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PERSONALITY DISORDERS, FACT OR FICTION? THE DARK FUTURE OF THEIR DIAGNOSIS

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Abstract

The categorical diagnosis of personality disorders (PDs) has been criticized for various reasons, among which are overlapping of symptoms between different disorders, their high comorbidity, and the dichotomous nature of their diagnosis. These criticisms have led to the development of a dimensional approach in the latest versions of the classification systems, DSM-5/DSM-5-TR and ICD-11, considering two substantial aspects for its new diagnosis: personality functioning, and a series of pathological features. Despite the large amount of literature that has been published since the beginning of this century on this dimensional proposal, it is not clear, to date, that this approach enhances clinical utility. The vague, abstract, and inoperative exposition of what constitutes personality functioning and the complex and forced designation of major and minor traits (facets) in the DSM-5/DSM-5-TR, and only major and optional traits in the ICD-11, complicate, in an unusual way, the dimensional diagnosis of PDs. This paper discusses all of these issues in an attempt to shed some light on the potentially dark future of the current PDs panorama.
KEY WORDS: *personality disorders, dimensional diagnosis, alternative model (AMPD), DSM-5, ICD-11.*

Resumen

El diagnóstico categorial de los trastornos de la personalidad (TTPP) ha sido criticado por diversas razones, entras las que se encuentran el solapamiento de síntomas entre distintos trastornos, su elevada comorbilidad o el carácter dicotómico de su diagnóstico. Estas críticas han llevado al desarrollo de un planteamiento dimensional en las últimas versiones de los sistemas de clasificación, DSM-5/DSM-5-TR y CIE-11, considerando dos aspectos: el funcionamiento de la personalidad y una serie de rasgos patológicos. A pesar de la cuantiosa literatura publicada desde principio de este siglo sobre esta propuesta dimensional, no está claro, a día de hoy, que tenga alguna utilidad clínica. La vaga, abstracta y poco operativizable exposición de lo que constituye el funcionamiento de la personalidad y la compleja y forzada designación de rasgos mayores y menores (facetas) en el DSM-5/DSM-5-TR o sólo mayores y opcionales en la CIE-11, complican el diagnóstico dimensional de los TTPP. En este trabajo se discuten todas estas cuestiones en un intento de aportar algo de luz para un futuro menos sombrío que el actual panorama de los TTPP.

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PALABRAS CLAVE: *trastornos de la personalidad, diagnóstico dimensional, modelo alternativo (MATP), DSM-5, CIE-11.*

Introduction

Classification of personality disorders (PDs)[1] has been controversial since its inception. Thus, since the first minimally reliable classification system, such as DSM-III (APA, 1980), a separate section, Axis II, was dedicated to personality disorders, different from all other mental disorders. Why? It did not seem to make much sense and, in fact, in DSM-5 (APA 2013) this axis was removed and PDs were included along with the other disorders, without artificial separations. A low degree of agreement has also been found between different methods when determining the presence of PDs, not only when we want to identify the presence of a personality disorder (PD), but also when we want to find out if there is a specific personality disorder. Another controversial issue, closely related to the previous one, is the consideration of PDs from a categorical position or from a dimensional position (see Millon and Escovar, 1996). The categorical taxonomy produces simple and clear descriptions, but less close to reality, although it is more similar to the way clinicians work, whereas a dimensional model presents the potential for more precise information but is also more complex and difficult to reliably interpret. Of course, someone might think that, on the one hand, Axis II is eliminated in order to better assimilate PDs to the rest of the mental disorders, but, on the other hand, the dimensional proposal segregates them by proposing a form of diagnosis (dimensional) totally different from the rest of the clinical disorders (categorical). Furthermore, the section on PDs has long been subdivided (DSM-III) into three *clusters*: A (bizarre or eccentric subjects), B (dramatic, theatrical, emotional, or voluble subjects) and C (anxious or fearful subjects), without clear empirical support and without all the disorders included in each cluster meeting these general grouping characteristics. For example, antisocial and narcissistic personality disorders, included in cluster B, are not "dramatic, theatrical, emotive or voluble". Continuing with the differences between the PDs and the rest of the mental disorders, it is pointed out that many of the former are egosyntonic disorders (versus egodystonic disorders of the latter), that is, that individuals with this type of problem often feel comfortable with the symptoms characteristic of that problem, perhaps because their existing self-concepts and the behavioral patterns they manifest are all they know and remember (O'Connor and Dyce, 2001).

In summary, PDs constitute a group of clinical problems for which attempts have been made to differentiate them from other classes of mental disorders, but,

[1] Abbreviations frequently used in this article are listed in Appendix 1.

at the same time, they have been equated to the latter. That is, prior attempts hold that "they are the same, but different". This creates a very complex and controversial state of affairs. Therefore, it is not surprising that there are a number of unresolved issues regarding the conceptualization, diagnosis and treatment of this group of disorders. We will devote the remainder of this article to review and discuss some of these problems.

Personality and personality disorders

Before addressing PDs as such, we can briefly review some characteristics of what experts consider personality to be. The American Psychological Association (APA, 2018) defines *personality* as the enduring configuration of characteristics and behavior that comprises an individual's unique adjustment to life, including major traits, interests, drives, values, self-concept, abilities, and emotional patterns. In this approach to personality, we already have our first problem: it is not very clear what the "enduring characteristics" encompass. Other authors refer to a set of patterns of thoughts, emotions and actions that characterize a person from early life and that are stable, permanent over time and across different situations (McCrae and Costa, 2003; Ruiz et *al.,* 2012). Something similar is the definition of personality proposed by Phares (1988) as a pattern of characteristic thoughts, feelings, and behaviors that distinguishes people from each other and that persists over time and across situations. Or the definition proposed by Millon and Everly (1985) as a pattern of cognitive, affective, and behavioral traits, deeply rooted and widely manifested, that persist over extended periods of time. Therefore, it is to be assumed that personality dysfunctions would be found in those thoughts, emotions and actions, something clearly agreed among cognitive behavioral psychologists, which constitute the targets of interventions with patients who come to therapy, something generalizable to most of the clinical problems/disorders for which they consult. But other health professionals have a very different view of personality, as we will see below, both in terms of concept and intervention.

Considering the notion of personality that we have just outlined, how would we describe *personality disorders*? We can say that they are characterized by maladaptive patterns of thoughts, feelings and behaviors that begin very early in life and are perpetuated over time and across different situations. They usually constitute significant deviations from what would be normal life patterns and particularly from the interpersonal behavior of the same sociocultural group to which the individual belongs (Caballo, 2009; Caballo *et al.,* in press). The development of a PD, like all other mental disorders, depends on the interaction of genetic elements (biological predisposition) and environmental factors (including parental education and the individual's experiences since birth). The effects of biology must always be

understood in light of their interactions with a psychosocial context. For example, a certain temperament tends to make the development of a PD more likely and would determine the type(s) of PD that may develop (Paris, 2015). On the other hand, *personality styles* would mark a tendency of the individual to act, feel or think in a certain way, since the formation of a personality style is inherent to the evolutionary development of every human being and influences the interaction of the person with their environment. These characteristics would not be considered pathological, since they would not be accentuated and would be flexible enough to allow the person to modify and adapt their responses to the specific demands of the situation and context (Millon & Davis, 2000). That is, they are functional and do not cause any impairment in any vital area (personal, social, occupational, etc.) According to the previous authors, the distinction between *styles*, as we could call these characteristics, and PDs would lie in their pathological level (degree). Styles and PDs would form part of a continuum, so that the former would remain in the normality range and disorders in the pathology range.

Classification of personality disorders

As we pointed out at the beginning of this paper, classification of PDs has been plagued with problems since its inception. From the dedication of a separate section to the rest of the mental disorders to the questioning of its traditional form of diagnosis. With the emergence of DSM-III, a number of PDs have been incorporated, most of which have remained in the official part (section II) of the latest version of the DSM (DSM-5-TR; APA, 2022), but others have appeared briefly and then been removed from the classification as specific disorders. Examples of the latter are passive-aggressive, depressive, self-defeating, and sadistic disorders, which disappeared as of DSM-IV (APA, 1994). Additionally, since the DSM-III-R (APA, 1987), PDs have been presented in three groups, A, B and C, with supposed common characteristics that characterize each of these groups. However, as we have indicated above, these groups have no empirical support, and the supposed common characteristics are not so common. For its part, ICD-10 (WHO, 1992) included basically the same specific PDs as DSM-IV, except for narcissistic disorder and schizotypal personality disorder, the latter included in the schizophrenia group and not in the PDs group.

