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Why the Categorical Model Fails Clinical Psychology

Classification is a human activity. We naturally categorize objects, tasks, and experiences. We find a task easy or difficult, feel that a new food is tasty or unpalatable, and regard a new acquaintance as a pleasant type of person or not (Waugh, 2019, p. 1).

Manie sans délire – literally translating to "mania without delusion" – was Phillippe Pinel's word for what we now consider personality disorders (PDs; Pinel, 1806). Psychopathologists since Pinel have attempted to demarcate the limits of normality. Emil Kraepelin was the pioneering architect behind the categorical diagnosis system that is still used today (Crocq, 2013). Despite its advancement after Kraepelin, the categorical approach to taxonomy hinders further progress. It *fails* clinical psychology.

The categorical diagnosis model assumes a medical model of taxonomy, rooted in Kraepelin's seminal idea that mental illnesses function similarly to medical illness, whereby an individual either *has* or *does not have* a personality disorder (Trull & Durrett, 2005). The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013) – a clinician's standard of identifying psychopathology – espouses the categorical tradition. The DSM-5 specifies thresholds that indicate whether one 'meets criteria' to afford a diagnosis. These lists of criteria were first introduced in the DSM-III (American Psychiatric Association, 1980) to determine whether someone receives a diagnosis. Nevertheless, if patients fall slightly below the threshold, they will not be treated as a case, and insurance may not cover their treatment.

Advantages of Categorical Approach

A categorical system of diagnosis has some advantages. Among these benefits is clinical utility (First, 2010), a direct result of strict guidelines about what symptoms constitute abnormality. Clinical utility encompasses several facets, like communication, user-friendliness, and treatment planning (Widiger & Mullins-Sweatt, 2010). There is a sense of familiarity with prototypical distinctions when describing clinical phenomena – like when clinicians hear the word "borderline," this automatically conveys a detailed clinical sketch. Thinking in Manichean rhetoric comes naturally to humans. Widiger (1993) highlights how this cognitive duality is a necessary and adaptive process, as it filters our perceived informational load. Widiger also points out that while beneficial, this tendency can become maladaptive when it oversimplifies within-group diversity.

Disadvantages of Categorical Approach

The benefits of classifying PDs also come with downsides that may outweigh their value. For example, the categorical approach cannot account for the heterogeneity or diversity in clinical presentations within each disorder (Flory, 2020). In other words, two individuals with the same diagnosis might "look" vastly different. This finding was previously mentioned above in Widiger's (1993) work. To further illustrate this, Samuel and Griffin (2015) point out that borderline personality disorder – diagnosed when a patient meets five of the nine criteria – can present itself in 256 various assortments and combinations of traits. Even more haunting, Samuel and Griffin note how two individuals with obsessive-compulsive personality disorder might share *no* diagnostic features, as this diagnosis only requires four of eight criteria to be given. These issues are byproducts of conceptualizing personality disorders as homogeneous constructs when they are heterogeneous.

What significant qualitative clinical differences exist between one individual who meets the criteria for a personality disorder and another who falls short by one missing criterion? Granted, this can be seen as a strength when guidelines dictate what is considered an 'official case.' The merit of thresholds is quite shaky, in any case. Widiger and Trull (2007) disclose that "no explanation, rationale, or even supportive discussion has been attempted for the diagnostic thresholds [for seven PDs in the DSM-IV-TR]" (p. 73). Borderline and schizotypal personality disorders were the only two diagnoses with warranted cutoffs. However, even these thresholds are founded upon outdated reasonings that no longer pertain (Skodol et al., 2002).

Personality disorders in a categorical system mostly co-occur together; it is less common for a patient with one PD only to meet criteria for one PD. Chmielewski and Trujillo (2020) note that an individual with one personality disorder is sixty percent more likely to have another one. This questions whether each disorder is an independent construct or merely a collection of related traits. After all, no single word can capture the fundamental nature of one's individuality. Indeed, PD treatment research recognizes this dimensional view. Effective treatment protocols like dialectical behavioral therapy (DBT), mentalization-based, and transference-focused psychotherapies target interconnected underlying personality disturbances, not specific disorders (Samuel & Griffin, 2015).

A comprehensive nosology should explain all clinical phenomena, yet the DSM cannot capture the population's full breadth of personality traits. Under DSM-IV criteria, PD—not otherwise specified (PDNOS) was diagnosed more commonly than any other PD (Verheul & Widiger, 2004). Psychiatrists and clinical psychologists employ this label when patients present with apparent personality dysfunction, but their symptomatology does not align with the ten

designated categories. A dimensional approach could amend these limitations and give more meaningful data about one's unique functioning.

