



Personality Disorders in DSM-5: A Commentary on the Perceived Process and Outcome of the Proposal of the Personality and Personality Disorders Work Group

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Abstract: There has been much discussion and controversy concerning the process undertaken and the decisions made with respect to the Personality and Personality Disorders Work Group (PPDWG) proposal for DSM-5, as well as the rejection of the work group's final proposal, by the American Psychiatric Association Board of Trustees. This commentary suggests that the way the PPDWG members were selected and the perceived secrecy associated with the PPDWG's deliberations almost assured that, despite the hard work and good intentions of the group members, the proposal would raise controversy and could ultimately fail. This commentary provides a personal perspective on some of the issues, assumptions, and preconceptions that arose between members of different theoretical and conceptual camps within the field of personality disorders. It concludes with suggestions as to how we might avoid these mistakes in the future and also how we might take advantage of the PPDWG's substantive work as we make future attempts to improve diagnosis in the area of personality disorders.

Keywords: dimensional diagnosis, DSM-5, nosology, Personality and Personality Disorders Work Group, personality disorders

“Two psychoanalysts are walking down the street in Manhattan, and one says to the other, ‘Tell me, what is there beyond psychoanalysis for understanding the mind?’ and the other analyst responds, ‘Ah, good question, we have both been psychoanalyzed, but tell me, have you ever been factor analyzed?’”¹

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Disclosure: The author of this manuscript was asked to be a consultant to the Personality and Personality Disorders Work Group (PPDWG) for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* in the last year of the group's existence, from November 2011 through December 2012. He was not a member of the original committee, and by the time he and another colleague joined the PPDWG, a major revision of the PPDWG's original proposal had been undertaken. Prior to the consultants joining the PPDWG, two members of the original group had already resigned, and whatever conflict or tension that allegedly existed within the PPDWG had disappeared. During the period that the author was a consultant to that group, the primary remaining task for the group was to prepare the PPDWG's proposals for review by two committees prior to the proposal going forward to the full DSM-5 Task Force and also to the Board of Trustees of the American Psychiatric Association for final approval or rejection. During the workings of the PPDWG, two (overlapping) groups of approximately 30 professionals not on the PPDWG signed and sent two letters to the PPDWG objecting to its process and proposals. The author of this commentary signed both of those letters prior to his joining the PPDWG as a consultant.

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INTRODUCTION

Much has been written about the response of the American Psychiatric Association (APA) Board of Trustees (Board) to the final proposal of suggested revisions for the classification of personality disorders (PDs) presented by the Personality and Personality Disorders Work Group (PPDWG). The final PPDWG proposal was rejected by the Board for inclusion in the main body of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), and it has been placed in Section III (“Emerging Measures and Models”) of DSM-5.² The process of how the final proposal was developed and ultimately rejected by the Board has been discussed elsewhere in detail,³ but a brief summary of the PPDWG's work would help to set the frame for this commentary. The Appendix lists some of the articles presented in special sections of various journals, both during the PPDWG process and upon completion of the work. Reviewing those articles should provide the reader not only with an historical perspective and commentaries on the process itself but also with post mortem observations on the eventual outcome. An excellent summary of events can be found in the 2013 article by Skodol and colleagues,³ which will be used as the basis for the remarks presented here.

BACKGROUND

The suggestion to develop a new edition of the DSM arose from a 1999 conference jointly sponsored by the APA and

National Institute of Mental Health (NIMH). The overarching idea was to shift psychiatric diagnosis away from a strictly categorical approach to a more dimensional approach. A book based on those discussions—*A Research Agenda for DSM-V*⁴—proposed that a “paradigm shift” in conceptualizing psychiatric diagnosis might be necessary. The need for a paradigm shift was used, in turn, as a rationale to exclude most of those who had been involved with DSM-IV from participating in either the initial series of planning meetings for DSM-5 or in its work groups.^{3,4} That decision—to intentionally exclude those who had been involved in previous DSM work groups—would be one of the main causes of tension as the PPDWG came together and moved to develop personality diagnoses for DSM-5.

