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Understanding Broader Community Perspectives on the Scientific Accuracy and Stigma of Personality Trait Labels

Kasey Stanton[1], Lindsay Gillikin[1], Liana Willis[2], Ricardo Woods-Gonzalez[3], Warner Myntti[4], Caroline Paige[5], Holly F. Levin-Aspenson[6], Christina G. McDonnell[1], and Noah N. Emery[7]

[1] Department of Psychology, University of Wyoming
[2] Department of Psychology, University of California, Riverside
[3] Department of Psychology, Arizona State University
[4] Department of Psychological Sciences, Vanderbilt University
[5] Department of Psychology, University of Notre Dame
[6] Department of Psychology, University of North Texas
[7] Department of Psychology, Colorado State University

Many labels are used within and across subfields to describe personality disorder (PD) and interpersonally-oriented trait dimensions. For example, "interpersonal disorders" is a suggested alternative label to "personality disorders" in clinical research. Other "dark trait" terms, though not proposed as formal labels for PDs, also are used in different research areas for describing externalizing traits. Terminology changes have been proposed both due to concerns about different descriptors' validity and their usage potentially being stigmatizing. Improving terminology consensus can also unify research and clinical assessment efforts, and we recruited participants from a range of sources who provided their views on terminology used in PD research toward this goal. This included data from 362 undergraduates, 408 adults recruited online, and 161 adults recruited from the community, and we used targeted recruitment strategies to ensure that individuals with a range of mental health histories were represented in our study. All participants completed questionnaires assessing their personalities and symptoms, and a subset of participants also completed structured clinical interviews. Results indicated that traditional "personality disorders" terminology were viewed favorably compared to other terms both in regard to scientific accuracy and stigma. Additionally, "interpersonal disorders" terminology was also viewed more favorably overall than many other terms, whereas "dark trait" terminology was viewed negatively. Participants' characteristics (e.g., personality, age) were mostly unrelated to their terminology views. These results provide insight into how various descriptors are viewed by the broader community and provide a foundation for future research investigating how different terms are perceived across contexts.

Keywords: personality disorders, dark triad, interpersonal, diagnosis, personality assessment

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Kasey Stanton https://orcid.org/0000-0002-4519-5214

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Correspondence concerning this article should be addressed to Kasey Stanton, University of Wyoming, Laramie, WY, United States. Email: kaseyjstanton@gmail.com

There have been proposals to fundamentally change how personality disorders (PD) are conceptualized, diagnosed, and labeled in the *Diagnostic and Statistical Manual of Mental Disorders* (currently 5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022; Monaghan & Bizumic, 2023). For example, alternative labels such as "interpersonal disorders" have been proposed as potentially more valid and clinically useful than traditional "personality disorders" terminology (Wright et al., 2022). Issues concerning terminology for describing interpersonal difficulties and externalizing traits (e.g., disinhibition) are not limited to the clinical literature, however. Recent debate centers on the utility of "dark triad" or "dark trait" labels for describing dimensions such as narcissism, psychopathy, and Machiavellianism that are studied across the social, personality, and industrial-organizational literatures (Kay & Arrow, 2022; cf. Andrews et al., 2024). Measures of PDs, the dark triad, and models such as the five-factor model (FFM) and interpersonal circumplex, though not isomorphic, all include some content assessing tendencies toward being empathetic and cooperative, or lack thereof (Rose et al., 2023). Other commonalities across select models include disinhibited externalizing tendencies that parallel (low) FFM conscientiousness being described as features of some PDs and psychopathy (Koehn et al., 2019; Vize et al., 2021).

Working toward common terminology for labeling overlapping traits can facilitate more direct comparison of findings and increase dialogue across subfields, as seen in studies examining the correspondence of trait ratings across models with the goal of unifying research efforts (e.g., Levin-Aspenson et al., 2023; Rose et al., 2023; Vize et al., 2021). However, in cases involving clear trait parallels across models, which terminology is optimal for labeling trait dimensions?

Integrating Broader Community Perspectives on Trait Terminology

One avenue for addressing these questions concerning terminology involves integrating perspectives from the broader public and community. Assessing broader community perspectives on the meaning of diagnostic terminology is important from a dissemination and implementation perspective to assess the degree to which public perceptions of constructs align with definitions used by researchers and clinicians. More specifically, assessing community members' perspectives on the meaning of terminology can sharpen measurement approaches by providing insight into sources of information that individuals draw upon when providing information about themselves (e.g., how varying the title of a measure might influence responses; Mason et al., 2023), in addition to assessing the clarity of administration instructions and item wording. For example, assessment validity may be negatively impacted if individuals rely on different sources of information than researchers and clinicians intend when reporting on their personalities and mental health histories (Mason et al., 2023; Stanton et al., 2018).

Example studies integrating broader community perspectives find that community adults generally agree with researchers and clinicians regarding which narcissistic PD features are central versus peripheral (Miller et al., 2017), thereby informing narcissism conceptualizations and assessment. Additionally, the dimensionally based Alternative *DSM-5* Model for Personality Disorders (AMPD) has been proposed as a system for addressing limitations of the categorical *DSM* PD model (Monaghan & Bizumic, 2023). Cano and Sharp's (2023) assessment of diagnostic model perceptions across undergraduate and clinical/community samples identified both potential benefits and challenges of using dimensionally based models for communicating clinical information with patients. Other research on clinical communication indicates that individuals who have received a borderline PD diagnosis often describe that providers fail to clearly communicate evidenced-based treatment options and the meaning of a PD diagnosis (Lester et al., 2020; Tedesco et al., 2023). Furthermore, Masland et al. (2023) provide recommendations for addressing borderline PD stigma, including guidelines for engaging lived-experience perspectives that could be used to build upon the illustrative studies reviewed.

Given proposals to refine PD terminology and conceptualizations, we focus here on understanding community members' perspectives toward terminology when used to describe PD traits specifically. Prior to describing our study goals, we review terms included in our study that (a) have been proposed to replace traditional PD labels and/or (b) are used in contemporary research, even if they have not been proposed as formal diagnostic labels (e.g., "dark triad" terminology, which has not been proposed for labeling PDs). As we discuss next, researchers have suggested that some terms are more valid than others and that some terminology is sensationalized and stigmatizing. However, questions concerning broader community perceptions of terminology remain largely unanswered, which is surprising in some ways given the widespread use of different terms and recent terminology proposals. Recognizing that lived and personal experiences may also shape researchers' viewpoints (Haywood et al., 2023; Tedesco et al., 2023), assessing community members' perspectives, including individuals with a PD diagnosis, provides data toward refining construct description in PD research.