In the latest versions of the DSM (DSM-5 and DSM-5-TR; APA, 2013, 2022) and the ICD (ICD-11; WHO, 2024) there are some variations from the previous ones. The official section of the DSM-5 (section II) includes, without any modification, the DSM-IV classification, but in section III an alternative hybrid categorical-dimensional classification of this group of disorders has been added. For its part, ICD-11 breaks drastically with the past and presents as official classification its dimensional model

of PDs, in which it only maintains the borderline pattern as a recognizable PD from ICD-10. In summary, the categorical position is maintained only in section II of DSM-5, while the dimensional model is preferred by section III of DSM-5 and by ICD-11.

The categorical approach versus the dimensional model

The diagnosis of most mental disorders uses a *categorical approach*, that is, diagnosis tries to establish precise categories with clearly defined properties in order to define the absence or presence of a constellation of symptoms. In other words, the individual has to meet a set of criteria (symptoms) in order to be diagnosed with a particular disorder. If they fail to meet any of them, they would not fall into the category of the disorder. This approach is therefore dichotomous in nature (i.e., you either have the disorder or you do not have it, there are no intermediate positions). Moreover, each diagnostic category (specific disorder) is different from the rest of the categories (specific disorders). In short, these categories should meet three basic criteria: they should be discrete, mutually exclusive, and exhaustive. However, the DSM-III (APA, 1980) claimed that there was no postulate stating that each mental disorder is a discrete entity with precise boundaries (discontinuity) with respect to other mental disorders and the absence of mental disorder. DSM-III added that the classification system of mental disorders serves to classify disorders, not persons. For its part, the *dimensional approach* attempts to measure the quantitative differences of the same element, ordering the symptoms according to degree of intensity. That is, a dimensional approach would identify and measure individual differences with respect to various psychological phenomena. In this way, the degree to which a problem manifests itself would be evaluated, taking into account the number of symptoms, their intensity and their variety. A dimensional system should also indicate at what point pathology exists to merit clinical attention.

If we accept the supposed advantages of the dimensional model, it would be considered that a dimensional, rather than categorical, assessment of psychological disorders would be closer to the reality experienced by individuals. Such an approach has been applied in recent years with PDs, both in section III of DSM-5 (APA, 2013) and in ICD-11 (WHO, 2024). The rationales for adopting the dimensional approach in both diagnostic systems have been diverse, ranging from improving the reliability and validity of PDs diagnosis (and not so much providing a simpler, faster and more attractive approach) (Bach and Tracy, 2022; Skodol, 2012) to reducing the stigma of categorical PD diagnosis (WHO, 2024) (although we think that the best way to change stigma would be through education, not by dimensionalizing a problem). We will now analyze the dimensional approach proposed by both DSM-5 section III and ICD-11.

Section III of DSM-5 proposes an alternative model for PDs (DSM-5-AMPD) called the hybrid categorial-dimensional model, whereas ICD-11 proposes a purely dimensional model. In both classification systems, PDs are characterized by difficulties in personality *functioning* (criterion A) and by pathological personality *traits* (criterion B), although the only essential criterion in ICD-11 is impaired personality functioning, with the traits serving as modifiers or descriptors that are not essential to the diagnosis. Both DSM-5-AMPD and ICD-11 require that, in addition, the individual meets several other criteria, such as the impairment being relatively inflexible, pervasive, stable, not better explained by another mental disorder, nor by the individual's stage of development, etc. We wish to emphasize, however, the ICD-11's insistence on focusing the diagnosis of PDs almost exclusively on inadequate personality functioning. The severity of this dysfunction will determine whether or not the person suffers from a PD in general, without specifying the type of PD. Once it has been diagnosed that the patient suffers from a PD, the clinician could go further and optionally assess the specific type of PD. For this purpose, 5 additional traits and a pattern are available. Let us now see what both the personality functioning and the pathological personality traits consist of.

Dimensional approach: the functioning of the personality

Alterations in personality *functioning* constitute the central axis of the diagnosis of PDs in both DSM-5-AMPD and ICD-11. But what does such functioning refer to? Personality functioning consists of two elements at the higher level: 1) functioning *of the self*, which involves, in turn, two subsections, *identity* (e.g., experience of oneself as unique, stability of self-esteem, accuracy of self-appraisal) and *self-direction* (e.g., utilization of constructive and prosocial internal standards of behavior, ability to self-reflect productively), and 2) *interpersonal* functioning, which includes *empathy* (e.g., tolerance of different perspectives, understanding the effects of one's own behavior on others) and *intimacy* (e.g., desire and capacity for closeness, mutuality of regard reflected in interpersonal behavior). These four sub-elements are assessed according to the level of impairment, from 0 (healthy, adaptive functioning) to 4 (extreme impairment in functioning). ICD-11 varies somewhat in determining the severity of PD (no PD, personality dysfunction, mild, moderate, or severe PD). One of the problems with introducing a severity dimension to these general and abstract descriptions of impaired functioning is that it increases the risk of stigmatization from the first clinical impression in patient-therapist communication, as such functioning would not be based on objective and reliable criteria (Herpertz *et al.,* 2017). In summary, disturbances in interpersonal and self functioning constitute the core of personality psychopathology in both DSM-5-AMPD and ICD-11.

At this point, we may wonder whether this proposal regarding personality functioning represents an advance over the reviled categorical classification. Interestingly, the initial decision as to whether or not a patient has a PD is basically a categorical decision. Then the clinician will have to decide whether that PD is mild, moderate, severe or extreme in nature, which would also correspond to a categorical decision (Bach *et al*., 2022). In addition, the concept of personality functioning included in both the DSM-5-AMPD and ICD-11 is so vague and inoperative that opinions on this concept can only be varied and diverse. Thus, Sharp and Wall (2021) argue that deficits in personality functioning should be understood as the failure of an "intrapsychic subjective system" to adapt to and accomplish the tasks of adult life. Other researchers have suggested that the operationalization of dysfunction needs to be refined to assess specific and concrete descriptions of how impairment manifests (e.g., Sleep and Lynam, 2022). Some proponents of the dimensional model argue that personality dysfunction should identify what is unique to PDs. "Criterion A is intended to play an important role in distinguishing what is a personality disorder from what is not" (Morey, 2019, p. 1195). Other authors claim that "deficits in self and interpersonal functioning are the central feature of personality pathology and it would be the centrality of these alterations in the functioning of self and others that would distinguish personality pathology from other kinds of psychopathology (e.g., mood, anxiety, etc.) (Pincus *et al*., 2020). But what has actually been found out is that self/interpersonal deficits are identified in people with a mental disorder who do not have a PD. Sleep *et al*. (2019a) reported that deficits in criterion A were as highly correlated with mood, anxiety, and other mental disorders as with PDs, somewhat inconsistent with the claim that personality functioning impairments are unique to PDs. Similarly, if deficits in personality functioning are at the core of personality disorder, they should be evident in all syndromes. Existing research has not supported this expectation (Widiger & Hines, 2022). Moreover, according to these authors, it is far from clear how intrapsychic deficits or impairments in criterion A are distinct from personality traits or even necessarily intrapsychic.

On the other hand, proponents of the new ICD-11 dimensional approach agree that a global determination of severity, regardless of typology, is the backbone of the diagnosis of PDs. However, this proposal appears to be vague, imprecise, and therefore uninformative, as well as minimalist and unsophisticated for specialized clinical practice (Bach *et al*., 2022). Similarly, the multidimensionality of personality functioning put forward by the DSM-5-AMPD has been questioned, pointing out that the 4 factors proposed for diagnosing personality dysfunction overlap with each other (Sleep *et al.,* 2024) and that it would perhaps be more useful to consider such dysfunction as unidimensional. Emery *et al*. (2023) insist that, despite the apparent distinctions between these domains of personality functioning, personality

dysfunction is hypothesized to be a unidimensional construct that would indicate the severity of personality pathology. However, if the personality functioning construct were unitary, it is not clear why it should be decomposed into 2 higher-level items with 2 subitems each (Widiger & Hines, 2022).

