Either all mental disorders are personality disorders or there are no personality disorders: A reply to García and colleagues (2024)

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'Believe those who are seeking the truth. Doubt those who find it.'

Andre Gide

García and colleagues (2024) present a timely review of the alternative model of personality disorder (AMPD), focusing on the psychometric strengths and limitations of its two components: criterion A (maladaptive ways of viewing oneself and others) and criterion B (maladaptive personality traits). In reviewing the literature, the authors suggest that "personality can be used as a unifying framework to organize not only personality pathology but also mental disorders more generally" (p. 8); that "criterion A lacks incremental validity over criterion B" (p. 11), and, finally, that the "AMPD classification [...] would gain feasibility and coherence if Criterion A is discarded" (p. 18). Although the premises of their argument appear correct, their final conclusion does not logically follow from them, rendering their argument philosophically invalid. Here, we comment on this logical fallacy and suggest that the valid conclusion of García et al.'s (2024) review is that *"**either all mental disorders are personality disorders or there are no personality disorders**."*

To understand how this conclusion follows logically and inevitably from García et al.'s (2024) reviewed evidence, we first outline the existing diagnostic practice of personality disorder and then explore the consequences of removing its criterion A or replacing that criterion A with another criterion that was suggested by García and colleagues (2024). Currently, diagnosing personality disorder (using the ICD-11 or DSM-5 AMPD) involves two steps. First, the severity of patients' personality functioning is assessed with a measure that reflects maladaptive ways of viewing oneself and others (Morey et al., 2022). For a personality disorder diagnosis to be considered, the severity level (criterion A) must be at least moderate in DSM-5 AMPD (American Psychiatric Association, 2013) or mild in ICD-11 (World Health Organization, 2019).

Upon establishing this baseline level of severity, the next step (criterion B) is to examine extreme (and thereby maladaptive) personality traits. These traits are the maladaptive equivalents of the well-known five-factor traits: neuroticism, conscientiousness, agreeableness, extraversion, openness to experience (Widiger, 2017). Four of these traits are present in both the DSM-5 AMPD and the ICD-11, though under different names: negative affectivity (high neuroticism), disinhibition (low conscientiousness), antagonism (high disagreeableness), and detachment (low extraversion). The final trait for the ICD-11 is anankastia (high conscientiousness), while for the DSM-5 AMPD, it is psychoticism (an aspect of openness). For a diagnosis of personality disorder to be given, clinicians must establish the presence of at least one maladaptive trait in DSM-5 AMPD (American Psychiatric Association, 2013). Notably, though, for the ICD-11, this step is supplementary and a complete diagnosis of personality disorder can be provided based solely on the first criterion of severity (World Health Organization, 2019).

Thus, the AMPD diagnosis of personality disorder is currently based on the synergistic formulation of two criteria: severity (based on maladaptive ways of viewing oneself and others; criterion A) and personality (based on extreme and maladaptive personality traits; criterion B). García and colleagues (2024) recommend discarding the former marker of severity to achieve more "feasibility and coherence in the AMPD classification system." Discarding this criterion A would indeed simplify the classification system since it would render the diagnosis of personality disorder entirely dependent on the presence of one or more extreme personality traits. This would result, in the words of García et al. (2024, p.6), in the conception of "pathological personalities as extreme variants of normal-range traits." Indeed, this is a position that is somewhat dogmatically held by various proponents of the trait-based model of personality disorder, who dismiss criterion A (poor ways of viewing oneself and others) and suggest that only criterion B (personality traits) is necessary for diagnosing disorders of personality (Sleep & Lynam, 2022; Widiger & Hines, 2022).

Here, we demonstrate that if we extend this argument to its logical endpoint, we reach a classification system wherein all mental disorders are personality disorders. To understand how this outcome follows logically and inevitably from the trait-based definition of personality pathology, we ask our readers to carefully consider the following evidence, which is all in fact quoted from García et al. (2024, p. 6-8, bold ours).

First, ***mood disorders*** (such as anxiety and depression) are strongly related to "high neuroticism and low extroversion and conscientiousness" according to "a meta-analysis of 175 studies (Kotov et al., 2010)." In fact, "low extroversion is particularly related to social phobia and panic disorder/agoraphobia but not to specific phobias (Brandes & Bienvenu, 2006)."

Second, "personality domains involving negative emotionality and low extroversion and conscientiousness are key factors in the development of **PTSD** (DiGangi et al., 2013)" and **obsessive-compulsive disorder** "shows the highest relationship with neuroticism (d = 2.07; Kotov et al., 2010)."

Third, "neuroticism is also strongly related to **somatoform disorders** and—in conjunction with perfectionism, low extroversion, negative urgency, and sensitivity to social rewards—to **eating disorders** (Farstad et al., 2016; Lahey, 2009)."

Fourth, "personality is also related to **alcohol** and **drug use disorders** in complex ways," with disinhibition being "the best predictor at younger ages," but antagonism being "a stronger predictor among older individuals (Creswell et al., 2016)."