Review of Terminology Proposals and Terminology Used in Contemporary Research

First, Wright et al. (2022) proposed rebranding PDs as "interpersonal disorders" as discussed. More explicit focus on interpersonal dynamics through this relabeling may sharpen treatment planning by identifying interpersonal antecedents of affective, cognitive, and behavioral responses (e.g., social reactivity characteristic of narcissistic PD). This rebranding may also shift treatment focus from viewing the individual and their personality as problematic, to focusing more collaboratively on issues an individual may be experiencing in specific contexts (Wright et al., 2022). However, Widiger et al. (2023) describe potential issues with Wright et al.'s (2022) "interpersonal disorders" proposal, including that interpersonal difficulties and impairment may not sufficiently differentiate PDs from other disorders, among other issues (e.g., the degree to which interpersonally focused models are comprehensive).

Second, other descriptors not proposed as formal terminology replacements also are used as variants of standard PD terminology in contemporary research. This includes terminology such as "personality pathology," which is sometimes used to refer to PD traits dimensionally or in a general sense rather than referring to one specific PD (e.g., Cano & Sharp, 2023; Rodriguez-Seijas et al., 2023; Watson & Clark, 2023). Additionally, "characterological" terminology features less prominently in contemporary than past research based on previous *DSM* versions (Bliton et al., 2017), but is still

used in some cases to describe relatively stable symptom experiences (e.g., "characterological depression" Fjermestad-Noll et al., 2019).

Lastly, we also included "dark trait" terminology in our study, keeping in mind that (a) dark triad terminology has not been proposed as a formal replacement for *DSM* diagnostic labels and (b) "dark traits" (e.g., narcissism, psychopathy, Machiavellianism) often are conceptualized as subclinical traits that are studied outside the clinical literature (Koehn et al., 2019). Furthermore, although dark trait measures have been used in some research on narcissistic, antisocial, and other "cluster B" PDs (e.g., di Giacomo et al., 2023; Stead et al., 2012; Vossen et al., 2017), dark trait models and measures have little alignment with the criteria of other PDs (e.g., schizotypal PD) that do not describe externalizing traits or features. Acknowledging these considerations, descriptors such as "dark" have been criticized for potentially lacking precision (Kay & Arrow, 2022), though others argue that the dark triad provides a valid framework for guiding efficient externalizing trait assessment (Andrews et al., 2024). Dark trait terminology (including terms such as "evil" and "nightmare" traits used in recent studies) also has been criticized as being sensationalized and stigmatizing (Kay & Arrow, 2024; Miller et al., 2022).

In lieu of dark trait labels, alternatives such as "aversive" and "socially aversive" traits are sometimes used (Kay & Arrow, 2022; Muris et al., 2017), though these terms have not been proposed as formal PD labels either. One consideration with using terminology such as "socially aversive" concerns its degree of applicability for describing specific traits and behaviors that may not always be perceived as "aversive" or negatively by others across situations and contexts (e.g., specific narcissistic traits may be associated with leadership emergence, though not effectiveness; how others perceive these traits may vary over time and according to different contextual factors; Grijalva et al., 2015; Johnson et al., 2012; Muris et al., 2017). Acknowledging these issues, we included "socially aversive traits" terminology in our study to enable comparison with other labels.

Current Study Goals

Our study provides insights into how different descriptors are perceived by community members recruited from different sources, which provides data toward unifying research efforts and construct description as reviewed. Specifically, we present results summarizing over 900 participants' views on the degree to which they view terminology used in PD research to be scientifically accurate, stigmatizing, and acceptable for use by researchers and clinicians. This included recruiting (a) undergraduates, (b) adults recruited online, and (c) other adults from the community recruited using methods to increase the likelihood that individuals with a PD diagnosis and other mental health histories were represented. Given that participants were recruited from a range of sources, we refer to participants collectively as "community members" for brevity going forward when discussing the broader implications of findings.

Second, we also examined how ratings of community members' own PD traits assessed across self-report and interview methods were associated with their terminology views. In addition to assessing PDs, we assessed other commonly experienced internalizing symptoms and substance use, as well as other variables often included in studies on mental health attitudes such as age, gender, education level, and treatment history (e.g., Furnham et al., 2011; Koepernik et al., 2022; Stanton et al., 2018). Including these other variables in addition to PD ratings enabled us to determine the extent to which any notable associations were more specific versus generalized. For example, it is possible that having a PD diagnosis and/or elevated PD trait levels may alter individuals' views of specific terms if terms are viewed as more personally relevant. Including assessment of other symptoms and substance use allowed us to draw clearer conclusions regarding the extent to which observed associations were nonspecifically associated with a range of mental health variables versus PD ratings specifically.

Timestamped Analytic Information and General Predictions

Our study was not preregistered, but we timestamped several general predictions and our analyses prior to conducting them on the Open Science Framework (OSF): https://rb.gy/dbwvq. Our analyses were largely exploratory with a focus on summarizing community members' viewpoints and then quantifying observed differences and associations. Acknowledging this, our first general prediction was that dark trait terms—particularly terms such as "evil" that may carry a moral connotation—would be viewed as stigmatizing and rated unfavorably overall. Predictions for other terms were harder to quantify a priori: For example, on the one hand, traditional PD terminology may be viewed favorably if it is perceived as having scientific legitimacy due to being the *DSM*'s descriptor; conversely, perhaps traditional PD terminology may be viewed somewhat negatively due to the stigma often associated with PD diagnosis. Next, self-ratings of personality, education level, and individuals' own mental health treatment history have been shown to be associated with attitudes toward PDs and mental health literacy (e.g., Furnham et al., 2011; Koepernik et al., 2022). However, our scope differed by focusing on terminology perceptions, and we did not have firm predictions for specific associations due to a lack of prior research directly examining views of trait terms. As a general prediction, we anticipated that various participant characteristics would associate moderately at most in magnitude (i.e., 0.30) with their terminology ratings. Although prior research has not assessed terminology views, we predicted this given that community members' own characteristics tend to associate weakly with general PD attitudes, even if these associations are statistically significant at different p value thresholds (Koepernik et al., 2022; Stanton et al., 2018).

Method

Transparency and Openness: Study Data, Materials, and Evaluation of Response Validity

Study data, analytic syntax, and materials are available on the OSF (Stanton, 2023): https://rb.gy/dbwvq. As described on the OSF, select demographic and write-in response data were removed from datafiles shared on the OSF to ensure participant anonymity, and a datafile with all study data linked is available upon request from the first author.