Sleep *et al.* (2019b) noted that the existing literature on the combined performance of the DSM-5-AMPD hybrid model has questioned the incremental validity of criterion A (personality functioning), as it has not been found to add substantial variance beyond pathological traits (criterion B), likely due to substantial overlap between the two criteria. This raises the question of the limited utility of having two strongly interrelated components (Miller *et al.,* 2018). Diagnosis within the DSM-5-AMPD would require elevated levels of maladaptive traits, as defined by criterion B, as well as evidence of personality disturbance, as defined by criterion A. Given the substantial overlap between the two criteria, it appears that only criterion B would represent unique variance in predicting traditional PD diagnoses (Emery *et al*., 2023). Nevertheless, proponents of the role of personality functioning have suggested that it was important to include this criterion because its content would help distinguish personality pathology from other forms of psychopathology. However, it seems unlikely that criterion A would distinguish between personality-based and nonpersonality-based forms of psychopathology, given the substantial overlap between PDs and the rest of the mental disorders and the fact that personality may well constitute the source from which many forms of psychopathology arise. For their part, Morey *et al*. (2020) claimed that impaired personality functioning provides a critical link between normal and maladaptive range traits. But Emery *et al*. (2023) found no strong evidence that impaired personality functioning could statistically explain the relationship between normal and maladaptive personality traits. It does not appear, therefore, that impaired personality functioning serves as a process through which normal-range traits exert their effect on maladaptive traits. These authors also found that the overlap between maladaptive personality traits cannot appreciably be explained by deficits in personality functioning. Rather, other variables must contribute to the overlap that is often observed between maladaptive traits. It is also noted that characteristics corresponding to criterion A are significantly associated with mental distress, poor well-being, and relationship problems (Bach & Tracy, 2022), which would support the thesis that criterion A on personality dysfunction (mild, moderate or severe) could apply to a large part of the population. This concept could have the same bias that the concept of neurosis had at the time, i.e., it could be so general that it does not identify specific psychopathological conditions, but rather common life problems in human beings. Therefore, based on criterion A, a large part of the population could be diagnosed with a personality disorder or dysfunction, especially if we use

ICD-11, which gives the main weight for the diagnosis of PDs to this criterion, while assigning a secondary and optional role to pathological personality traits.

Finally, we would like to emphasize that we do not have a clear point of distinction between normal personality functioning, personality difficulties, and personality disorder, which is really the clinician's first task when assessing a patient. We would need to develop meaningful features of distinction that are easily recognizable by a clinician, but relevant in terms of personality (Bateman, 2011). The lack of empirically defined cut-off points could prompt clinicians, and—what might be more critical—health policymakers and funding bodies to be the ones making decisions about whether a patient is sufficiently distressed or impaired to warrant a clinical service. Instead of basing these important clinical decisions on two levels of the diagnostic process (personality disfunction and pathological traits), they will be restricted to the assessment of severity of malfunctioning alone, thereby separating the decision about whether treatment is needed from the one about which treatment to offer (e.g., when to provide hospitalization, when to recommend which psychotherapy method or/and medication, or when to shift a patient into a specialized treatment) (Herpertz *et al*., 2017).

Dimensional approach: pathological personality traits

In addition to personality dysfunction, the dimensional model requires pathological traits, which are necessary in DSM-5-AMPD (criterion B) and optional in ICD-11. The traits chosen were based on the *five-factor model* (*FFM*) (e.g., Costa and McCrae, 1985; Costa and Widiger, 1994) and are organized into five domains in the DSM-5-AMPD, four coming from that model, such as *negative affectivity* (neuroticism), *detachment* (low extraversion), *antagonism* (low agreeableness), *disinhibition* (low conscientiousness), and a fifth, *psychoticism*, added in order to be able to diagnose schizotypal personality disorder. In addition, these five major trait domains encompass *25* specific *trait facets*, such as, for example, anxiousness, separation insecurity, submissiveness, hostility, depressivity, suspiciousness, impulsivity, etc. (APA, 2013). ICD-11, on the other hand, includes six trait domain qualifiers that *can be* used (optionally) in PDs or personality difficulties to describe the characteristics of the individual's personality that are most salient and contribute to impairment. Trait domains *are not diagnostic categories* but represent a set of dimensions that correspond to the underlying structure of the personality. ICD-11 proposes the same first four major traits as DSM-5-AMPD (although naming antagonism as *dissociality*), plus the *anankastic* trait and the *borderline pattern*. This category of personality traits or patterns is to be used only in conjunction with one of the three levels of severity (mild, moderate, or severe) of personality disfunction or personality difficulty.

About personality traits we can say that they are stable over time. It is generally believed that traits directly influence behavior (Matthews *et al.,* 2003). One of the main tasks of a scientific trait psychology is to distinguish the internal properties of the person with respect to overt behaviors and to investigate the causal relationships between them. To avoid circularity, it is essential to seek to *identify the underlying physiological, psychological, and social bases of traits*, which are the true causal influences on behavior (Matthews *et al*., 2003). Although this enterprise would appear to be somewhat limited from its inception. For example, Jang and Choi (2022) noted that "finding the genes for what makes a person feel 'keen,' 'helpless,' 'timid,' or 'guilty' would be far more informative and clinically significant than the gene for neuroticism which these emotions predict" (p. 31). And the fact is that at the level of clinical practice, a trait is defined by its cognitive, behavioral, and emotional/physiological characteristics. If we want to have more precise information about a trait, we will have to assess these characteristics. Therefore, one might think that defining personality by its traits is circular. We say that an individual has such a personality trait based on those characteristics and, once we have established that the individual possesses such a trait, we will reassess the pathological level of that trait by means of these same characteristics.

Addressing personality pathology traits more closely, we see that some proponents of the dimensional system have noted that the general preference for the trait system has been attributed specifically to ease of use, completeness, patient comprehension, conceptualization of personality pathology, usefulness for treatment planning, potential for improved diagnostic assessment, and perceived association with therapeutic outcomes, among other factors. Most of these claims are not true (Bach and Tracy, 2022). For example, that patients have a better understanding of the whole framework of the trait system is more than doubtful or that some researchers talk of therapeutic outcomes when there has been no improvement in the treatment of PDs since the publication of DSM-5-AMPD is, to say the least, surprising. Similarly, although the Five Factor Model (FFM) traits are bipolar, assessing both high and low levels of each trait, the pathological trait domains are primarily conceptualized as unipolar and the current structure suggests that maladaptive behavior exists predominantly at one end, usually the lower end, of a given trait domain (FFM). Furthermore, the pattern of interrelationships between DSM-5-AMPD maladaptive trait domains is different from the pattern of interrelationships between FFM traits. Specifically, FFM traits are considered orthogonal (or at least show minimal intercorrelations), whereas maladaptive traits show considerable cross-facet saturation across domains and, additionally, relatively large correlations between broad domain traits (Emery *et al.,* 2023; Somma *et al.,* 2019).

When assessing PDs from the dimensional position it is not going to be easy, in many occasions, to give a specific name or diagnosis based on the traits, both in the DSM-5-AMPD and in the ICD-11. There are traits that are cross-cutting for several PDs. For example, the trait of antagonism (DSM-5-AMPD) or dissociality (ICD-11) characterizes both narcissistic disorder and antisocial disorder. In the first system it may be easier since the characteristics of section II have been taken as a basis and translated into traits. In ICD-11 there is a lack of clarity in this regard, making the use of specific labels very complicated. The logical approach would be to diagnose PD (mild, moderate, or severe) with dissociality. To include, in this case, the label of a specific PD (e.g., narcissism) would go beyond what is proposed by ICD-11, so it is doubtful that health professionals would find it clinically useful. Another relevant issue is that while ICD-11 has not been able to describe borderline personality disorder (BPD) with the four major traits of the dimensional classification and has had to propose a fifth, such as the borderline pattern, the DSM-5-AMPD been able to do so. As Livesley (2021) pointed out, traits are useful ways of representing some aspects of individual differences, but personality is much more than traits, and BPD is much more than maladaptive traits. What is interesting, moreover, is that there appear to be strong associations of DSM-5-AMPD pathological traits with DSM-5 Section II categorical PDs, as well as overlap between the latter and ICD-11 trait domains (Bach *et al*., 2018; Fang *et al*., 2021). However, this issue of the relationships between the categorical PDs of DSM-5 section II with the pathological traits of the dimensional proposals, DSM-5-AMPD and ICD-11, does not seem to arouse much enthusiasm among researchers, especially among proponents of the dimensional model (Levin-Aspenson, 2023).

