DSM-5 Personality Disorders:
What went wrong; what we’ve learned

John Gunderson, MD
Conflicts of Interest

• Pride in status quo

• May 2008: “They thought you were too traditional”
Sept. 2009

“It’s histrionic.” (Zanarini)
“How can you advocate for a proposal you don’t support” (Phillips)

“If you want to influence the decisions, you need to detail your responses line-by-line” (Skodol)
May 2010

“Why don’t you quit?”
We have all reviewed the proposal for changes in the DSM-5 personality disorders. We recognize that the effort to use a scientifically-established architecture for personality using traits and dimensions has great promise for identifying the latent structure of all mental disorders and thus has the potential to frame future classification systems. The Personality Disorders Work-groups effort to fulfill this hope has required creative and ambitious efforts to revise the definition of personality disorder, identify key domains of personality psychopathology, and the introduction of prototypes. We believe the proposal and changes are too radical and are likely to be destructive for the following reasons.
We call upon the PD Work Group to actively seek feedback from representatives of the undersigned research and clinical community. Without integrating that feedback into a revised proposal, field trials cannot hope to address the issues that are relevant to our field’s progress.

The signers are:

Anthony Bateman, MD, Aaron Beck, MD, Donald Black, MD, Nancee Blum, MSW, Martin Bohus, MD, Lois Choi-Kain, MD, John Clarkin, PhD, Michael First, MD, Peter Fonagy, PhD, Glen Gabbard MD, Marianne Goodman, MD, John Gunderson, MD, Perry Hoffman, PhD, Otto Kernberg, MD, Harold Koenigsberg. MD, Mark Lenzenweger, PhD, Marsha Linehan, PhD, Paul Links, MD, Robert Michels, MD, Thomas McGlashan, MD, Antonia New, MD, Joel Paris, MD, Elsa Ronningstam, PhD, S. Charles Schulz, MD, Kenneth Silk, MD, Paul Soloff, MD, Barbara Stanley, MD, Erik Simonsen, MD, Mary Zanarini, PH.D.
August 2010

“I thought you were a friend”
Personality Disorders in DSM-5

DSM-5 in its proposed form presents a significant shift in the approach to diagnosing personality disorders. The diagnostic criteria outlined in DSM-III and DSM-IV and the introduction of axis II were intended to focus attention on these syndromes in clinical practice and to foster research on their diagnosis, epidemiology, psychobiology, clinical course, and treatment. A diagnostic system should be clinically relevant, encompass the spectrum of personality syndromes seen in practice, facilitate their recognition, and still be simple enough to be used by busy clinicians, including those who do not specialize in the assessment and treatment of personality. At the same time, the diagnostic scheme needs to reflect and support progress in research that leads to increased understanding and better treatment of these illnesses. Regrettably, the proposed system for classifying personality disorders is too complicated, includes a trait-based approach to diagnosis without an adequate clinical rationale, and omits personality syndromes that have significant clinical utility.

The proposed DSM-5 diagnostic scheme for personality disorders is an unwieldy conglomeration of disparate models that cannot happily coexist and raises the likelihood that many clinicians will not have the patience and persistence to make use of it in their practices. The resultant draft criteria encompass 5 levels of personality functioning, 5 personality types, 6 personality trait rating scales, and 4–10 trait rating subscales or facets per trait rating scale.

A clinically useful approach should focus on types of people, not types of ratings scales. The primary unit of diagnosis should be a personality syndrome—a configuration or pattern of functionally interrelated personality processes encompassing cognition, affectivity, interpersonal functioning, behavior, coping, and defense. Mental health professionals think in terms of syndromes or patterns (as recognized by all previous versions of the DSM), not in terms of deconstructed
Dec. 2010

“Confusion & Incoherence”
(Livesely)
Confusion and Incoherence in the Classification of Personality Disorder: Commentary on the Preliminary Proposals for DSM-5

W. John Livesley

Abstract: The compilation of Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 afforded an unprecedented opportunity to advance the study of personality disorder by constructing an evidence-based, etiologically informed classification. The conceptual models and empirical knowledge are available and the field is looking for substantial changes to the way personality disorder is classified and diagnosed. Given the opportunity and need, the preliminary proposal by the DSM-5 Personality and Personality Disorders Work Group is disappointing. The proposal totally reformulates the way personality disorders are classified so that there is virtually no continuity with the previous system. The reformulation is a confusing mixture of innovation and a return to previous ways of representing diagnostic constructs that is inconsistent, incoherent, impractical, and frequently incompatible with empirical facts. Particularly problematic is the replacement of criterion-based diagnosis with a prototype matching system that, if implemented, will result in personality disorder being diagnosed in a fundamentally different way from all other disorders in psychiatry and medicine. Implementation of the proposal would have serious adverse consequences for patients, treatment, research, and administrative and legal applications, especially in the area of psychological injury and law.