Participants and Procedure

All procedures complied with American Psychological Association ethical standards, and all participants provided informed consent. Participants were required to be 18 years or older and residing in the United States. All participants completed questionnaires assessing their terminology views, personalities, and symptoms, and select participants completed clinical interviews.

We combined data from undergraduates, adults recruited online using the Prolific platform, and adults recruited from other locations into a combined sample (details of each subgroup are described subsequently). Participant questionnaire data were screened prior to analysis for response validity (e.g., participants failing to respond to nearly all items), and surveys administered to all participants also included multiple validity attention check items (e.g., select "disagree a little"). The undergraduate sample originally consisted of 488 participants. However, 126 undergraduates failed validity checks ($n = 52$) or failed to complete most questionnaires ($n = 74$), reducing the undergraduate sample size to 362 participants (74.2% of original participants). Much smaller percentages of data were removed for samples of (a) participants recruited from Prolific (original $n = 441$; $n = 13$ and 20 failed validity checks and failed to provide PD terminology data, respectively; final $n = 408$; 92.5% of original) and (b) adults recruited from other community sources (original $n = 165$; $n = 4$ failed validity checks; final $n = 161$; 97.6%). Appendix S1 in the online supplemental materials provides additional details concerning response validity assessment and handling of remaining missing data, which was very minimal after removing invalid cases.

After removing problematic cases, our combined sample size was 931 participants. Regarding the recruitment details of specific samples, undergraduate participants ($n = 362$) were recruited from a Psychology Department subject pool at a university in the western United States. Undergraduates were recruited between September 2022 and May 2023 and received course credit for participation. Second, participants ($n = 408$) recruited online using Prolific, a crowdsourcing data collection platform, participated during August 2022. We refer to this sample as the "Prolific" sample going forward. Only participants who had previously responded "yes" to built-in Prolific filter questions about having a current or previous mental health diagnosis were eligible to participate. Prolific participants received US$5 compensation, with median completion time being approximately 20 min. Our third sample, referred to as the "community sample" ($n = 161$) going forward, was recruited using advertisements posted at a range of locations. These locations included online mental health resource websites (e.g., the National Education Alliance for Borderline Personality Disorder; Depression and Bipolar Support Alliance websites), local community mental health centers, a University-based outpatient clinic, and other community and online locations. These participants' total involvement was expected to require approximately 1.5 hr total due to including both questionnaires and a clinical interview, and compensation was US$35.[1]

Demographic information is provided in Table 1 for the combined sample and each sample separately. Most participants in the combined sample were White or European American (88.6% overall); 8.9% were Hispanic or Latine. Most participants were women, and average age was 29.1 years ($SD = 11.9$; range = 18–76), though there was considerable variation in age in the combined sample and in the Prolific and community samples. Over half of combined sample participants reported currently accessing mental health treatment (psychotherapy and/or medication) due to using the targeted recruitment strategies described. Across samples, 4.3% of participants ($n = 40$) self-reported having a diagnosis of "borderline personality disorder or another personality disorder" ($n = 19$, $n = 17$, and $n = 4$ for the number of participants self-reporting a PD diagnosis in the community, Prolific, and undergraduate samples, respectively).

Self-Report Measures Administered Across Samples

Terminology Ratings

The full set of instructions and questions participants used to rate their PD views are provided in Appendix S2 in the online supplemental materials and on the OSF. Prior to rating terms, participants viewed a paragraph summarizing the *DSM* general PD criteria. They were also provided with example PD labels in this opening descriptive material (e.g., narcissistic PD, borderline PD) and were presented with material describing that viewpoints differ regarding which terminology is optimal for describing PDs. Nine different PD terms (e.g., "interpersonal disorders"; "dark traits") were included across items administered. Participants both rank-ordered terms and provided graded ratings of terms on a 1–6 scale.

For rank-ordered questions, participants ranked (a) how scientifically accurate they found terms, (b) the degree to which they found terms stigmatizing, and (c) which terms they preferred that researchers and clinicians use. Items using a rank-ordered format provided information complementing items where participants rated each term separately on a 6-point scale. For example, in cases where two terms had similar mean ratings of scientific accuracy, including rank-ordered items enabled us to determine which of these two terms participants preferred when asked to rank them. Questions used to obtain mean ratings involved participants rating terms on a 6-point scale as reviewed, with questions focusing on similar themes of (a) scientific accuracy, (b) the extent to which each term was viewed as stigmatizing, and (c) overall acceptability for use by mental health professionals (generally paralleling the "preferred use" rank-ordered question, though wording was changed to fit a 1–6 response format).

Regarding our rationale for administering the specific items reviewed, we included an item assessing stigma because some terms included in our study have been identified as potentially sensationalized, in addition to PDs commonly being stigmatized more generally (Masland et al., 2023). Scientific accuracy also was assessed because terms such as "interpersonal disorders" have been proposed as potentially more valid empirically than traditional PD terminology (Wright et al., 2022; cf. Widiger et al., 2023). Lastly, items assessing preferred use and acceptability of use by mental health professionals were included to provide more comprehensive assessment. Specifically, inclusion of these items enabled us to examine how participants would view terms being used in research studies or treatment settings in a more concrete sense, in addition to items assessing attitudes toward potentially more abstract aspects of terms (e.g., their degree of scientific accuracy). For example, it is possible that participants could view a term as scientifically accurate, but also view a term less favorably in other ways if it were used to describe self-relevant traits or experiences. Across questions, the ordering of terms was randomized so that no one term was systematically viewed before or after others. Finally, after completing all other questions, participants had the opportunity to suggest any alternative labels they thought would be optimal for PD description other than the terms they already viewed.

[1] For studies providing financial compensation, compensation rates varied slightly from those shown above for some initial study participants during early study recruitment phases. Compensation rates were adjusted with ethics board approval after obtaining more accurate estimates of participation completion times to ensure adequate compensation.