To conclude this section, we would like to mention that some authors have pointed out that trait models are largely descriptive, atheoretical and do not explain anything (e.g., Livesley, 2021). This issue is of clinical importance because it reflects the failure of trait theory to provide explanations of the origins, internal structure, and functions of traits, which are necessary to develop effective ways to treat pathological traits. There are also substantial methodological problems with trait models, notably the reliance on a single research strategy (factor analysis of ratings of self or others by large samples of participants) and the difficulties this poses, as well as the way in which these models rely on the lexical hypothesis that the structure of popular concepts can serve as the basis for a scientific taxonomy. Popular concepts of traits adjectives are too vague, diffuse, and saturated with evaluative content to be useful for scientific purposes, and commonsense explanations rarely match scientific explanations of the same phenomena. There is also reason to question whether natural language really does contain adjectives referring to some clinically important behaviors (Livesley, 2021). In PDs clinicians recognize phenomena that laypeople do not readily distinguish.

What about personality styles?

As mentioned above, Millon and Davis (2000) spoke of a kind of continuum with respect to PDs, from style to disorder. Oldham and Morris (1995) devoted a whole book to the description of personality styles, following the DSM-IV categorical classification, and including a kind of questionnaire for their assessment (although a bit complex to score). Our research team also developed years ago a self-report measure called the "Exploratory Personality Questionnaire" (EPEQ-III; Caballo *et al.,* 2009, 2011) (see a sample of items in Appendix 2). This self-report instrument consists of 170 items assessing 14 personality styles based on the diagnostic symptoms of PDs posed by the DSM-IV (10 styles) and by other previous versions of the DSM (passive-aggressive, depressive, sadistic, and self-defeating). Each style is assessed by 12 items that reflect the specific symptoms of each corresponding PD and each item is answered on a 7-point Likert scale, from 1= Not at all characteristic of me to 7= Totally characteristic of me. The EPEQ was validated by means of the Millon's Clinical Multiaxial Inventory" (MCMI-III; Millon, 1994) and the correlations of each EPEQ style with each MCMI-III PD ranged from .50 (the lowest, for histrionic and obsessive-compulsive personality disorders) to .70 in the case of dependent disorder or .72 in the case of depressive disorder (Caballo *et al*., 2011). Although the EPEQ was intended to assess personality styles in people from the general population, it is likely that, in many cases, extreme scores are indictive more of a PD than a style. Our routine use of the EPEQ-III in the clinic provides us with a great deal of information regarding patients who typically present with a mental disorder, in general.

An added value of this line of research, considering the dimensional conceptualization of PDs, are some studies on the relationship between personality styles (assessed with the EPEQ-III) with some personality traits and with social behaviors that affect interpersonal relationships, as is the case of social skills. In the first case, we examined the relationships between the Big Five traits (based on the FFM) and personality styles (Caballo *et al*., 2009) and found that *Openness* did not have high correlations with any of the styles. The trait *Conscientiousness* (or low Disinhibition) was only positively and significantly related to the obsessive-compulsive style. *Agreeableness* (low Antagonism) was negatively related to almost all styles, especially paranoid, schizoid, antisocial, passive-aggressive, and sadistic styles. *Extraversion* (low Detachment) was positively related to histrionic and narcissistic styles and negatively related to schizoid, borderline, dependent, depressive and, especially, to avoidant styles. Finally, *Emotional Stability* (low Negative Affectivity) was negatively related to all personality styles, especially to borderline and depressive styles. Regarding the differences between men and women, the latter scored significantly higher in the dependent and borderline styles

and significantly lower in the narcissistic and antisocial styles. With respect to the Big Five traits, men scored higher than women on *Extraversion* and *Emotional Stability* while women scored higher on *Conscientiousness* and *Agreeableness*. There were no differences in *Openness (*Caballo *et al*., 2009).

Regarding the second area of research, the relationship with social skills, we found that only two styles had significant positive correlations with social skills in a systematic way. First was the histrionic personality style, clearly the most highly related to social skills, and second was the narcissistic style. In contrast, the least skillful styles were the avoidant personality style, clearly in first place, followed by the dependent, schizoid, and paranoid styles. However, there were also some styles that were neither characterized by high social skills nor by deficits in social skills. These neutral styles were the obsessive-compulsive personality style first and then the antisocial personality style (Caballo *et al*., 2014).

In summary, this approach to PDs by considering them at the extreme end of a style-disorder continuum could be an option, at least at the clinical level, when diagnosing this area of mental disorders, without the complexity presented by dimensional or hybrid models, but including some dimensionality in the assessment of PDs. Given that the symptoms of each of the classic PDs are well known, it is possible to establish to what extent the individual satisfies each of these symptoms on a 7-point Likert scale (EPEQ-III style) and to establish cut-off points for each PD (as has been done, in many cases, for other mental disorders).

The research approach vs. the clinical approach

Numerous papers published in recent years on PDs in the scientific literature focus on personality traits, both pathological and normal. The development of trait theory is based on the latent factor model that assumes the occurrence of some higher-order entity that explains trait covariation at the subordinate level. For example, primary trait measures such as anxiousness, separation insecurity, and submissiveness are assumed to be indicators of a latent variable called neuroticism, negative affectivity, or emotional dysregulation, with the assumption that this entity regulates primary trait functioning (Livesley, 2021). Trait theory usually assumes that latent variables are real entities. However, this is an assumption: there is no reason, a priori, to suppose that statistical relationships reflect the structure of psychobiological mechanisms. It should be noted, however, that alternative models of trait relationships are possible. For example, primary traits might covary because they are functionally related and not because they are part of or regulated by a higher-order entity. An important issue for the clinical application of trait models is the assumption that the factor structure derived from large sample data matches how personality is organized in the individual (Livesley, 2021). As we have previously

noted, the individual difference structure of the population is not the same as the personality structure of the individual. Data on the dimensions on which individuals differ do not explain their behavior. This creates a problem for the clinical application of such models, because clinicians are not concerned with group structure, but rather with how personality is organized in the individual. Uncertainty about the value of group structure for understanding individual personalities is a good reason to be cautious about using these structures in a diagnostic classification.

But what is the clinical utility of the profuse research on traits? If we consider that *clinical utility refers* to the practical usefulness of a model, including aspects such as ease of use, usefulness for communication with other professionals and with the patient, usefulness for describing all personality problems, and usefulness for the *formulation of effective treatment* (Bach and Tracy, 2022; First et *al*. 2004), we could say that this research would have very little "clinical utility". First (2010) highlights the difficulties of devising a classification scheme that meets the needs of both the clinical and research communities. In the case of DSM-5-AMPD and ICD-11, the challenge should have been to adapt the complex dimensional trait scheme developed and used almost exclusively by the research community to clinical use. The DSM-5/DSM-5-TR states that the official section of its classification of PDs (section II) should serve for clinical practice while the alternative model (section III) should do so for research purposes. This would make some sense, given the difficulty in operationalizing PDs from the dimensional position in everyday clinical practice. The abstract concepts involved in assessment from such a position, especially regarding personality functioning (criterion A) and the multitude of facets (25) included in criterion B, make dimensional diagnosis of PDs difficult in clinical settings, where time is often limited, and clear and precise concepts are required. ICD-11 does not improve diagnostic clarity, although it does not contemplate the facets raised by DSM5/DSM-5-TR, but it does share the approach to personality functioning and the trait domains (at least 4 of them). Concepts such as self-identity or self-direction pose problems of operationalization and clarity. Nor is it that aspects such as empathy or intimacy are easy to assess, particularly in the short space of time available to a mental health professional in their work. It does not improve clinical assessment, but neither does it improve treatment, which we will discuss later.