Keywords: Personality disorder . DSM-5 . Critique

The study of personality disorder (PD) labors under a profound handicap—the lack of a valid diagnostic classification. The decision to revise the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association 2000) and compile DSM-5 afforded an unprecedented opportunity to construct an empirically based, etiologically informed system. The conceptual tools and empirical data required are readily available. The construct validation framework that has been so successful in developing valid measures of personality could readily be adapted to classifying PD (Blashfield and Livesley 1991; Skinner 1981, 1986). Robust data on the structure of normal and disordered personality are available to build a system with solid empirical foundations (Clark 2007; Livesley 2007, in press a, b; Trull and Durrett 2005; Widiger and Simonsen 2005). The study and treatment of PD urgently needs such a system. Voluminous studies document serious problems with DSM-IV, including extensive diagnostic overlap, poor coverage, high prevalence of the PD not otherwise specified diagnosis (PD-NOS), limited agreement among different measures, and lack of structural validity (Krueger and Eaton 2010). These problems hinder compilation of a coherent body of scientific knowledge about personality pathology and the development of valid conceptual frameworks to guide research and practice.

The author wishes to thank two reviewers for their helpful comments.

W. J. Livesley (*)
Department of Psychiatry,
2255 Wesbrook Mall,
Vancouver, BC, Canada V6T 2A1
e-mail: livesley@interchange.ubc.ca
Feb. 2011

“I didn’t know he wrote that.” (Skodol)

“I’m glad we can agree that “submissiveness” characterizes BPD.”
“You should be grateful that BPD will be retained.”
DATE:  July 11, 2011

TO:  Dr. David Kupfer, Task Force Chair
     Dr. Darrel Regier, Task Force Vice Chair

CC:  DSM-5 Task Force
     APA Board of Trustees
     DSM-V Personality & Personality Disorders Workgroup

FROM:  Experts on Research and Treatment of Personality Disorders

SUBJECT:  Recurrent problems with the latest DSM-5 Personality and Personality Disorder Proposal

The proposed revisions in the classification of PDs posted on June 21 continues to represent an unprecedented change in the existing system for classifying PDs. It also represents a radical change from the versions which were previously posted. In many respects, however, it reflects the same problems as those two prior proposals. In brief, it is too complicated, it is unfamiliar to the clinicians who will be expected to use it, it will aggravate (not ameliorate) the problems with clinical utility, it lacks a scientific rationale, it is an amalgam of trait psychology and the existing topology lacking both a conceptual and empirical base, the efforts to capture existing types are disconnected from what is known about these disorders, and there is no effort to integrate the evidentiary base of DSM-IV or subsequent research (or if there is, it is undocumented).
The proposed revisions in the classification of PDs posted on June 21 continues to represent an unprecedented change in the existing system for classifying PDs. It also represents a radical change from the versions which were previously posted. In many respects, however, it reflects the same problems as those two prior proposals. In brief, it is too complicated, it is unfamiliar to the clinicians who will be expected to use it, it will aggravate (not ameliorate) the problems with clinical utility, it lacks a scientific rationale, it is an amalgam of trait psychology and the existing topology lacking both a conceptual and empirical base, the efforts to capture existing types are disconnected from what is known about these disorders, and there is no effort to integrate the evidentiary base of DSM-IV or subsequent research (or if there is, it is undocumented).
Signatories

Blaise Aguirre, MD, Anthony Bateman, MD, Aaron Beck, MD
Donald Black, MD, Nancee Blum, MSW, Martin Bohus, MD
Lois Choi-Kain, MD, John Clarkin, PhD, Linda Dimeff, PhD
Michael First, MD, Peter Fonagy, PhD, Glen Gabbard MD
Marianne Goodman, MD, John Gunderson, MD,
Perry Hoffman, PhD, Otto Kernberg, MD,
Harold Koenigsberg. MD, Ken Levy, PhD
Marsha Linehan, PhD, Paul Links, MD, Terry Maltzberger, MD
Shelley McMain, MD, Robert Michels, MD, Antonia New, MD
Joel Paris, MD, Paul Pilkonis, PhD, Elsa Ronningstam, PhD
S. Charles Schulz, MD, Kenneth Silk, MD, Paul Soloff, MD
Barbara Stanley, MD, Erik Simonsen, MD, Drew Westen, PhD
Frank Yeomans, Mary Zanarini, PhD, Marc Zimmerman, MD
Nov. 2011

“Some of those who signed really don’t remember what they agreed to – just did it to placate/please you.”
Feb. 2012

“It’s pretty much settled – a very constructive process.”
(Kupfer)
“You don’t understand, they are only working to get a proposal they can all agree to.” (Silk & Koenigsberg)

“You should know that I agree with most everything you wrote about. The meetings were awful. That’s why I quit.” (Verhuel)
Ken Kendler letter
Dec. 2012

bully pulpit?

“Would you present the other side?”
Jan. 2013

DSM-IV PDs will be retained
FUTURE PROCESSES

- criteria for change (incremental, scientific, clinically useful)
- selection of workgroup members
- communications
FUTURE CONTENT

- BPD & ASPD on Axis I with different criteria for change

- Other PD’s dimensionalized on Axis II

- Retain DPD, PPD, + ? HPD
  (move STPD to schizophrenia)

- Simplify definition of PD’s