Table 1
Demographic and Treatment Information for the Combined Sample and Each Individual Sample

Variable or category	Combined ($N = 931$)	Undergraduate ($n = 362$)	Prolific ($n = 408$)	Community ($n = 161$)
Age (*M*, *SD*, range)	29.1 (11.9, 18–76)	20.6 (4.2, 18–50)	35.1 (11.6, 18–76)	33.0 (13.0, 18–76)
Gender				
Women	66.1	76.0	56.1	68.9
Men	30.1	21.5	39.0	26.7
Nonbinary	3.7	2.5	4.7	3.7
Racial identity				
White or European American	88.6	91.7	87.5	84.5
Multiracial	4.8	3.0	6.4	5.0
Asian American	3.1	0.6	5.9	1.9
Black or African American	3.8	1.7	4.9	5.6
Native American or Alaska Native	2.3	2.5	2.5	1.2
Middle Eastern or North African descent	0.8	0.6	1.0	0.6
Ethnicity				
Hispanic or Latine	8.9	10.8	8.1	6.8
Education[a]				
Some high school	2.1	—	2.7	0.6
High school or equivalent	11.1	—	13.7	4.4
Some college, associates, or vocational	37.9	—	41.0	30.2
Bachelor's degree	34.0	—	31.6	40.3
Advanced degree	14.6	—	10.8	24.5
Current treatment (medication and/or therapy)	52.1	36.2	66.2	52.2

[a] Data from undergraduates were not used for computing combined sample education values. All values other than those for age are percentages. In addition to the information shown, 3.3% of the combined sample, 2.2% of undergraduates, 4.7% of Prolific participants, and 2.5% of community participants were transgender. Small percentages of participants also endorsed other response options or wrote-in responses for questions about gender and selected other variables, and percentages exceeded 100% in some cases because participants could select multiple response options (also see Table S7 in the online supplemental materials). Therefore, descriptions of some table variables and values differ slightly in some cases from those reported in the main text when group comparisons were made.

Self-Ratings of Personality and Personality Functioning

All participants completed the 25-item Personality Inventory for *DSM-5*-Brief Form (PID-5-BF; APA, 2013). The PID-5-BF assesses trait domains of Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism using five items for each domain. The PID-5-BF uses a 4-point scale (0 = *very false or often false* to 3 = *very true or often true*). Prolific and community sample participants also completed the 12-item Level of Personality Functioning Scale-Brief Form 2.0 (LPFS-BF 2.0; Weekers et al., 2019). The LPFS-BF 2.0 uses a 4-point scale (1 = *completely untrue* to 4 = *completely true*), and item scores were summed to create a general personality functioning index (Weekers et al., 2019).

Self-Ratings of Other Symptoms and Substance Use

All participants completed the Dysphoria (10 items), Mania (five items), and Euphoria scales (five items) from the Expanded Version of the Inventory of Depression and Anxiety Symptoms (IDAS-II; Watson et al., 2012). The IDAS-II uses a 5-point scale (1 = *not at all* to 5 = *extremely*) scale in reference to the past 2 weeks. Undergraduate and community participants also completed the 10-item Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993) and the eight-item Cannabis Use Disorders Identification Test-Revised (CUDIT-R; Adamson et al., 2010) to assess alcohol and cannabis use, respectively, and possible impacts of use. Both the AUDIT and CUDIT-R provide assessment of the past 6 months, and all items were rated on a 0–4 scale.

Interview Measures Administered to Community Sample Participants

Approximately 90% (145/161) of community participants completed clinical interviews in addition to self-report questionnaires, which were administered using secured Zoom accounts. Interview assessment generally paralleled self-report assessment by targeting (a) internalizing symptoms, (b) substance use often studied in relation to PDs (Trull et al., 2018), (c) borderline PD traits studied widely in the clinical literature (Masland et al., 2023), and (d) other externalizing traits studied across the clinical and other literatures (Watson & Clark, 2023).

Internalizing assessment included 13 items from Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND; Tolin et al., 2018), a semi-structured open-source interview. Of these items, eight assessed major depressive symptoms (major depressive symptoms other than thoughts of death/suicidal ideation[2]). Items assessing worry, tension, irritability, feeling anxious in social situations, and fearing social judgment also were included to increase comprehensiveness of commonly experienced internalizing symptoms that associate strongly with depressive symptoms (Conway et al., 2022). Next, select items from the Structured Interview for *DSM-IV* Personality (SIDP-IV; Pfohl et al., 1997) were administered to assess PD traits. This included (a) the nine items used to assess narcissistic PD traits, (b) the seven items for assessing antisocial PD criterion A traits, and (c) seven items assessing borderline PD traits. All SIDP-IV items were rated on a 0 (*not present*), 1 (*subthreshold*), or 2 (*present*) scale. Ratings for each PD were summed to create a composite for each diagnostic construct rather than combining them into broader composites as was done for the DIAMOND

[2] This major depression item and two of the borderline PD items were not administered due to logistic and ethics board restrictions related to the remote assessment of suicidality. Study interviewers were trained to follow structured, evidence-based protocols for risk assessment if needed even though these questions were not included.

internalizing items because they constituted a larger, more heterogeneous set of items overall (i.e., 23 PD items vs. 13 internalizing items). Additionally, interview versions of the AUDIT (10 items) and CUDIT-R (eight items total) mirroring their self-report versions were administered. All AUDIT and CUDIT-R items were rated on a 0–4 scale. We considered combining AUDIT and CUDIT items into a single substance use index, but opted against doing so because AUDIT and CUDIT-R total scores correlated weakly in our data ($r = .21$; $n = 140$).

Interviewers were PhD-level clinical psychologists, graduate students in doctoral psychology programs, postbaccalaureate researchers with a bachelor's degree in psychology, and senior-year undergraduates, all of whom were supervised by a PhD-level psychologist while conducting interviews ($N = 8$ total interviewers). Interviewers completed a detailed training process including didactics on interviewing and symptom criteria, observing several or more interviews, being observed for multiple interviews before conducting interviews independently, and attending recurring training and review meetings. Interviews were audio recorded, and a second independent rater recoded 25 of the initial interviews for computing interrater reliability (IRR). Intraclass correlation coefficients (ICCs) computed to quantify IRR indicated acceptable to strong agreement for all ratings (ICC = .78 for narcissistic traits; all other ICCs > .85).

Results

Overview and Descriptive Statistics for Trait, Symptom, and Substance Use Ratings

Our presentation of results follows our timestamped analytic plan (again see https://rb.gy/dbwvq), with only a few minor deviations involving how specific ratings of participants' personality and mental health ratings were used in select analyses, as summarized in Appendix S1 in the online supplemental materials. Table S1 in the online supplemental materials provides descriptive statistics and coefficient omega estimates for self and interview ratings of personality and mental health (all coefficient omegas >.70 for self-report measures; >.75 for interview ratings), and correlations between these measures are shown in Table S2 in the online supplemental materials. When comparing values and reporting correlations in subsequent sections, we report statistical significance at a $p < .001$ level given the wide range of analyses conducted using a large sample.