One of the inherent limitations of dimensional models stems from the fact that these personality trait systems use the same descriptors to profile all cases and all personality types. The descriptors should be general enough to be applicable to many categories, so they are inherently ambiguous (First, 2010). Personality traits, in the absence of clinical context, are too confusing for clinicians to interpret, raising serious doubts about the clinical applicability of the trait dimensional approach. Someone might think that this is why ICD-11 has in practice almost eliminated the contribution of pathological traits to the diagnosis of PD. Bateman (2011)

considered this to be something that seems unfortunate, if not negligent, as the lack of research is now taken as a lack of validity of clinically relevant observations. This author goes on to say that he doubts that saying someone has a severe personality disorder with problems of detachment, disinhibition, negative affectivity, and dissociality conveys the same level of clinically useful information as the traditional categorical description. The diagnosis of PDs at the clinical level should be more specific than the generalist approach of DSM-5-AMPD and ICD-11. Clinicians are not likely to diagnose the person as having a sense of self that is perfectionistic and moralistic, relating to others in a way that shows limited empathy and expects compliance with their way of doing things, and, in addition, having anankastic traits (Huprich, 2020). Some proponents of the dimensional model complain that one of the problems with section II of the DSM-5/DSM-5-TR is that it includes many PDs and that each disorder comprises many symptoms. If we compare the diagnostic symptoms included in (categorical) section II of DSM-5 with the diagnostic elements set out in (dimensional) section III of DSM-5-AMPD (limited, logically, to the six common disorders), we see that the number of criteria is not very different, i.e., 49 symptoms in the categorical section versus 54 items in the dimensional section (to which 20 more would be added if we count the five options for each element of the personality functioning impairment level). When compared to the options offered by ICD-11, these increase uncontrollably to amounts difficult for a clinician to assume (at least 175 diagnostic options or index terms) (e.g., moderate personality disorder with prominent features of negative affectivity, prominent dissocial features, prominent features of disinhibition, prominent anankastic features and prominent features of detachment). This is indeed unhealthy for the health professional. It does not seem, therefore, that the complexity of the dimensional diagnosis of TTPP has decreased much in comparison with the categorical model, but rather the opposite.

In summary, that the number of investigations on aspects of the PDs dimensional model has increased exponentially in recent years is beyond doubt. That the curriculum of its researchers has grown notably, too. But whether all this has any relevance in the field of PDs, especially regarding its assessment and, particularly, its treatment, remains to be seen.

Some problems in the assessment and diagnosis of personality disorders

The assessment and subsequent diagnosis of PDs has always been a controversial issue. It seems clear that the diagnosis should always be made by means of an interview, with questionnaires or scales providing additional information. However, if PDs are considered to be egosyntonic, it is difficult to think that a good part of their behaviors can be considered inappropriate by the subject.

Therefore, the interviewer often has to interpret that what is appropriate for the individual is inappropriate for the interviewer. PDs such as narcissistic or antisocial are clear examples.

On many occasions it is pointed out that certain subjects suffer from a PD (both health professionals and mass media), but it is not specified which disorder. What does a histrionic disorder have to do with a schizoid disorder, or a paranoid disorder with an avoidant personality disorder? The difference between many of the disorders is not particularly complicated, but for this matter it is necessary to have a clear understanding of their characteristics. Thus, for example, a narcissistic disorder does not necessarily seek attention, but rather to be admired (something that the DSM-5-AMPD does not seem to understand very well). A histrionic disorder does not necessarily seek to be admired, but to attract attention (something that is not a problem for DSM-5-AMPD because it removed that PD). But it is sometimes posited that a common feature of both disorders is attention-seeking (e.g., Dawood *et al.,* 2020). Now, ICD-11 deletes the various diagnostic categories by making a single decision about whether or not there is a personality disorder (unspecified), then its severity and, finally, its quality based on the big five traits. If we dwell on the criteria that an individual has to meet to be diagnosed with a PD, we enter the realm of uncertain interpretations. If professionals complained that it was difficult to diagnose PDs with the categorical system, now they face additional complications. Not only is it difficult, but there are no clear and operationalizable concepts regarding the diagnosis of a PD by the ICD-11 dimensional system, since its diagnosis is centered on personality functioning. We have already seen the numerous problems that this concept entails.

We also want to emphasize, as we pointed out earlier, that DSM-5 eliminated Axis II to place PDs on the same level as other mental disorders, but at the same time, criterion A (without a minimally adequate empirical basis) attempts to capture what is unique to personality pathology or what differentiates it from other forms of psychopathology. Where do we stand? Sometimes it seems that there is a tug-of-war between pressure groups. Criterion A, which is more psychoanalytically based, is included in exchange for including criterion B, which is more empirically based. At the same time, we are keeping some PDs from the previous edition in order to please traditional clinicians as well.

As an example: avoidant personality disorder versus social anxiety disorder

Avoidant personality disorder (AvPD), one of the PDs that have been retained in the DSM-5/DSM-5-TR, is characterized by social inhibition and hypersensitivity to negative evaluation, symptoms that are also central to social anxiety disorder (SAD), especially when the problem is generalized (SAD-G). Some studies that have

attempted to differentiate SAD from AvPD (e.g., Lampe and Sunderland, 2015) have not been very successful. SAD-G and AvPD constitute essentially the same diagnosis and there is no empirical basis for separating them as distinct disorders. The differences that may exist between SAD and AvPD would be very similar to those that might occur between SAD and SAD-G.

The problem of the double diagnosis that already existed for the same group of symptoms, SAD-G and AvPD (Caballo, 2009), has not been solved with the new DSM-5-AMPD proposal (in ICD-11 the AvPD would not even appear). When describing the pathological features following this hybrid categorical-dimensional system, AvPD would be diagnosed with the trait domains of *Negative Affectivity*, especially in the features of anxiety, shame, low self-esteem, or *Detachment*, with the features of avoidance of social interactions, lack of friendships and avoidance of intimacy. These aspects could also be perfect descriptions of SAD-G. If the categorical system can be used to diagnose the latter disorder, why should it not be used to diagnose SAD-G? Someone might say that in the case of AvPD, *personality dysfunction* would also be included. But we have already seen that this criterion A is redundant with respect to the pathological traits of PDs and does not contribute anything new. We have also seen that it is not unique to PDs but is closely related to all other mental disorders. Is there a key feature that we have missed in order to distinguish the two diagnoses? Welander-Vatn *et al.* (2019) found a positive relationship with neuroticism and a negative association with extraversion for both AvPD and SAD in phenotypic analyses. They also found a genetic overlap of SAD and AvPD with these two traits. However, they point out that there were some differences between the two disorders. Thus, the negative correlation with extraversion was stronger for SAD, whereas a stronger positive correlation was identified between SAD and neuroticism. However, the comparison with AvPD was of SAD, not SAD-G, so this work did not help to differentiate the two disorders.

Some studies have explored the possible relationship between personality functioning, proposed by the dimensional approach of the DSM-5, and AvPD. One of them demonstrated a virtually nonexistent correlation (r= .01) between the global personality functioning score and the DSM-IV criteria for AvPD (Hutsebaut *et al.*, 2017) and another reported weak to moderate correlations ($.17 \leq r \leq .44$) between the scores of the four elements of personality functioning and the DSM-IV criteria for AvPD (Few *et al.*, 2013). According to Buer *et al*. (2020), for individuals with a DSM-IV-based diagnosis of AvPD, *empathy* was the item with the lowest impairment score. This subdomain also illustrates a discrepancy between the description of personality functioning and the specific criteria for AvPD. For impairment in *empathy*, diagnostic criterion A for the AvPD is "preoccupation with, and sensitivity to, criticism and rejection, associated with distorted inference of others' perspectives as negative" (APA, 2022, p. 885). This statement seems more descriptive of the

typical characteristics of SAD. The low sensitivity of personality functioning measures for AvPD questions the idea of a threshold based on a global score of personality functioning for screening purposes for AvPD.

Turning to the clinical level and with the aim of testing possible advantages of the dimensional approach, we could try to diagnose AvPD (assuming it is a different disorder from SAD-G) following the DSM-5-AMPD. Thus, it is assumed that we should first assess personality functioning (despite the null relevance we have already seen that it has for dimensional diagnosis). One approach to assessing the four sub-elements could be as follows:

1. *Identity* (*self* domain): assessment of self-esteem (by means of Rosenberg's "Self-Esteem Scale", RSES; 1965) and excessive feelings of shame (by means of their responses to one of the basic dimensions of social anxiety, "Criticism and embarrassment", in the interview and in the "Social Anxiety Questionnaire for adults", SAQ; Caballo *et al*., 2012, 2015).

2. *Self-direction* (*self* domain): not explicitly assessable; establishing the personal objectives to treatment; lack of personal risk-taking involving participation in interpersonal contact activities is implicit in the diagnosis of AvPD and SAD-G. It would not be necessary to consider this part of personality functioning.

3. *Empathy* (*interpersonal* domain): this area would not be correctly formulated for the AvPD. It is not a question of empathy (patients can be very empathetic to the problems of others), but rather a fear of criticism or rejection, something we already routinely assess in the SAD-G.

4. *Intimacy* (*interpersonal* domain): this area is also not well expressed for patients with an AvPD. Fear of interacting with strangers or unfamiliar people, as well as with people they are emotionally attracted to are two of the basic dimensions of SAD routinely assessed by SAQ (Caballo *et al.,* 2012, 2015). We do not need to turn to personality functioning to address these fears, especially since subjects can clearly modify their behaviors on these dimensions without turning to supposed changes in their personality functioning.

