Using it to diagnose PD is problematic. As noted earlier, the definition of PD as self and interpersonal dysfunction was proposed to differentiate disorder from extreme trait variation. Using similar constructs to assess core pathology and individual differences confounds the diagnosis of PD and trait assessment. This problem also occurs with the use of empathy to assess interpersonal dysfunction because the trait is part of the antisocial/psychopathic/antagonism domain (DeYoung, 2015). Using the same or similar constructs for Criteria A and B makes it difficult to interpret the significance of the "substantial cross-sectional and conceptual overlap" between them that the reviewers noted. This is a serious conceptual limitation because theoretical models of PD need to explain the relationship between core pathology and trait structure. Definitions of other components also lack conceptual clarity. For example, it is not clear why "poor differentiation of thoughts from actions," "genuine fulfillment is virtually inconceivable," and "internal standards for behavior are virtually lacking" are considered aspects of self-directedness. Such basic problems challenge the AMPD's credibility and raise doubts about its substantive validity and hence its construct validity.

Levels of Severity

Although a measure of severity is useful, the decision to assess five levels of dysfunction seems overly ambitious and unnecessary. We have neither the empirical knowledge nor the conceptual structures to assess severity in such detail. This is illustrated by self-esteem (APA, 2013, pp. 775–778). Across Levels 2 to 4, self-

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esteem is variably described as diminished, vulnerable, and fragile. Do these features actually constitute a gradation in severity? How can they be differentiated? And even if these distinctions can be made reliability do they matter? Our understanding of effective interventions has not progressed to the point where intervention strategies can be related to such detailed assessments of severity. This concern and doubts about validity noted earlier, suggest that Bach and Tracy's recommendations for treatment based on level of personality functioning (M/s Table 1) should be viewed with caution. Nevertheless, the idea is important—diagnostic assessment and treatment strategies ultimately need to be integrated. But for now, a pragmatic distinction between severe and less severe PD would probably be both achievable and sufficient (Livesley & Clarkin, 2015).

AMPD Trait Model

An attractive feature of the trait model is that it offers a dimensional perspective that captures both broad constellations of individual differences and the nuances of individual presentations that are so important for treatment. But as with the LPFS, there are problems with how these innovations are implemented. Some problems are common to all tradition trait models but some specific to the AMPD scheme.

General Problems With Trait Models of PD

Although this is not the place to review the conceptual and methodological concerns raised about trait models, two issues are pertinent to evaluating the AMPD: (a) problems with the trait concept and (b) theoretical and methodological issues with traditional models of trait structure. A persistent concern is whether traits are descriptive rather than explanatory, an issue pertinent to the construction of causal models of PD. Although trait psychology generally rejects this concern by noting that traits are heritable, this does not fully address the problem because trait psychology does not explain how consistent behavioral outputs are generated in response to relevant inputs. Despite recent attempts to address the problem (DeYoung, 2015; Fleeson & Jayawickreme, 2015), we still lack the coherent account needed to develop effective strategies for managing maladaptive traits. A related concern is that trait models are not helpful in understanding personality dynamics and organization (Huprich, 2018). This is such a serious clinical limitation that advocates of the AMPD have proposed combining the five trait domains with the circumplex model of interpersonal functioning (Hopwood, 2018). Trait assessment is also largely concerned with the level or intensity of traits, whereas clinically it is often more important to know how traits are expressed and whether their expression is adaptive or not. The AMPD also limits accounts of individual differences to maladaptive traits, although the personality literature notes that personality also includes characteristic adaptations and narrative identity (McAdams & Pals, 2006). Even this decomposition of personality may not capture the diverse impairments constituting PD. Although not all such features are pertinent to diagnostic classification, there are good clinical and theoretical reasons to adopt a wider conceptualization of personality pathology than is represented by five factors. Although the clinical limitations of trait psychology could be easily remedied, trait psychology's failure to do so has created a situation in which psychiatric taxonomy needs to use traits for diagnostic purposes, but clinical practice requires a more elaborate theory of traits than is currently available.