Alternatives to the Categorical Approach

Criticisms of the categorical system had existed long before DSM-5 came onto the scene. Thomas Widiger was one of the first researchers to acknowledge these shortcomings and provide an alternative: a dimensional approach (Widiger, 1993). Akin to the categorical approach, there is no single continuous assessment model of PDs but numerous proposals (e.g., Oldham & Skodol, 2000; Westen & Shedler, 2000; Clark, 1990; Eysenck, 1987). Luckily, these perspectives share more similarities than differences (Trull & Durrett, 2005), but this paper will focus mainly on Widiger's analysis. Widiger borrows from Goldberg's (1990) seminal idea that all personality condenses into five traits (i.e., openness, conscientiousness, extraversion, agreeableness, neuroticism). When it comes to defining abnormality, Widiger adopts this five-factor model (FFM) as a sufficient framework, where personality dysfunctions are maladaptive variants of these five dimensions (Widiger & Trull, 1992).

Dimensional models can solve many of the shortcomings of a categorical one, are more informative of an individual's behavioral profile, and would better facilitate treatment (Widiger & Trull, 2007). Dimensional models remove the idea of qualitatively different "boxes" and assume everyone shares similar personality traits; some people have maladaptive concentrations of specific traits. Unlike the dearth of construct validity evidence for DSM personality disorders (Skodol et al., 2005), the FFM shows unparalleled support for its construct validity (McCrae & Costa, 1999).

Clinical utility may be the most contentious criticism of a shift to dimensional diagnosis. Critics like Frances (1993) confer with dimensional model proponents (e.g., Widiger) on

everything except its practicality. Frances argues it would be a prodigious feat to align categorical DSM diagnoses with the International Classification of Diseases or train clinicians to use them. To Frances, despite its many flaws, the categorical model's utility outweighs the 'gaps' the dimensional model fills. Others conclude differently. Verheul (2005) condemns the categorical system as uninformative and shows less clinical utility evidence than any dimensional model proposals. Researchers on both sides of the argument mostly agree unanimously about the empirical strengths and weaknesses of each model's clinical utility. The discrepancy lies in opinion: Does the hassle of implementing a dimensional model outweigh its benefits?

Diagnostic accuracy is vital, and if clinicians and researchers do not have precise representations in diagnostic manuals, there is a lack of certainty about *what* needs to be treated and studied. This paper weighed the salient differences between the categorical and dimensional approaches to classifying personality pathology. It attempted to argue for a transition from the outdated and highly problematic categorical taxonomy to the more empirically sound and nuanced dimensional approach. Nevertheless, how does the field move forward?

Future Directions

Implementing radical changes like dimensional assessment and diagnosis will only transpire after some time. Efforts have been underway, as this paper hoped to illustrate, but the field needs to adopt them faster. An intermediate step in deliberation is the Alternative Model for Personality Disorders (AMPD) in DSM-5's Section III, Emerging Measures and Models (American Psychiatric Association, 2013). This hybrid model intends to nudge novel ideas into the clinical arena without interrupting accustomed practices using the original system. The AMPD operates under the assumption that all personality pathology has a framework of

disturbances in self (i.e., identity and self-direction) and interpersonal functioning (i.e., empathy and intimacy). Overlaying these disturbances are five trait domains (i.e., negative affectivity, detachment, antagonism, disinhibition, psychoticism) with 25 trait facets.

Contrary to a binary system, the AMPD rates individuals' *level of personality functioning* within each trait domain, culminating in an overall indication of personality problems. Since AMPD is a hybrid nosology, there still lies a feeling of "categories within categories" instead of an actual dimensional, continuous conceptualization of personality functioning. Nevertheless, the AMPD might be a groundbreaking step forward in future editions of the DSM, eventually escorting dimensional applications behind it.

References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Chmielewski, M., & Trujillo, M. (2020). The need for a more rigorous approach to diagnostic reliability: Commentary on categorical assessment of personality disorders. In C. W. Lejuez & K. L. Gratz (Eds.), *The Cambridge handbook of personality disorders*. (pp. 369–372). Cambridge University Press. https://doi-org.stetson.idm.oclc.org/10.1017/9781108333931.064

Clark, L. A. (1990). Toward a consensual set of symptom clusters for assessment of personality disorder. In J. N. Butcher & C. D. Spielberger (Eds.), *Advances in personality assessment, Vol. 8.* (pp. 243–266). Lawrence Erlbaum Associates, Inc.

Clarke, D. E., & Kuhl, E. A. (2014). DSM-5 cross-cutting symptom measures: a step towards the future of psychiatric care?. *World psychiatry: official journal of the World Psychiatric Association (WPA), 13*(3), 314–316. https://doi.org/10.1002/wps.20154

Crocq M. A. (2013). Milestones in the history of personality disorders. *Dialogues in clinical neuroscience, 15*(2), 147–153. https://doi.org/10.31887/DCNS.2013.15.2/macrocq

Eysenck, H. J. (1987). The definition of personality disorders and the criteria appropriate for their description. *Journal of Personality Disorders, 1*(3), 211–219. https://doi-org.stetson.idm.oclc.org/10.1521/pedi.1987.1.3.211

First, M. B. (2010). Clinical utility in the revision of the *Diagnostic and Statistical Manual of Mental Disorders (DSM). Professional Psychology: Research and Practice, 41,* 465–473.