Considering the above sub-elements, we should determine whether the person is moderately or severely impaired in at least two of these elements, something that patients with an AvPD (or SAD-G) would certainly meet because they are common symptoms of the disorder. So far, the dimensional diagnosis does not seem to add anything new. Once criterion A has been met, we would go on to decide whether criterion B is satisfied based on three or more of the following four pathological features (one of which has to be *Anxiousness*):

1. *Anxiousness* (facet of *Negative Affectivity*): emotional/physiological and cognitive symptoms typical of anxiety. Common in both SAD and AvPD. Nothing new.

2. *Withdrawal* (facet of *Detachment*): reticence to participate in social situations and avoidance of social contacts; lack of initiation of social contacts. Common in SAD and AvPD. Nothing new.

3. *Anhedonia* (facet of *Detachment*) (this facet does not seem to be well formulated for AvPD): lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure or take interest in things. These features are more typical of schizoid personality disorder, removed from DSM-5-AMPD. We do not believe that this is a typical feature of AvPD, although that does not preclude that some subjects may suffer from it.

4. *Intimacy avoidance* (facet of *Detachment*): avoidance of close or romantic relationships and interpersonal attachments. Common in both SAD and AvPD. Nothing new.

We do not comment on the ICD-11 diagnosis for AvPD because it has nothing to offer. Its diagnosis would be the same as for any other PD based on personality dysfunction (of little relevance for AvPD and probably for most PDs). If we were to use the optional pathological features, they would be very similar to those noted above from DSM-5-AMPD. In summary, the dimensional approach to AvPD does not offer anything novel or useful when applied clinically to patients with AvPD. Whether it is clinically useful in any other PD is something that will have to be demonstrated, far from the fanaticism of defending the dimensional model of PDs tooth and nail.

Finally, we will briefly describe recent research on the treatment of SAD that also included a measure of AvPD and several related symptoms (Caballo *et al.,* 2021; Salazar *et al.,* 2022). In an attempt to see whether the typical characteristics of AvPD could be modified in the same way that those of SAD are modified when applying a treatment program for social anxiety (*Multidimensional Intervention for Social Anxiety* [MISA program], Caballo *et al*., 2023a, 2023b), we included a pre-post-treatment and 6-month follow-up measure of AvPD, which consisted of putting on a 5-point Likert scale the 7 items corresponding to the questions assessing the diagnostic criteria of AvPD on the "Personality Questionnaire" (screening measure) of the *Structured Clinical Interview for DSM-IV Axis II Personality Disorders*, SCID-II; First *et al.,* 1997). The results were that scores on the AvPD followed the same patterns as the other measures assessing defining symptoms of SAD (Caballo *et al.,* 2021) as well as related symptoms (e.g., depression, worry, self-esteem, etc.), improving their scores, substantially, at post-treatment and follow-up (Salazar et al., 2022), with very large values of the effect size (Cohen's *d*) from pre- to post-treatment (*d*= 1.31) (*N*= 25) and with improvements even at six months with respect to post-treatment (although not statistically significant). Furthermore, correlations of the self-report measure of AvPD at pretreatment assessment with two questionnaires assessing social anxiety in 104 patients diagnosed with SAD were high, of .66 with the "Social Anxiety Questionnaire" (SAQ) and of .67 with the

"Liebowitz Social Anxiety Scale" (LSAS, Liebowitz, 1997), while the correlation between the SAQ and the LSAS was .75 (unpublished data). If all subjects who participated in the MISA program had been diagnosed with a SAD-G, it is likely that the correlations between the social anxiety measures and that of the AvPD would have been even higher. We have never found reasons to differentiate AvPD from SAD-G and the results of the MISA program intervention seem to support this perspective.

Exploring some problems in the treatment of personality disorders

The possible presence of biological factors in mental disorders, in general, and in PDs, in particular, need not have important implications for treatment. In fact, no drug with a specific effect on any PD has yet been developed, not even for BPD. Moreover, most patients with PDs fare better without medication (Paris, 2015). In the absence of effective psychopharmacological treatments specific for PDs, psychological therapy remains the treatment of choice. However, such treatment is largely limited to patients with BPD, but neglects all other PDs. One might think that the situation could be improved by chunking PDs into traits, facets, and features of personality functioning. Some authors claim that considering the severity of PD as the central axis of the diagnosis in ICD-11 allows health services to target their interventions more effectively (Bach and Mulder, 2022). These authors go on to say that "those with mild PD are thought to have more mature defenses and fewer immature defenses, whereas persons with severe PD have more immature defenses and fewer mature defenses" (p. 554), returning to a psychodynamic position that seemed to have been overcome in the days of empirically based treatments. Moreover, it seems that it does not matter the kind of PD, but whether it is more severe or mild. As we have already indicated in previous pages, is complicated to think what, for example, a narcissistic disorder would have to do with a borderline disorder when it comes to intervention, except that in the label of both the term personality disorder would be included.

One of the paradoxes of the current PDs classifications is that, although the rationale for their development is to facilitate treatment, there is little evidence that the current diagnostic constructs are useful for planning intervention or predicting outcomes (Livesley, 2021). Bateman (2011) writes that he agrees that it would be helpful to the clinician if the new dimensional system would help establish formulas that would indicate more specific treatments, but, unfortunately, this is not happening given our current state of knowledge. Some authors (e.g., Bach and Mulder, 2022) made the bold suggestion that the domain groupings themselves might indicate a treatment model, but they only cite empirically validated treatments long ago for a single PD, BPD. Moreover, if we were to consider the dimensional

model, it is likely that treatment would only be offered to those individuals who fell into the severe personality disorder levels (Bateman, 2011). This author pointed out that, almost by definition, such persons will present disturbances in four or even five domains, so they will not fit perfectly in only one. Even if some patients have a better fit, our current treatments have been developed for patients who meet a different set of criteria, so it is unlikely that patients who fit into one of the new domains will belong to the same group of patients as the one in which the treatments were tested.

Following the dimensional approach, some authors have argued that treatment of personality dysfunction should address the global aspects of dysfunction, such as mentalization problems, identity disturbances, and alexithymia, rather than the traits themselves (Bach & Mulder, 2022). That is, treatment would address understanding (not modifying) the traits, while attempting to change the dysfunction and manifestations in terms of the severity of PD. However, as we have already mentioned above, we think that elements of personality functioning, such as modification of the SELF, centered on *identity* and *view of self*, do not seem to be appropriate targets of pharmacological or cognitive behavioral treatment. INTERPERSONAL functioning, as formulated, does not seem to be a reasonable goal either, by focusing on *empathy* and *intimacy*. We have already stated that someone could think that by proposing the interpersonal area as an essential part of the functioning of the personality we could be talking about social skills. This would indeed be an adequate and operationalizable objective. But no, nothing could be further from the truth. We are talking about empathy and intimacy, two concepts that are not part of the dimensions that usually make up the construct of social skills (Caballo 1997; Caballo *et al.,* 2017) and that probably do not constitute the most characteristic elements of interpersonal functioning. As Gunderson and Zanarini (2011) pointed out, having a PD focus on interpersonal relationships would be logical, but this proposal is only theoretical, as it is up to the clinician's judgment whether or not patients' relationships "achieve mutual regard" (an aspect of *intimacy*). It may seem simple, but it is a vague and overly subjective assessment. While cognitive behavioral therapists have produced an extensive literature on the effectiveness of social skills training for numerous psychological problems, training in empathy or intimacy does not seem to have a minimally adequate basis. For example, aspects of *intimacy* such as the desire and capacity for closeness or mutuality of regard reflected in interpersonal behavior or aspects of *empathy* such as the comprehension and appreciation of others' experiences and motivations (DSM-5-AMPD), are inadequate objectives and difficult to approach from a cognitive-behavioral perspective (let alone from a psychopharmacological perspective). However, some authors have proposed that criterion A of the dimensional proposal can be used dynamically to monitor clinical functioning, while

the traits of criterion B remain relatively stable due to their temperamental nature. Therefore, traits would tend to be more or less resistant to change, whereas functional personality impairment would be more malleable (Bach and Tracy, 2021; Wright *et al.,* 2016). In short, for these and other authors we have cited above, clinical practice should pay some attention to *understanding* traits (i.e., criterion B), while focusing essentially on *changing* basic personality functioning (criterion A).