The PPDWG took its task seriously and initially tried to consider all possible approaches to PD diagnosis, keeping in mind that the DSM-5 Task Force wanted a paradigm shift.³ The group reviewed the results of a survey that had polled the members of two research organizations studying PDs; a strong majority supported a hybrid dimensional-categorical model for diagnosing PDs.⁵ Early tension in the PPDWG surrounded the potential retention of some categorical diagnoses versus moving the entire structure of PD diagnosis into a dimensional framework. Even when the group seemed to agree upon primarily a dimensional approach, tensions arose over which dimensional approach should be adopted.³ Ultimately (and without reviewing here all the steps and changes in the proposed models for diagnosing PDs), the final model was essentially one based upon level of functioning combined with a hybrid dimensional-categorical framework for the individual PD diagnostic types or categories.³ By this time, however, two members of the PPDWG had resigned. It appears that the resignations decreased the overall tension within the group and allowed a final proposal to go forward to the two review committees, the Scientific Review Committee and the Clinical Public Health Committee that reported to the APA Board.

While the PPDWG and its members believed that they had made effective efforts to share the group’s proposals with the greater psychiatric community and also with those professionals who considered themselves to have substantial expertise in PDs, two letters were written to the APA Board, the DSM-5 Task Force, and the PPDWG that vehemently objected to the nature and the degree of the proposed changes. PPDWG members felt that they had responded openly to the concerns expressed in the first letter, and the PPDWG did make changes in its proposal after the first letter. Essentially the same group of people wrote a second letter about a year later, however, stating that the changes were insufficient and that their original concerns were still operative.³ Although the PPDWG’s final proposal was not considered favorably by either the Scientific Review Committee or the Clinical Public Health Committee—committees reporting to the Board—the proposal proceeded up the chain. After being accepted by the DSM-5 Task Force, it was rejected

by the Board. This author has written elsewhere⁶ about why the proposal caused so much turmoil among people who considered themselves to be experts within the PD field and also why the proposal was eventually rejected by the Board. This current article attempts to look at some of the assumptions and biases that developed during the life of the PPDWG and how those assumptions and biases, despite evidence to the contrary, persisted and colored the way that those outside the PPDWG viewed the PPDWG’s efforts and proposals.

DSM-5 has been published. The field of PD research is now trying to determine how to strengthen and improve the field, not only for research but also for patients.

COMMENTARY ON THE DSM-5 PPDWG

This article’s epigraph might be viewed as illustrating an important, but extreme, distinction in how members of the PD research and clinical community who were not members of the PPDWG viewed the membership of the PPDWG. The PD research and clinical community saw themselves as academic clinicians who did academic clinical research—a group that might be identified, broadly speaking, with the psychoanalysts in the quip, though in truth they practiced all types of psychotherapy. They felt locked out of influencing the PPDWG under the belief that the PPDWG had been taken over by academic clinical psychologists, the factor analyzers in the epigraph. While the PPDWG had both psychiatrists and psychologists among its membership, it was thought that the more clinically oriented psychiatrists in the PPDWG had yielded the agenda and influence in the group to those who were primarily interested in traits and the dimensional relationship of personality-disordered individuals to normal personality. The division or tension was probably more prominent between those outside versus inside the work group than it was within the work group itself, though as discussed in the summary above, the resignations from the PPDWG indicate that the work group was not without its own tensions.

In truth, a number of members of the PPDWG saw themselves essentially as clinicians. Yet to many outside the PPDWG, the membership felt stacked against the clinicians and heavily filled with people who held PhDs in psychology. These psychologists were classified as academics in departments of psychology not affiliated with psychiatry. They were thought to be more interested in factor analysis that leads to the establishment of traits and dimensions than they were in treatment or clinical issues. Another source of criticism was that the psychologists’ data supporting these traits and dimensions were gathered not from actual patients but largely from undergraduate college students filling out questionnaires for professors or from other nonclinical populations.

This description of the PPDWG’s intellectual makeup and of its supposedly more influential members presents a picture that appears more polarized along disciplinary lines than was the actual situation within the work group. Nonetheless,

many of those among the PD research and clinical community believed this polarization to be real and substantial. Not counting the chair and cochair, 4 of the 9 PPDWG committee members were physicians. If one includes the chair and cochair, then 6 of 11 were physicians. By contrast, in the Anxiety, OCD, and PTSD work group, 11 of 14 members were physicians, and in the Mood Disorders Work Group, 11 of 13 were physicians. Not all the other groups had a majority of physicians when not counting the chairs and cochairs. Substance-Related Disorders, Sleep-Wake Disorders, Gender and Cross-cultural Issues, and ADHD and Disruptive Behavioral Disorders work groups did not have a majority of physicians among their members.