Views of Terminology: Ranking Frequencies and Mean Ratings

Terminology Ranking Data

As Table 2 shows, "personality disorders" was ranked most highly for both (a) scientific accuracy and (b) preferred use by researchers and clinicians by over half of the participants (59% and 57.6%, respectively). It also was most commonly ranked as the least stigmatizing term (30.7%; lower ranks indicate being ranked as less stigmatizing). We conducted McNemar tests for comparing proportions in the same sample for the most preferred term, which in this case, involved comparing frequencies for "personality disorders" with the term that was rated as most preferred the second most frequently. For both scientific accuracy and preferred use, "personality pathology" was ranked as the preferred term the second most frequently (9%, 10.2%, respectively) and "interpersonal disorders" the third most frequently (8%, 9.2%, respectively), but these frequencies were significantly lower at $p < .001$ than those for "personality disorders." Next, "interpersonal pathology" was ranked as the least stigmatizing term by 15.4% of participants, but this was significantly lower than the 30.7% for "personality disorders" (p value $< .001$). Regarding other terms, "dark traits" was rated as the second least scientifically accurate (77.7%), second least preferred (76.1%), and second most stigmatizing term (80.1%). Only the term "evil traits" was ranked less favorably. "Socially aversive traits" also received lower scientific accuracy and preferred use rankings, as well as higher stigma rankings.

We then used chi-square tests to examine whether the frequency at which "personality disorders" was ranked as the most preferred term varied as a function of the following categorical variables across metrics examined (i.e., scientific accuracy, preferred use, least stigmatizing): Sample, treatment status, gender,[3] and self-reported PD diagnosis. Across all comparisons, there were no differences at $p < .001$ in the frequency of "personality disorders" being ranked as the most favorable term. Tables S3 (undergraduate), S4 (Prolific), and S5 (community) in the online supplemental materials provide breakdowns of this frequency rank information for each sample. As these tables show, "personality disorders" was ranked as the most scientifically accurate, most preferred, and least stigmatizing term in each sample (with chi-square tests failing to indicate significant cross-sample differences at $p < .001$ as reviewed). Regarding other aspects of cross-sample consistency, "dark traits" and "evil traits" were consistently ranked as second and first most stigmatizing, least scientifically accurate, and least preferred, respectively (frequencies >70% for each rating across samples).

Mean Terminology Ratings

Correlations between all nine mean ratings across metrics are provided in Table S6 in the online supplemental materials. Ratings for the same term's scientific accuracy and acceptability were moderately to strongly correlated in some cases, though not so strongly as to be redundant. Terms' stigma ratings generally correlated weakly to moderately with their other ratings.

Mean values and *SD*s for terms rated using rating scales (rather than rankings) in both the combined and each individual sample are presented in Table 3. Mean rating data for terms corresponded with their ranking data. For example, "personality disorders" tended to have higher mean scores for scientific accuracy and acceptability and lower scores on stigma than other terms. Terms such as "interpersonal disorders" again were viewed positively overall, with "dark traits" and "evil traits" receiving high ratings for stigma (average response > 5.0/6 across samples) and low mean ratings on other metrics. As Tables S7 and S8 in the online supplemental materials display, patterns of mean scores were similar when separating our

[3] We recognize different methods for creating comparison groups. For our comparisons, groups were defined as (a) cisgender women; (b) cisgender men; and (c) individuals of any gender-diverse identity (e.g., nonbinary, agender; transgender; also see Table S7 in the online supplemental materials). Sizes for these groups were 602, 272, and 57 participants, respectively. Participants could select multiple response options in our demographic questionnaire, so these group sizes do not align exactly with some of the values shown in Table 1 due to these comparisons requiring us to assign participants to groups.

Table 2
Frequency Ranks of Terminology Views in the Combined Sample

Term	First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eighth	Ninth
Scientific accuracy									
Personality disorders	**59.0**	11.1	7.5	8.3	4.2	5.6	2.9	0.9	0.5
Interpersonal disorders	8.0	**27.4**	22	11.2	14.3	9.6	5.3	1.4	0.8
Personality pathology	9.0	**25.0**	15.3	18.1	15.1	10.2	5.3	0.4	1.5
Interpersonal pathology	7.9	10.3	14.8	20.7	18.6	17.3	8.1	0.7	1.6
Characterological disorders	4.2	9.7	15.7	14.8	15.2	20.1	16.8	2.2	1.3
Character pathology	3.4	6.6	10.4	14.1	17.7	24.4	19.4	2.8	1.1
Socially aversive traits	6.8	7.7	12.6	10.4	11.4	10.1	**36.6**	2.3	2.1
Dark traits	0.2	1.6	0.8	1.5	2.2	1.4	3.8	**77.7**	10.7
Evil traits	1.4	0.7	0.9	0.9	1.3	1.3	1.6	11.6	**80.3**
Preferred use by researchers and clinicians									
Personality disorders	**57.6**	11.2	7.6	6.7	6.3	6.0	3.8	0.4	0.4
Personality pathology	10.2	23.6	13.4	19.2	15.5	10.3	5.6	1.2	0.9
Interpersonal disorders	9.2	23.5	22.2	13.4	14.6	9.3	5.5	1.2	0.9
Interpersonal pathology	6.8	11.5	15.8	21.7	17	16.3	7.6	2.0	1.3
Characterological disorders	3.7	10.7	16.1	13.3	15.1	21.6	16.4	1.3	1.8
Character pathology	3.1	7.3	13.2	13.6	17.6	24.9	17.6	2.0	0.8
Socially aversive traits	7.7	10.5	10.2	10.7	10.7	8.2	**38.3**	1.5	2.1
Dark traits	0.9	1.1	0.5	0.7	2.3	1.3	3.0	**76.1**	14.1
Evil traits	0.8	0.5	0.9	0.7	0.9	2.1	2.2	14.3	**77.8**
Stigma									
Evil traits	**82.6**	7.7	0.9	0.7	1.0	0.8	0.3	2.6	3.5
Dark traits	6.8	**80.1**	2.2	1.2	1.4	1.4	0.3	3.7	2.8
Socially aversive traits	1.4	1.8	**42.3**	8.6	7.9	11.1	9.0	6.5	11.3
Characterological disorders	0.7	1.7	14.2	23.8	18.9	12.1	15.4	7.4	5.8
Character pathology	0.4	1.8	13.8	19.0	15.0	13.9	16.0	12.9	7.1
Personality pathology	1.2	1.5	5.4	11.4	12.8	14	18.5	21.3	13.8
Interpersonal disorders	0.4	1.8	5.1	12.9	17	18.8	13.7	20.5	9.7
Interpersonal pathology	0.9	2.0	3.6	9.6	16.1	18.2	19.0	15.3	15.4
Personality disorders	5.5	1.4	12.5	12.8	9.9	9.8	7.7	9.7	**30.7**

Note. $N = 922$ for overall preferred use ratings; 921 for perceived scientific accuracy ratings; and 920 for perceived stigma ratings. Terms that were ranked more highly were viewed as more stigmatizing. All values are percentages, and percentages equal or greater than 25% are bolded.

sample by gender and current treatment status in addition to being similar overall across sample type.[4]

Per our timestamped analytic plan, we formally compared mean scores and examined associations with other self-report and interview measures for the following four terms that have been the focus of recent proposals and debate: "personality disorders"; "interpersonal disorders"; "socially aversive traits"; and "dark traits." We also focused on quantifying mean differences and associations for these theoretically key terms because it would have been unwieldy to compare all terms, and these terms tended to receive high or low mean rankings and ratings anyway.