Flory, J. D. (2020). Categorical assessment of personality disorders: Considerations of reliability and validity. In C. W. Lejuez & K. L. Gratz (Eds.), *The Cambridge handbook of personality disorders*. (pp. 356–364). Cambridge University Press. https://doi-org.stetson.idm.oclc.org/10.1017/9781108333931.062

Frances, A. (1993). Dimensional diagnosis of personality: Not whether, but when and which. *Psychological Inquiry, 4*(2), 110–111. https://doi-org.stetson.idm.oclc.org/10.1207/s15327965pli0402_7

Goldberg, L. R. (1990). An alternative "description of personality": The Big-Five factor structure. *Journal of Personality and Social Psychology, 59*(6), 1216–1229. https://doi-org.stetson.idm.oclc.org/10.1037/0022-3514.59.6.1216

McCrae, R. R., & Costa, P. T., Jr. (1999). A Five-Factor theory of personality. In L. A. Pervin & O. P. John (Eds.), *Handbook of personality: Theory and research.,* (2nd ed; pp. 139–153). Guilford Press.

Oldham, J. M., & Skodol, A. E. (2000). Charting the future of Axis II. *Journal of Personality Disorders, 14*(1), 17–29. https://doi-org.stetson.idm.oclc.org/10.1521/pedi.2000.14.1.17

Pinel, P. (1806). *A treatise on insanity*. Messers Cadell & Davies, Strand. https://doi-org.stetson.idm.oclc.org/10.1037/10550-000

Samuel, D. B., & Griffin, S. A. (2015). A critical evaluation of retaining personality categories and types. In S. K. Huprich (Ed.), *Personality disorders: Toward theoretical and empirical integration in diagnosis and assessment.* (pp. 43–62). American Psychological Association. https://doi-org.stetson.idm.oclc.org/10.1037/14549-003

Skodol, A. E., Gunderson, J. G., Pfohl, B., Widiger, T. A., Livesley, W. J., & Siever, L. J. (2002). The borderline diagnosis I: Psychopathology, comorbidity, and personality structure. *Biological Psychiatry, 51*(12), 936–950. https://doi-org.stetson.idm.oclc.org/10.1016/S0006-3223(02)01324-0

Skodol, A. E., Oldham, J. M., Bender, D. S., Dyck, I. R., Stout, R. L., Morey, L. C., Shea, M. T., Zanarini, M. C., Sanislow, C. A., Grilo, C. M., McGlashan, T. H., & Gunderson, J. G. (2005). Dimensional representations of DSM-IV personality disorders: Relationships to functional impairment. *The American Journal of Psychiatry, 162*(10), 1919–1925. https://doi-org.stetson.idm.oclc.org/10.1176/appi.ajp.162.10.1919

Trull, T. J., & Durrett, C. A. (2005). Categorical and dimensional models of personality disorder. *Annual Review of Clinical Psychology, 1*(1), 355–380. https://doi-org.stetson.idm.oclc.org/10.1146/annurev.clinpsy.1.102803.144009

Verheul, R. (2005). Clinical Utility of Dimensional Models for Personality Pathology. *Journal of Personality Disorders, 19*(3), 283–302. https://doi-org.stetson.idm.oclc.org/10.1521/pedi.2005.19.3.283

Verheul, R., & Widiger, T. A. (2004). A meta-analysis of the prevalence and usage of the Personality Disorder Not Otherwise Specified (PDNOS) diagnosis. *Journal of Personality Disorders, 18*(4), 309–319. https://doi-org.stetson.idm.oclc.org/10.1521/pedi.18.4.309.40350

Waugh, M. H. (2019). Construct and paradigm in the AMPD. In C. J. Hopwood, A. L. Mulay, & M. H. Waugh (Eds.), *The DSM-5 Alternative Model for Personality Disorders: Integrating multiple paradigms of personality assessment.* (pp. 1–47). Routledge/Taylor & Francis Group. https://doi-org.stetson.idm.oclc.org/10.4324/9781315205076-1

Westen, D., & Shedler, J. (2000). A prototype matching approach to diagnosing personality disorders: Toward DSM-V. *Journal of Personality Disorders, 14*(2), 109–126. https://doi-org.stetson.idm.oclc.org/10.1521/pedi.2000.14.2.109

Widiger, T. A. (1993). The DSM-III—R categorical personality disorder diagnoses: A critique and an alternative. *Psychological Inquiry, 4*(2), 75–90. https://doi-org.stetson.idm.oclc.org/10.1207/s15327965pli0402_1

Widiger, T. A., & Mullins-Sweatt, S. N. (2010). Clinical utility of a dimensional model of personality disorder. *Professional Psychology: Research and Practice, 41*(6), 488–494. https://doi-org.stetson.idm.oclc.org/10.1037/a0021694

Widiger, T. A., & Trull, T. J. (1992). Personality and psychopathology: An application of the five-factor model. *Journal of Personality, 60*(2), 363–393. https://doi-org.stetson.idm.oclc.org/10.1111/j.1467-6494.1992.tb00977.x

Widiger, T. A., & Trull, T. J. (2007). Plate tectonics in the classification of personality disorder: Shifting to a dimensional model. *American Psychologist, 62*(2), 71–83. https://doi-org.stetson.idm.oclc.org/10.1037/0003-066X.62.2.71