It is difficult to understand that some authors expect general personality functioning to be especially useful for clinical management and decision making (e.g., prognosis and best treatment) (Bach and Simonsen, 2021). We wonder if evidence-based treatments serve a purpose or whether we need to rethink interventions in the case of PDs and consider only clinical judgment so that we can say that the treatment has worked, and that personality functioning has improved. In addition, when these authors raise the possible new clinical utility of addressing personality functioning as a target of therapy in PDs, they do not consider the treatment of narcissistic, antisocial or obsessive-compulsive personality disorders, for which there are currently no empirically validated treatments and where the supposed advantage of addressing personality functioning could be proven, but rather they address the only PD where we already have validated treatments, BPD, and for which the inclusion of personality functioning, as part of those treatments, would have to demonstrate, if that were possible, its usefulness. Whether the new dimensional proposal improves in any way clearly effective treatments, such as dialectical behavior therapy for BPD, would require much research, and it is unclear if cognitive behavioral therapists would be willing to include in their clinical practice such ethereal concepts as "personality functioning", with its constituent elements. Even more so if it is assumed, as some authors (e.g., Bach and Simonsen, 2021) have pointed out, that a high level of personality functioning is based on such (fuzzy) concepts as mature defenses, identity integration, object relations, and reality testing. What cognitive behavioral therapist is going to adopt such ideas? Moreover, the above authors propose concepts of severity for self-focused personality functioning, according to ICD-11, which would be stated as follows: mild severity would be when the experience of self is to some extent poorly integrated - somewhat incoherent, superficial or discontinuous, and contradictory, with significant distortions, whereas moderate severity would be when the experience of self is poorly integrated, unstable, incoherent, extremely superficial or systematically grandiose or devalued, and finally, extreme severity would be when one's experience of self is disintegrated - highly incoherent, especially superficial, discontinuous, and chaotically unstable, with little or no sense of having a central "I". The straw that breaks the camel's back is the additional proposal that clinicians may benefit from supervision and personal therapy when working with patients with severe PDs, something that would be less applicable if we are talking about milder PDs.

Presumably this proposal refers to psychodynamic therapy, because, although Linehan (2015) has made a similar proposal in regarding dialectical behavior therapy, it is not easy to find psychologists working with people with BPD who take on personal therapy after treating particularly severe BPD patients.

Despite the criticisms of the personality functioning proposal, both for the diagnosis and treatment of PDs, there are still authors who insist that the dimensional model proposed by ICD-11 is not only complete but clinically useful (Famamam and Zamanlu, 2018; Figueroa, 2018; Hopwood *et al.,* 2020). Authors convinced that the ICD-11 proposal connects the psychiatric classification of PDs manifestations with scientific evidence. Really? For them, the changes in ICD-11 will improve diagnostic efficacy and patient care, while stimulating research to further improve the assessment and treatment of psychopathology. Again, really? Some authors go further and among the mechanisms of change they propose from the dimensional approach of PDs is to improve the social environment of the person with a PD, including socioeconomic status, living and working conditions, formal and informal social supports, social network, social integration, as well as the quality of interpersonal relationships in professional and personal life (Kramer *et al.,* 2022). In short, these authors propose that a theoretical-integrative approach should be increasingly adopted, the aim of which would be to use concepts belonging to a multitude of theories, clinical practices, and contexts. This seems more like a toxic-integrative approach.

To conclude this section, we highlight the confusing perspective expressed by many of the advocates of the new dimensional model of PDs. We believe that this is not the way to find more robust and effective treatments. Most current clinical interventions do not target broad trait domains, such as neuroticism, but rather change the more specific behaviors represented by "lower order traits," such as anxiousness, avoidance, emotional instability, or impulsivity (Livesley, 2021). It turns out that these are usually symptoms not only of PDs but of many mental disorders for which cognitive behavioral therapy has been shown to be very effective. What we have seen so far as a contribution to the treatment of PDs from the dimensional approach is frankly disappointing. The juice wasn't worth the squeeze!

How did we arrive at the current situation?

The ineffectiveness of treatments, both psychological and pharmacological, the comorbidity of the symptoms of some PDs and the difficulty of their study have led to dissatisfaction with the field. In the case of psychiatrists, it is difficult to support a whole group of disorders for which there are no pharmacological treatments. In the case of psychologists, the consideration of personality (and, concomitantly, of its disorders) as something that tends to remain constant throughout life and is difficult

to modify, does not fit very well with the conception of treatment of problems that do not have a proven biological basis. However, in the study of personality traits a yet-to-be-discovered biological basis has always been maintained as part of the explanation. Another issue is that there are psychologists who question the existence of biologically determined personality or traits.

Interestingly, there are numerous publications, both in the form of articles and books, devoted to the dimensional classification of PDs, particularly in recent years. We do not quite understand the reason for this accumulation of writings that have no clear clinical application, except in what could be a relatively unexplored field that is capable of containing and triggering numerous investigations, without knowing very well whether it is for the progress of the area or to satisfy the curiosity (and, sometimes, to increase the curriculum vitae) of researchers.

One of the criticisms of the categorical classification of PDs, as noted above, has been the significant overlap between the different disorders and that, therefore, many patients diagnosed with a PD have, in addition, other comorbid PDs. Another criticism is that the ICD-10 (and, by extension DSM-IV) classification has led to under-diagnosis of PDs in people with other mental disorders, which coupled with the specialized training required for its application by mental health professionals, has led to question about the use of these discrete diagnostic categories for their lack of validity and insufficient clinical utility (Tyrer *et al*., 2015). This is an artificial problem. Practitioners' lack of knowledge about PDs symptoms should not call into question the diagnosis of PDs. This situation is remedied with more study and training, not by changing a categorical classification system for a more complex dimensional model, more diffuse and, we repeat, with dubious clinical utility.

Is it useful to maintain the diagnosis of personality disorders?

We believe that the diagnosis of specific PDs should be maintained. The usefulness of specific diagnoses such as antisocial, narcissistic, or borderline disorders seems clear. The lack of effective treatment of the first two would only reveal our current ignorance in addressing them, but that does not mean that they should no longer be diagnosed. It is as if medical illnesses for which there is no treatment today would cease to be diagnosed. Maintaining these diagnoses would promote research on them so that one day we could achieve adequate and effective treatments. As some authors point out, psychopathy is a social construct of clinical and/or forensic psychologists and psychiatrists in their effort to describe a personality syndrome of substantial social importance. "The psychopathic syndrome is probably the most dangerous and virulent constellation of personality traits that one can imagine—hence, the long-standing interest in identifying its presence" (Crego and Widiger, 2015, p. 674). Something similar could be said of narcissistic personality

disorder. Although they are not treatable, at least for now, their diagnosis would be of great use to protect society. For example, preventing a subject with an antisocial or narcissistic PD from being president of a country or of a large company, or from holding important positions of command in the army or the police. It is not trivial that mental health professionals could anticipate the dire consequences that a public figure, with this type of TP, in relevant positions in a society, could cause to it. Although one might object to the use of the term "disorder", the change of name would be of minor importance, as long as research advances in the knowledge, prevention, and possible treatment of these psychological conditions.

On the other hand, we have to insist on the use of specific behavioral criteria as key aspects to diagnose PDs, especially antisocial and narcissistic disorders. Self-reports of these types of subjects are unreliable and the only way to get a truthful diagnosis are observable behaviors, which can also be obtained through information from people in their environment. The new dimensional model does not seem to go that way. Widiger and Hines (2022) pointed out that the DSM-5-AMPD hybrid criteria sets constitute a move away from the behaviorally specific criteria of DSM-IV toward personality trait descriptors. This does not seem to be the best way forward in the applied diagnosis of PDs, least of all with the disorders we have outlined above. Proponents of the dimensional model acknowledge, at least in large part, that there are no empirically validated therapies to address both psychopathological traits and personality dysfunction.