We quantified differences between these four terms using repeated measures analysis of variance (rmANOVA). This approach is an extension of a paired samples t test for comparing more than two ratings in the same data set, and differences between ratings are compared as within-person differences. We conducted a rmANOVA for each metric (scientific accuracy, acceptability, stigma). A Greenhouse–Geisser correction was used due to sphericity assumption violations across models, and the overall model for within-person differences was significant at $p < .001$ in all three cases, scientific accuracy $F(2.81, 2{,}600.56) = 1{,}562.28$; acceptability $F(2.69, 2{,}484.87) = 1{,}837.32$; stigma $F(2.43, 2{,}239.66) = 846.45$. Pairwise comparisons for individual term ratings also were significant at $p < .001$ for every comparison (e.g., when comparing the scientific accuracy rating for "socially aversive" with scientific accuracy ratings for other terms). The only exception was that the mean difference for stigma ratings for "interpersonal disorders" and "personality disorders" was not significant at $p < .001$ ($p = .04$; mean difference = 0.12; Cohen's $d = 0.09$). Table S9 in the online supplemental materials provides mean and effect size differences for all pairwise comparisons, and means for "dark trait" ratings differed at an effect size >1.0 from ratings for all other terms for all comparisons across models.

Correlations for Term Ratings and Other Study Measures

Pearson correlations for other study self and interview ratings with terminology ratings are provided in Table 4. Correlations for self-ratings tended to be very weak: Only 2/168 exceeded |.15| (rs = .22 and .18 for IDAS-II Euphoria with "dark traits" ratings). Correlations for interview ratings were slightly stronger in some cases (e.g., with scientific accuracy ratings of "dark traits"), though only the correlation for

[4] One deviation from our timestamped analytic plan that is described in Appendix S1 in the online supplemental materials includes not reporting a sequence of two-way ANOVAs where sample, gender, treatment status, and whether participants self-reported having a PD diagnosis were entered into models as between-person factors (e.g., a two-way ANOVA where term ratings of scientific accuracy constituted a within-person factor and sample type was entered as a between-person factor). Examination of these models indicated that interactions for between- and within-person factors were not significant in some cases (e.g., for gender and stigma ratings) and in cases where significant interactions and pairwise comparisons were observed, overall patterns of results did not change (e.g., "dark traits" always received a mean rating well below other terms). Therefore, these results would have required significant detail to explain without altering overall conclusions.

Table 3
Mean Ratings of Terminology Views in the Combined and Each Individual Sample

Term	Combined		Undergraduate		Prolific		Community	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Scientific accuracy								
Personality disorders	5.08	1.20	5.05	1.23	5.21	1.08	4.84	1.36
Interpersonal disorders	4.28	1.23	4.11	1.23	4.45	1.15	4.25	1.38
Personality pathology	4.23	1.22	4.15	1.21	4.39	1.19	3.97	1.26
Interpersonal pathology	4.00	1.22	3.88	1.19	4.18	1.18	3.81	1.32
Character pathology	3.67	1.29	3.70	1.21	3.80	1.29	3.27	1.37
Character disorders	3.66	1.34	3.72	1.29	3.76	1.30	3.25	1.47
Socially aversive traits	3.60	1.42	3.33	1.40	3.84	1.39	3.62	1.43
Dark traits	1.62	1.10	1.61	1.02	1.59	1.08	1.73	1.32
Evil traits	1.48	1.05	1.52	1.00	1.39	0.98	1.60	1.29
Acceptability for use by researchers and clinicians								
Personality disorders	5.16	1.15	5.12	1.22	5.29	1.04	4.94	1.23
Interpersonal disorders	4.61	1.22	4.42	1.26	4.82	1.11	4.52	1.31
Personality pathology	4.54	1.27	4.44	1.28	4.74	1.19	4.27	1.40
Interpersonal pathology	4.50	1.25	4.31	1.28	4.73	1.13	4.33	1.38
Character pathology	4.17	1.36	4.21	1.25	4.28	1.36	3.78	1.53
Character disorders	4.11	1.36	4.19	1.26	4.20	1.35	3.70	1.53
Socially aversive traits	3.84	1.51	3.55	1.48	4.06	1.49	3.94	1.57
Dark traits	1.55	1.15	1.54	1.06	1.49	1.08	1.73	1.44
Evil traits	1.40	1.01	1.39	0.89	1.35	0.98	1.55	1.28
Stigma								
Evil traits	5.63	1.00	5.46	1.17	5.83	0.66	5.53	1.19
Dark traits	5.53	1.09	5.34	1.28	5.75	0.73	5.39	1.29
Socially aversive traits	3.63	1.55	3.68	1.54	3.65	1.54	3.48	1.61
Character disorders	3.24	1.35	3.04	1.30	3.32	1.36	3.48	1.36
Personality disorders	3.03	1.60	2.93	1.65	3.02	1.55	3.28	1.61
Character pathology	2.92	1.41	2.64	1.25	3.08	1.49	3.18	1.48
Interpersonal disorders	2.91	1.36	2.86	1.40	2.90	1.36	3.07	1.27
Personality pathology	2.70	1.35	2.46	1.20	2.82	1.38	2.95	1.48
Interpersonal pathology	2.60	1.30	2.45	1.21	2.63	1.33	2.86	1.37

Note. *N*s for the combined sample ranged from 919 to 931; from 359 to 362 in the undergraduate sample; from 404 to 408 in the Prolific sample; and from 153 to 161 in the community sample. Character = characterological. Terms were rated on a 1–6 scale across categories (i.e., scientific accuracy, acceptability, stigma), and higher stigma ratings indicate a term being rated as more stigmatizing. Terms are listed from highest to lowest mean.

antisocial PD traits with scientific accuracy ratings for "dark traits" was significant at $p < .001$ due to the smaller sample size for these correlations ($r = .30$, $p < .001$; $n = 145$). We also examined how self-reported PD diagnostic status correlated with term ratings using polyserial correlations (not reported in Table 4). These correlations were consistently very weak and nonsignificant (all rs $< |.10|$; correlation *N*s = 926–930).