Myth and prior assumptions often can replace or distort a clearer view of reality. Among the two resignations from the committee, one person was a psychologist, and the other was an MD/PhD. Neither of the two who resigned represented the more dynamic perspective among the PPDWG. Although the nonphysician members of the PPDWG were thought to do clinical work, they were not thought of as clinicians. Many among the PD research and clinical community still thought that these clinical psychologists did not see patients *per se*; instead, they were perceived as seeing *clients*, and only for the purpose of teaching others. Yet the individual with strongest ties to psychodynamic psychotherapy among all members of the PPDWG spent most of her professional time practicing psychotherapy, and she was a clinical psychologist. The perception nevertheless persisted that these academic psychologists were uninformed as to how medicine worked and that they had little appreciation of how psychiatry fit, or tried to fit, into the rest of medicine. After all, these psychologists were thought to be trait-psychology adherents, people interested in factor analysis rather than, as in the quip, psychoanalysis as a metaphor for all clinical work.

But perhaps the real emotional issue driving this tension between the PPDWG and the PD research and clinical community was not based upon differences in discipline whatsoever. Perhaps it was that many of those among the PD research and clinical community viewed themselves as having been very involved in the prior DSM-III⁷ and DSM-IV⁸ versions of the developed PD criteria, and now they felt completely left out, dismissed, and even locked out of the DSM-5 process.⁶ (See Appendices A and B in Gunderson [2013].)⁹ Viewed through the emotions stirred up through the DSM-5 process, people began to believe that these stereotypes were actual types. Despite the respect that most members of the PD professional community, across both the PPDWG and the PD research and clinical community, had for one another, those emotional beliefs made it more difficult for each side to hear the other.

Eventually, the work of the PPDWG culminated in a final proposal that was a reasonable compromise between a completely trait- or prototype-based proposal, which had been reflected in earlier versions, and the criteria-based diagnostic

schema of DSM-IV.⁸ In this author's opinion, this final proposal was an excellent step forward, and it was far from the radical leap that members of the APA DSM-5 review committees and the APA Board perceived it to be.^{6,10}

Yet, the way that PPDWG members were selected, the alleged secrecy of the DSM process, and the perceived pressure on the PPDWG to produce a radical revision of what was known formerly as Axis II created considerable suspicion among PD researchers not involved in the process.⁶

No doubt mistakes were made, but they were probably more misguided decisions by the DSM Task Force than deliberate manipulations of the process. One of these misperceptions was that the Task Force deliberately composed the PPDWG to achieve the outcome they wished—namely, a dimensional model developed not from clinical work in psychiatry but from factor-analytic studies performed in academic clinical psychology. The PD research and clinical community resisted the direction of the PPDWG. What the former group wanted was a diagnostic schema that would help their patients by furthering how to understand and treat them better. Many members of the PPDWG, however, felt that the only way to learn how better to treat those patients was by fostering new research within the PDs. That research would help redefine diagnosis by employing traits and dimensions that were the products of studies from trait psychology. Each group felt that they had the best approach.

The idea of adopting a radically different system for diagnosis in DSM-5 was put forth with the hope that it would apply to all of the diagnostic categories in DSM-5,⁴ but it appears, in retrospect, that only the PPDWG took the task seriously. Why the PPDWG but not other work groups did so cannot be explained by the author since he was not on the committee during the period that the PPDWG debated this issue. It was claimed that the old (DSM-IV) diagnostic schema for PDs was radically flawed.³ Yet these same flaws could be found across all psychiatric diagnoses—for example, the lack of specific laboratory tests or markers for any diagnosis, high rates of comorbidity within and across diagnostic groupings and also across Axes I and II, lack of stability of diagnoses over time even for relative brief periods, and lack of specific treatments for specific diagnostic groups.^{3,4,9,10} More specific to the PD diagnostic categories, there were complaints of poor and arbitrarily set cutoffs and thresholds for the number of criteria necessary in the current (DSM-IV) polythetic categorical model.^{11,12} It was proposed that those flaws precluded careful research because the criteria-based model of DSM-III and -IV represented a compromise between neo-Kraepelinian psychiatry and psychoanalysis.¹³ Because of extensive comorbidities and the overuse of PD-NOS (PD not otherwise specified), too many patients did not fit cleanly into the current diagnostic schema—a situation that hindered research.¹³