Fifth, "**attention-deficit/hyperactivity disorder** showed high associations with low conscientiousness (d = -0.95) followed by neuroticism and low agreeableness (0.85 and -0.64, respectively) in a meta-analysis of 40 data sets using the FFM (Gomez & Corr, 2014)."

Sixth, "cross-sectional and longitudinal research has identified high neuroticism as a risk factor for the development of **schizophrenia** (Franquillo et al., 2021)" and "correlations higher than 0.80 with neuroticism have also been found for **bipolar disorder** (Hanke et al., 2022)."

Seventh, "in recent meta-analysis, Lodi-Smith et al. (2019*)* reported substantial mean differences in FFM traits when groups with **autism spectrum disorder** were compared with control groups, with Hedges g effect sizes ranging from -0.88 (conscientiousness) to -1.42 (extroversion)."

Finally, it is worth noting that in several cases, personality traits are (paradoxically) more predictive of mental disorders compared to personality disorders (see Kotov et al., 2010; Ringwald et al., 2023; Samuel & Widiger, 2008 for meta-analyses; see also our arguments later).

The evidence reviewed clearly demonstrates that extreme and thus maladaptive personality traits are found in a plethora of mental health conditions, suggesting that indeed all such conditions can be viewed as personality conditions when we adopt a trait-based definition of personality pathology (criterion B). In other words, if personality disorder is merely a disorder of extreme personality traits, then all mental disorders can be cast as personality disorders because all mental disorders inherently entail personality extremeness. Of course, we all know better than to label every depressed, anxious, and autistic person as having a personality disorder simply because they score highly on measures of personality. Instead, we clinically understand that there is something different between these clinical cases and the classic "personality disorder" cases. And that something clearly is not reducible to personality traits.

Rather, that something appears to be a particular consequence of personality traits: maladaptive ways of relating. Clinically, the most striking feature of personality disorders has little to do with personality traits and much to do with the interpersonal consequences of those traits. These consequences include, but are not limited to, tendencies to view oneself and others in extreme and unstable ways (splitting), attachment and intimacy problems, and difficulties in forming therapeutic alliances or cooperating with others in any work-related capacity (Hopwood et al., 2013). All these relational problems have prognostic and diagnostic utility (Zavlis, 2023), propelling even prominent adherents of criterion B (maladaptive traits) to note that during therapy, we do not treat "the traits themselves" but rather "their consequences" (Tyrer & Mulder, 2022, p.85).

Indeed, it is all these defining consequences of personality pathology that criterion A aspires to capture. To elaborate, Criterion A was never meant to be an alternative to criterion B (personality traits) but rather a complementary aspect to it: a measure of the most severe aspects of personality disorder which were empirically demonstrated to be identity and interpersonal difficulties (Bender et al., 2014). García and colleagues (2024, p. 11) suggest that criterion A is needless because it

"overlaps broadly with the pathological traits of Criterion B" and thereby "lacks incremental validity over Criterion B." However, in saying this, the authors entirely misconstrue the point of criterion A. Criterion A was constructed to *specify* criterion B, not *replace* it (see Wright et al., 2022). Moreover, criterion A was derived *from* measures of personality, so it cannot possibly be conceived as distinct from five-factor measures of personality (see Bender et al., 2014). Instead, it should be viewed as a specific facet of personality that aims to capture the essence of personality problems. In that sense, it is also futile to pit criterion A against criterion B in contests of incremental validity: Criterion B will always win because it is a much broader and elaborate version of criterion A.

On this, it is further worth noting that criterion B is so broad and comprehensive that it could be better conceptualised as "a unifying framework to organise [...] mental disorders more generally," not personality disorders more specifically (something that is paradoxically also acknowledged by García and colleagues, 2024, p. 8). To understand why this is the case, one only has to take a close look at the nomological network of personality traits: Personality traits are so broad that they capture variation in arguably all themes of human life, including emotional themes, behavioural themes, cognitive themes, and interpersonal themes (see Deaux & Snyder, 2012). Consequently, they are related to anything and everything and outperform most other psychological constructs in tests of incremental validity (Widiger, 2017).

And therein lies the intricacy: The breadth of personality is also its weakness. More specifically, the breadth of personality is a strength when it comes to general psychological predictions: To the extent that personality traits capture most themes of human life, they are bound to predict the most important life outcomes, including marriage outcomes (Sayehmiri et al., 2020), financial outcomes (Alderotti et al., 2023), occupational outcomes (Barrick & Mount, 1991), wellbeing outcomes (Anglim et al., 2020), as well as psychopathology outcomes (Kotov et al., 2010). At the same time, however, this breadth becomes a weakness when it comes to specific predictions of personality disorders: Clinically speaking, a diagnostic measure needs to be able to uniquely define and predict something, not generally describe and predict everything (Aboraya et al., 2005). García and colleagues (2024) rightly lament that criterion A cannot yet uniquely predict personality disorders. However, the exact same criticism applies even more so to criterion B (personality), since, as we have reviewed earlier, personality traits are involved in virtually all psychopathologies. In that sense, personality (i.e., criterion B) is better conceived as a general framework to organise all psychopathologies broadly, *not* personality pathologies specifically.