Summary of Participant Write-in Responses for Ideas for Terminology

Lastly, 7.2% of all participants (67/931) provided write-in responses for alternative PD terminology ideas. Two study authors independently organized responses into groups for data reduction. Data reduction rather than a more extensive coding approach was selected given the nature of the responses collected (i.e., brief write-ins only) and the small number of total write-in responses. Responses were organized into six groups as Table S10 in the online supplemental materials shows: (a) "Personality differences" terminology ($n = 11$); (b) general mental or behavioral health language ($n = 6$; e.g., "behavior health disorders"); (c) neurodiversity or related terminology ($n = 5$; e.g., "neurodivergent traits"); (d) terminology emphasizing regulation ($n = 4$; e.g., "emotion regulation disorders"); (e) terms including disability language ($n = 2$; e.g., "personality disability"); and (f) "uncategorized" if not aligning with a previous grouping ($n = 19$). Raters grouped 41/47 (87.2%) of terms into the same group (i.e., did each rater assign each term to the same group; kappa coefficient quantifying grouping consistency = .82). Other responses ($n = 20$) described broader viewpoints or repeated a term already listed in our questionnaire (e.g., "personality disorders") and were not included in the groupings reviewed.

Discussion

Our study provides insight into how terminology used in PD and related research areas is viewed by community members, including individuals currently accessing treatment (representing a majority of our sample). On the whole, traditional PD terminology was viewed more favorably than other terms, with "interpersonal disorder" terminology also being viewed more positively than some terms. In contrast, dark trait terms were viewed unfavorably. Community members' mental health histories and other characteristics (e.g., age) tended to correlate very weakly with their terminology ratings across examination of over 200 correlations. Similarly, we did not observe marked differences in terminology views by categorical grouping variables (e.g., current treatment status), suggesting strong consistency in results overall.

PDs Terminology

"Personality disorders" terminology was viewed favorably overall as reviewed. Similarly, the variant term of "personality pathology"

Table 4
Correlations for Other Study Measures With Ratings of Scientific Accuracy, Acceptability, and Stigma

Scale	Scientific accuracy				Acceptability of use				Stigma			
	Dark	PD	Interp	Soc Av	Dark	PD	Interp	Soc Av	Dark	PD	Interp	Soc Av
Self-report												
IDAS-II Euphoria	**0.22**	−0.06	−0.02	0.08	**0.18**	−0.04	0.00	0.06	−0.10	0.05	0.05	−0.02
PID-5 Disinhibition	**0.15**	−0.03	0.02	0.04	**0.14**	−0.01	0.02	0.07	−0.06	0.02	0.03	−0.02
IDAS-II Mania	**0.11**	−0.02	0.00	0.02	0.08	−0.02	0.00	0.01	0.00	0.04	0.04	0.01
PID-5 Detachment	0.10	0.04	0.07	0.06	0.04	0.05	0.05	0.07	0.03	0.02	0.05	−0.02
PID-5 Psychoticism	0.10	−0.03	0.03	0.04	0.09	−0.01	0.00	0.05	−0.03	0.03	0.03	−0.02
LPFS Functioning	0.08	−0.01	0.01	−0.01	0.04	0.04	0.07	−0.03	−0.12	−0.04	−0.01	0.01
PID-5 Negative Affectivity	0.06	0.01	0.02	−0.03	−0.01	0.00	0.03	−0.04	0.01	0.00	0.01	0.05
PID-5 Detachment	0.10	0.04	0.07	0.06	0.04	0.05	0.05	0.07	0.03	0.02	0.05	−0.02
PID-5 Antagonism	0.08	0.03	0.02	0.03	0.07	−0.01	−0.02	0.06	−0.02	−0.04	0.03	−0.02
IDAS-II Dysphoria	0.07	0.04	0.06	0.05	0.02	0.04	0.07	−0.01	0.03	0.02	0.06	0.03
CUDIT-R Cannabis	0.09	−0.05	−0.03	−0.04	0.15	0.01	−0.01	−0.02	−0.07	0.01	0.01	0.01
AUDIT Alcohol	0.04	−0.02	0.00	0.00	0.03	0.05	0.05	0.05	−0.09	−0.05	0.00	−0.04
Age	0.01	0.00	0.06	**0.12**	−0.01	0.00	0.07	0.11	0.13	0.03	0.07	−0.01
Education	−0.09	−0.02	0.03	−0.04	−0.04	−0.02	0.02	−0.01	0.09	0.01	0.03	0.08
Interview												
Antisocial	**0.30**	0.03	−0.01	0.14	0.26	0.19	0.05	0.10	−0.03	−0.07	0.10	0.07
Internalizing	0.24	0.04	0.02	0.11	0.25	0.01	0.05	0.04	−0.04	0.01	0.00	−0.01
Borderline	0.23	−0.04	0.04	0.17	0.22	0.13	0.09	0.15	−0.09	−0.01	0.05	−0.07
CUDIT-R Cannabis	0.23	0.03	0.04	0.10	0.23	0.18	0.17	0.17	−0.08	−0.08	0.09	0.05
Narcissistic	0.18	0.05	0.09	0.10	0.16	0.01	0.00	0.07	0.02	0.08	0.05	−0.05
AUDIT Alcohol	0.03	0.07	0.00	0.09	0.08	0.12	0.15	0.07	−0.07	−0.18	−0.07	−0.07

Note. Dark = dark traits; PD = personality disorders; Interp = interpersonal disorders; Soc Av = socially aversive traits; IDAS = Inventory of Depression and Anxiety Symptoms; PID-5 = Personality Inventory for *DSM-5*; LPFS = Level of Personality Functioning Scale; CUDIT-R = Cannabis Use Disorders Identification Test-Revised; AUDIT = Alcohol Use Disorders Identification Test. Correlations that are significant at $p < .001$ are bolded. *N*s ranged from 926 to 931 for PID-5 and IDAS-II correlations; from 566 to 569 for LPFS correlations; from 521 to 523 for self-report AUDIT and CUDIT-R correlations; and from 130 (for internalizing) to 145 (for antisocial and narcissistic trait ratings) for interview ratings.

tended to receive higher ratings than many other terms, even if it was not rated as highly as "personality disorders." These findings are encouraging given these terms' widespread use, though it would be helpful to use different study designs to examine the extent to which these results were due to "personality disorders" being the current *DSM* terminology (which participants may reasonably assume is indicative of this terminology having more than legitimacy than other terms due to being used in diagnostic manuals). Furthermore, it is possible that other terms not included here would be viewed more favorably than any of the terms included. Our assessment of community members' viewpoints was brief overall, and qualitative research assessing views of terminology in much more depth than was done here would be useful going forward (see Mason et al., 2023 for an example focused on personality assessment that used in-depth approaches with fewer participants).