The dark horizon for the diagnosis of personality disorders

That some PDs characterize and explain, with relative clarity, the behavior of a whole range of people seems obvious. Or at least it seemed so, until the dimensional model was proposed. The prototypes of narcissistic, antisocial, borderline, avoidant, and obsessive-compulsive personality disorders describe and anticipate, to a large extent, the behavior of individuals diagnosed with those disorders. But we eliminate them because we are unable to address them effectively or we describe them on the basis of forced and distorted characteristics to fit a model (the FFM) that we have turned into a panacea to explain a field that we find difficult to manage. Perhaps there is another solution. The dimensional model proposed by DSM-5-AMPD and ICD-11 does not seem the best option to help clinicians diagnose and treat PDs. It is a complex, far-fetched, and difficult way for health professionals to put into practice, both at the assessment and treatment levels. In fact, since the appearance of the DSM-5-AMPD in 2013, we have not found relevant contributions that improve intervention on PDs. Moreover, accepting the inane contribution of the dimensional model to the treatment of these disorders, their assessment is not improved either. The confusing, vague, and inoperative criterion A of the DSM-5-AMPD or the main

(and almost unique) feature of the ICD-11 make the dimensional diagnosis of PDs a fruitless, biased, and unnecessarily complicated and impractical task. It gives the impression that the purpose of ICD-11 is that any general practitioner can diagnose a PD based on personality functioning and then, if there is time and a mental health specialist, the concrete type of PD that the person suffers from can be further defined by the pathological traits in play. It really seems an inoperative proposal, hardly pragmatic. We do not believe that the criterion of personality functioning serves to diagnose anything pathological. Perhaps that the individual does not function as well as would be desirable (always from the subjective perspective of the evaluator). But that is as far as it goes, nothing more. This does not seem to be a scientific advance in the diagnosis of PDs.

On the other hand, criterion B of DSM-5-AMPD or the optional pathological traits of ICD-11 do not seem to solve some of the deficiencies that were criticized in the categorical diagnosis of section II of DSM-5 or ICD-10. For example, the overlap between different PDs was denigrated and also that a patient was often diagnosed not only with a single PD, but with several PDs. In the dimensional diagnosis by means of pathological traits, the trait domains (five in DSM-5-AMPD and six in ICD-11) form a common basis for the diagnosis of all PDs, so that the overlap between them and the diagnosis of several PDs at the same time will become customary. It seems that rather than solving the problem at hand, it will be aggravated.

In view of the above reasons, the outlook for the assessment, diagnosis and treatment of PDs seems rather dark. It is not possible to solve the deficits presented by an area of mental health by adding new problems and not solving the old ones. Therefore, we believe that the dimensional approach to PDs does not help to improve the treatment of PDs and makes the assessment and diagnosis of PDs a confusing task. It is true that this approach has given rise to a great deal of research, more theoretical than practical. But whether all this will serve to advance the field of treatment of PDs remains to be seen. It does not appear that these potential contributions are in any great hurry. Clinicians face a dark dimensional future unless they turn a deaf ear to this proposal and continue with the categorical diagnosis of PDs as maintained by DSM-5 Section II, which is what they seem to be doing when it comes to treatment (e.g., Emmelkamp & Meyerbröker, 2020; Feinstein, 2022; Sperry, 2016; Welander-Vatn *et al*., 2019). Not only when it comes to treatment, but when comparing categorical with dimensional diagnosis at the student or user (patients and families) level, the former is more highly valued than the latter (e.g., Cano and Sharp, 2023). These authors claim that their findings speak to the value of a clear diagnostic label and suggest that future revisions of the DSM should continue to focus on simplicity of communication, something that the dimensional model does not appear to have. The proposal that our research team made with the "Exploratory Personality Questionnaire" (EPEQ) (Caballo *et al*., 2011) could help in

that path of simplicity and, to some extent, dimensionality in the assessment of PDs. That is our contribution. We encourage researchers to make their own and not just consider the five-factor model (FFM) as a panacea for the diagnosis of PDs, because it is not.

Conclusions

Throughout this document we have tried to express our perspective on how diagnosis, research, and clinical approaches to PDs is developing and that we are not very optimistic. There is much theoretical research relative to practical research. Few, if any, realistic contributions have been made at the treatment level, and all seem to be treatments that we already knew, before the dimensional proposal, of a single PD, BPD. We insist on what we said before, "the juice wasn't worth the squeeze". What is even worse, we are heading towards an early and generalized diagnosis of PD if we follow the main ICD-11 requisite. A large part of the population could be diagnosed with a personality dysfunction from earliest childhood, surprising as this may seem. Some researchers advocate such early diagnosis of personality difficulties and consequent treatment from childhood, through adolescence and into adulthood (e.g., Newton-Howes *et al.,* 2015). The argument is that personality dysfunction could be associated with most mental disorders, so treatment would kill two birds with one stone (however unecological it may seem). On the one hand, it would prevent personality dysfunction from becoming a PD and, on the other hand, it would hinder the development of other mental disorders. Their proposal would be that of a utopian society, where psychological care would be available to everyone, all the time and with all the resources.

Based on the criteria of personality functioning, the diagnosis of PD could be generalized, and if a person does not have a PD, it is rare that he or she is spared from having a personality difficulty. When we do not know what is wrong with a person, but they have a mild problem, we always have the option of diagnosing them with a personality problem. And if it is a patient who follows a treatment, but improves slowly, it may be that he has a personality problem. Or, if despite treatment, he does not improve, he may have a personality problem. Moreover, we can go back to the time when we spoke of the "neurotic personality of our time" and, by modifying the title a little, we could update it to massively diagnose the "dysfunctional personality of our time".

To conclude this paper, we would like to reflect a little and point out that, while it is true that there are a number of problems with the categorical diagnosis of PDs, there are also difficulties with the rest of the mental disorders. And if we want to consider PDs at the same level as other disorders, we must do so also when it comes to assessment and treatment. As mentioned above, the classification of PDs needs

to move toward an empirically based atheoretical model, which has long been the goal of psychiatric nomenclature (Widiger and Hines, 2022). Many cognitive-behavioral psychologists use functional analysis as the primary tool for assessing (and understanding) psychological problems, including PDs. As Westen and Arkowitz-Westen (1998) pointed out, a functional personality assessment would be compatible with either categorical and dimensional diagnoses, and in the case of a given patient's behavior would ask questions such as "Under what circumstances are which dysfunctional cognitive, affective, motivational, and behavioral patterns likely to occur?" or more specific questions for particular behaviors such as, "Is the patient vulnerable to feeling ashamed and humiliated? Does this happen primarily with peers, authority figures, or romantic relationships? Does the patient respond to shame or humiliation devaluing others, by devaluing the self, or both?" This approach would be clinically useful and could be assessed reliably by using diagnostic methods that mirror the way clinicians diagnose personality in practice. However, the help of a useful, simple, friendly, and easily communicable diagnostic classification would always be welcome in this area. Let's hope that the future of the PDs field to be a bit brighter than the dark picture we are currently presented with.

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Appendix 1
Abbreviations frequently used in the article

Abbreviation	Meaning
ICD	International Classification of Diseases
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-5-AMPD	DSM-5 Alternative Model of Personality Disorders
FFM	Five-factor model
AvPD	Avoidant personality disorder
SAD	Social anxiety disorder
SAD-G	Social anxiety disorder of generalized type
BPD	Borderline personality disorder
PDs	Personality disorders
PD	Personality disorder

Appendix 2
Sample of EPEQ-III items

EXPLORATORY PERSONALITY QUESTIONNAIRE-III (EPEQ-III)
(Caballo, Guillén, Salazar, & Irurtia, 2011)

Answer by marking with an **X** in the corresponding box the degree to which each of the behaviors, thoughts or feelings included in the questionnaire are characteristic or characteristic of you, according to the following score:

1 = *Nothing* characteristic of me
2 = *Very* uncharacteristic of me
3 = Uncharacteristic of me
4 = *Moderately* characteristic of me
5 = *Quite* characteristic of me
6 = *Very* characteristic of me
7 = *Totally* characteristic of me

1.	I think there are people who try to take advantage of my ideas or what I do for their own benefit.	1	2	3	4	5	6	7
2.	I am not attracted to parties or social gatherings.	1	2	3	4	5	6	7
3.	I often have strange thoughts that I wish I could get rid of.	1	2	3	4	5	6	7
4.	When I want something, I try to get it any way I can, no matter if someone else gets hurt.	1	2	3	4	5	6	7
5.	Sometimes I have explosions of anger or rage that I can't control.	1	2	3	4	5	6	7
6.	When I'm at social gatherings I like to attract attention, to make people notice me.	1	2	3	4	5	6	7
7.	I consider my intelligence to be superior to that of most.	1	2	3	4	5	6	7
8.	I am a shy person who usually finds it difficult to establish relationships with others.	1	2	3	4	5	6	7
9.	I am comfortable when others make important decisions for me.	1	2	3	4	5	6	7
10.	The most important thing for me is to follow a strict procedure and order when doing things.	1	2	3	4	5	6	7