The traditional hierarchical model may also not be the best way to represent trait structure and relationships for clinical purposes. The model reflects the statistical methods used to explore trait relationships and lacks any theoretical basis (Block, 2010). It also reflects the assumption of the latent factor model that some higher order entity accounts for trait covariation that leads to the reification of the resulting structures although again there are no a priori reasons why statistical structure should mirror the psychobiological structure of PD. Because all traits are assumed to be organized into a hierarchy with five or so domains each composed of the same number of facet traits, its application to PD forces clinical entities into a relatively simple, rigid structure. However, it is questionable whether the diverse psychopathology of PD is sufficiently homogeneous to be accommodated by such a simple model. Moreover, this structure may not be the best way to represent trait relationships for clinical purposes. Traits could be conceptualized as covarying not because they are part of a higher order entity but because they form a network of functionally related mechanisms (Borsboom et al., 2003; Cramer et al., 2012). This kind of more functional conceptualization of trait structure would also converge better with other aspects of personality that are often the focus of clinical attention, such as needs, motives, narratives, scripts, and meaning systems.

Problems With the AMPD Trait Model

A specific concern is whether the AMPD five-factor model (FFM) is the best way to represent PD because reviews of earlier studies of the structure of PD (Mulder & Joyce, 1997; Widiger & Simonsen, 2005) found robust evidence of a four-factor structure. The AMPD added a fifth factor of psychoticism creating greater alignment with the FFM. Although a factor resembling openness was not identified in studies of PD traits, proponents of the FFM model proposed that extreme levels are related to schizotypy. The idea seems forced: The clinical features of schizotypy are phenomenologically distinct from manifestations of openness to experience. Moreover, questions remain about the definition of the fifth domain. Early studies labeled it "intellect," and recent commentary acknowledges that uncertainty remains, although it notes an emerging consensus that it is more related to fantasy, ideas, and esthetics (John, 2021), features that seem tenuously related to schizotypal phenomena. With the four-factor models of PD, schizotypy is a narrow-band construct with low loadings on several factors that could be viewed as a distinct trait relatively unrelated to broad domains. Again, there are no a priori reasons to assume all traits must necessarily fit into five equally broad domains.

The AMPD's divergence from earlier findings probably reflects differences in the initial pool of adjectives used to generate factor structure. Earlier studies used explicit procedures to ensure items were representative of PD by identifying descriptive features through literature reviews that were then reduced to fewer items using a similarly explicit process. The *DSM–5* process was more informal. Although the *DSM–5* working group was aware of the facet structure of four-factor models, committee members suggested additional traits. This may have allowed bias to creep into the process with the inclusion of multiple items to assess schizotypy resulting in

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the emergence of a psychoticism factor and greater convergence with the FFM. The question of whether schizotypy/psychoticism is a higher order domain or a primary trait is not a purely psychometric matter. It is also a theoretical issue that is difficult to resolve because trait psychology does not clearly differentiate domains and facet traits. There is also the problem of whether schizotypy should be considered a PD as *DSM* assumes or whether is part of the schizophrenia spectrum as *International Classification of Diseases, 11th Revision*, assumes, another issue that is difficult to resolve without a principled definition of PD.

Overall, there are just too many methodological, conceptual, and theoretical problems with the traditional trait model to warrant its unmodified adoption for a medical classification given the significance and consequences of medical diagnoses. The approach also imposes a rigid structure on diagnostic constructs that is premature at this stage of the field's development.

Conclusion: The Importance of Making Assumptions Clear

Despite its problems, the AMPD incorporates features that are necessary components of future classifications. However, it is not the destination that Bach and Tracy imply but rather a preliminary way station, somewhat off the main track, on the journey toward a scientific system. Progress requires that basic assumptions, underlying principles, and guiding perspectives are made explicit. This is highlighted by Bach and Tracy's stated intent to review the AMPD's "capacity to capture common features of personality pathology in a clinically informative manner, with particular focus on Borderline PD, narcissism, and psychopathy" (m/s p. 4). Their intent seems appropriate: Most clinicians probably consider these conditions prototypical of PD. Nevertheless, it implies assumptions about what conditions are valid and should be given priority. It is as if the authors have an "implicit theory" of PD that serves as the standard for evaluating new proposals. Again, these could be considered reasonable assumptions. However, we do not know what this "implicit theory" entails or the assumptions or rationale behind it. Nevertheless, it would almost certainly bias classification toward a focus on "externalizing" conditions. The example illustrates how easily our classifications are affected by unstated positions and why their development requires rigorous conceptual research to elucidate and evaluate underlying assumptions, define and refine constructs, evaluate the conceptual coherence and consistency of constructs and models, and test arguments and inferences.

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