Regarding other considerations related to use of standard PD language, it would have been interesting to assess terminology views in relation to the AMPD, which may eventually supplant current *DSM* PD descriptions as discussed (Monaghan & Bizumic, 2023). In addition to models such as the AMPD that would alter PD conceptualizations specifically, more comprehensive dimensional frameworks such as the Hierarchical Taxonomy of Psychopathology (HiTOP; Conway et al., 2022) would reshape diagnostic classification even more broadly. Issues concerning terminology precision and utility still would apply to models such as the HiTOP and AMPD (see Masland et al., 2023), even if labels refer to dimensions rather than traditional diagnostic categories.

Furthermore, efforts such as HiTOP illustrate the considerable heterogeneity within and across PD diagnoses, which may have impacted our results. For example, community members' views of specific terms could vary depending on the specific PD in question or even for some features of a single disorder more than others. Open-ended write-in responses indicated that some participants may have had specific diagnoses in mind, as two participants suggested the label "emotion regulation disorders," a label paralleling borderline PD. Other write-in responses possibly related to dimensional, continuum conceptualizations focused on describing "personality differences" and variation. Furthermore, write-ins related to neurodiversity may have been used to indicate that PDs should be viewed as reflecting differences aligning with neurodiversity perspectives, though we were not able to assess participants' intended meaning of write-in responses.

Interpersonal Terminology

The terminology "interpersonal disorders" (and also "interpersonal pathology") was viewed more favorably than other terms such as "dark traits" and "socially aversive traits," though less favorably than traditional PD terminology in some ways. When interpreting results, it is possible that community members' views may have been altered had they been provided with more detailed descriptions of each term and the justification for using a term, which was not possible to provide in this case due to time and resource constraints. For example, some participants' rankings and ratings may have been altered had they been presented with explanations of the possible benefits of "interpersonal" terminology, which may include it being less stigmatizing if it shifts focus from individuals' personalities to interpersonal difficulties they are experiencing. Regardless, in summary, when considering results holistically for "interpersonal disorders," community members seemed to view this terminology at least somewhat favorably overall.

Dark Trait Terminology

There are no formal proposals to label the PDs using "dark trait" terminology, and dark trait measures overlap with measures used to assess some PDs (e.g., narcissistic PD) much more than others (e.g., schizotypal PD, schizoid PD). Still, dark trait terminology is used in some PD research and in externalizing trait research more generally as discussed. As predicted, the term "evil" was viewed the most negatively of any term, and the more general descriptor "dark" also was viewed negatively overall. Notably, there was relatively little variation in how these terms were ranked (e.g., over 90% of participants ranked "dark traits" and "evil traits" as one of the three least scientifically accurate terms). We hope these specific results will provide useful information for researchers to consider when selecting terms for PD research, as these findings suggest that community members recruited from different sources consistently perceived these terms negatively and as inaccurate.

Related to dark trait research, "socially aversive traits" is another term sometimes used in place of dark trait terminology. Ratings for this term were more positive than those for dark trait terms based on these results. However, "socially aversive traits" still was not viewed positively overall, which is another important finding for researchers to consider given recent discussions around terminology usage (Andrews et al., 2024; Kay & Arrow, 2022).

Other Terminology

"Characterological" terminology also was included for the sake of comprehensiveness. These terms were rarely ranked or viewed as most preferred, but nor were they viewed particularly negatively. These findings provide useful information in that they suggest none of these terms represent a particularly compelling alternative to standard terminology. Had one of these terms been viewed particularly favorably then perhaps such a term would warrant more attention in future research, but that was not the case here.

Other Limitations, Future Directions, and Conclusion

In addition to the future directions already reviewed, although our study provides descriptive information about community members' views, we recognize that it does not address questions concerning construct boundaries, the utility of specific models in different contexts, or how terminology would be perceived in all situations (e.g., what constitutes a "dark" trait or the predictive validity of the dark triad or other frameworks; see Andrews et al., 2024; Kay & Arrow, 2022; Koehn et al., 2019; Muris et al., 2017 for theoretical reviews). We anticipate ongoing dialogue about these issues, and it would be useful to extend our study by examining perceptions of terms when they are used to refer to personality tendencies in social, personality, and other research areas in addition to focusing on PDs as was done here.

Next, community members' characteristics generally associated very weakly with their terminology views, although there were a few exceptions such as antisocial PD ratings correlating moderately with some dark trait terminology ratings. It would be interesting to examine the replicability and meaning of these and other associations in other samples, as well as to determine if other aspects of community members' mental health histories not assessed here might be related to their views of terminology (e.g., assessing other symptoms and traits; assessing familiarity with PD diagnostic criteria). Our sample also included relatively few individuals with a PD diagnosis ($n = 40$ self-reported diagnosis) even with use of targeted recruitment strategies, such that assessing views in other samples and in more depth would be useful as discussed. Other generalizability limits include our sample being homogenous in some ways (e.g., regarding racial identity), even though our sample was large overall.

Regarding other future directions, concerningly, trainees may develop more negative attitudes toward individuals with PDs as they progress in their training (Lindell-Innes et al., 2023). This highlights a need for improving training in PD diagnosis and treatment, and research could also extend our study by evaluating the extent to which mental health professionals' views of terminology align with those from the broader community (e.g., when comparing traditional PD with "interpersonal" terminology). Going forward, it also will be important to connect issues concerning terminology and stigma with efforts focused on improving the accessibility of evidence-based PD treatment options, rather than studying each in isolation. Research guiding treatment for some specific externalizing PD features also remains very limited overall (Nook et al., 2022). We commend recent efforts to disseminate efficient new treatments (Sauer-Zavala et al., 2023), as well as related efforts integrating treatment research with research focused on improving construct description and measurement (Sauer-Zavala, 2022).

In summary, we hope future research will build from these findings to better understand views of terminology, improve terminology precision, and sharpen construct definitions to unify study design and assessment approaches. Acknowledging the limitations described, our study represents one step toward this goal, and we hope these data provide useful information for researchers to consider when studying terminology perceptions and describing constructs.

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