Which leaves us again with the fundamental question at hand: What exactly should be used to organise personality pathology specifically? Here, García and colleagues (2024, p. 17) offer some valuable insights: they suggest that "a more feasible way of measuring severity might be to use a list

of *relevant negative consequences*" (italic ours). With this, we wholeheartedly agree. We can, of course, define personality disorders in terms of their relevant negative consequences. In fact, we could define all mental disorders in terms of the relevant negative consequences of their extreme personality traits, since, as we have previously seen, all mental disorders usually involve extreme personality themes. Doing so, however, reveals that there is no basis for labelling personality disorders as "personality disorders" for the following reasons.

First, according to the most recent meta-analyses, ***high neuroticism*** is most robustly associated with internalizing disorders (average Cohen's d = 1.71; Kotov et al., 2010), not personality disorders (average Cohen's d = 0.56; Samuel & Widiger, 2008). This makes sense: Internalizing disorders (depression, anxiety, specific phobias, and so on) are fundamentally emotional, because they are characterised by extreme emotions that tend to persist for long periods of time (Zavlis et al., 2024). In this sense, we can label their "relevant negative consequences" as emotional and call them (intuitively and perhaps circularly) ***emotional or mood disorders***.

Second, according to meta-analyses, ***low conscientiousness*** (or disinhibition) is most robustly associated with substance use disorders (average Cohen's d = 1.09; Kotov et al., 2010) and attention-deficit hyperactivity disorder (ADHD) (d = 0.95; Gomez & Corr, 2014), not personality disorders (average Cohen's d = 0.22; Samuel & Widiger, 2008). This, again, makes sense: substance use and attention-deficit problems are fundamentally problems of impulse (behavioural) control (Molina & Pelham, 2014; Wilens, 2004). Given this, we can denote their "relevant negative consequences" as impulse-behavioural and call them ***impulse disorders***.

Third, ***psychoticism*** (which is a maladaptive facet of trait openness) is uniquely associated with psychotic disorders, including schizotypal personality disorder, which is currently part of the psychosis spectrum (e.g., see Chmielewski et al., 2014; Widiger & Crego, 2019). Psychotic disorders are typified by cognitive-perceptual distortions, such as delusions and hallucinations (Bentall, 2003). Thus, we can label their "relevant negative consequences" as cognitive-perceptual and call them ***cognitive-perceptual*** or ***thought disorders*** (Kotov et al., 2017).

Finally, according to a recent meta-analysis by Ringwald et al. (2023) (which was not cited by García and colleagues, 2024), high disagreeableness (or antagonism) as well as high introversion (or detachment) are most robustly associated with personality disorders (average factor loadings = 0.35 and 0.50, respectively). These traits involve relational themes, which, in the words of García and colleagues (2024, p. 13), are "to navigate **relationships** based on either mutual exchange or dominance-exploitation (antagonism)" and "to establish **bonds** with mates, kin, or friends (detachment)" (bold ours). This again makes sense: the fundamental problems of personality

disorders are interpersonal (Hopwood et al., 2013). On that basis, we can label their "relevant negative consequences" as relational-interpersonal and call them the ***relational*** or ***interpersonal disorders*** (see Wright et al., 2022; Zavlis, 2023).

We can thus see that even when we categorise most psychopathologies in terms of personality, we still end up with the following (non-personality) categories: *emotional disorders* (high neuroticism), *impulse disorders* (high disinhibition), *thought disorders* (high psychoticism), and *interpersonal disorders* (high antagonism and detachment). Interestingly, the same themes emerge in factor-analytic studies of mental disorder domains, suggesting that the psychological themes of personality are inextricably linked to the psychological themes of psychopathology (Ringwald et al., 2023). These patterns suggest that there is nothing privileged about the association between personality and the traditional personality disorders. Instead, all mental disorders are invariably associated with personality themes that match their underlying pathologies. In that sense, all mental disorders both are and are not personality disorders.

Conclusion

In this paper, we presented a valid conclusion from García and colleagues' (2024) review: either (1) all mental disorders can be conceived as personality disorders; or (2) there is no basis for terming personality disorders as "personality disorders". The former conclusion follows from the observation that all mental disorders involve extreme personality traits, which means that if we only use extreme personality traits to define personality pathology, we will inevitably end up casting every mental disorder as a personality disorder. The latter conclusion follows from the alternative criterion A that García et al. (2024) suggested: namely, using the "relevant negative consequences" of personality traits to define personality psychopathologies. When we use this criterion, we reach an interesting system of classification wherein neuroticism defines the emotional disorders; disinhibition the impulse disorders; psychoticism the thought disorders; and, finally, antagonism and detachment the interpersonal disorders (formerly known as personality disorders). Our conclusion is that this latter system might present a fruitful diagnostic avenue. However, before it is adopted, its feasibility must be examined vis-à-vis the current system and the putative first one wherein all mental disorders are personality disorders.

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