Although these problems plague PD diagnosis, they also plague almost all other psychiatric diagnoses—and certainly

those that encompass the categories of mood and anxiety disorders. Further, when the PPDWG was meeting, few data supported the idea that dimensional diagnoses would lead either to cures for patients or, if not cures, at least to “better” research and treatment.¹⁴ Some PPDWG members asserted that the PD diagnostic categories established in prior editions of the DSM were ultimately destructive to, and stood in the way of advancing psychiatric knowledge through, systematic research.¹³

Thus, although potentially only the product of an emotionally driven impression or distortion, many felt that both the organizers of DSM-5 and the DSM-5 Task Force, in their desire for a dimensional model, were uninterested in what had gone before; that is, they were uninterested in how the various diagnoses within the PD category had developed. But if so, then the question must be asked, but cannot be answered, as to why that idea seemed so much more important when applied to the PDs? Many psychiatrists would surely subscribe to the idea that what has gone before has a great influence on, and can provide a good deal of clarification in understanding, the present. Many felt that the dimensional model thoroughly dismissed that past because the past was one of categorical classification. What was to happen to the 30 years of solid empirical research embedded in that categorical past? It should not, many thought, be so easily dismissed.

This apparent dismissal of past work on PD diagnosis was reinforced when the perception developed that the PPDWG’s decisions were being made primarily behind closed doors. And a lack of transparency seemed to characterize the whole DSM-5 endeavor. Unlike DSM-IV,⁸ where there were over 100 advisers to the 9 members of the Personality Disorders Work Group, there were only 8 advisers to the 11 members of the current PPDWG. And those advisers to DSM-5 served no more than a year at a time. In the DSM-IV process, the 100 advisers were regularly kept up-to-date as to how the work was progressing. They were often queried for opinions to help resolve what were thought to be complicated issues that the committee had trouble deciding. In DSM-5, opinions were not solicited in a regular fashion from most of the PD research and clinical community. While presentations were made at meetings, and discussions were open, the feeling and the experience of those not involved in the PPDWG process was that they really were locked out and that their expertise, wisdom, and experience were not of value.⁶ The perception was that what was happening in the committee room was kept secret and that what was released was quite controlled, even though the DSM-5 Task Force disagreed with that impression.^{15,16} All available information was supposedly posted on the DSM5.org website, but the information on that website felt very limited. Rumor was that members of the work group were instructed not to discuss the work or process until the first draft was ready for publication on the website, though as stated above, presentations were made, and discussions did take place. But it still felt like exclusion when compared to the DSM-IV process, especially since each of the few

advisers to the PPDWG had to be vetted by the overall DSM-5 leadership.

The continuing impression was that many of the details of the workings and deliberations of the PPDWG remained unavailable, though some of the discussions and deliberations have slowly come to light since the publication of DSM-5 (see Appendix). It is unfortunate that most of the articles listed there were published only after DSM-5 went to print. One hopes that we will learn even more as we go forward to DSM 6.0 so we might benefit from understanding the deliberations and compromises and struggles. In truth, many do not really know how the final decisions were made even for DSM-IV. But in the emotion-ridden climate surrounding DSM-5 PDs, the contrast between what should have happened and what was perceived as happening was a recurrent theme even if, in fact, the contrast was more myth than reality.

PPDWG members worked very hard throughout the process, took their task seriously, tried to reach a workable consensus, and tried to produce a user-friendly, research-informed, collaborative document (even though it did not appear that way to those who were not on the PPDWG). After feedback from the Scientific Review Committee and Clinical Public Health Committee, the PPDWG was willing to modify and adjust, taking into consideration the criticisms and input they had received both from those outside the process and from the two review committees. The PPDWG hoped that its final proposal would bridge the gap between the old criteria-based system and a new approach using traits—if not to make the diagnosis, then to inform and elaborate upon the diagnosis, with the consequence that fewer data about the patient would be lost.

Despite the above, some outside the PPDWG—on both sides of the argument—felt that compromise was not necessary. To some, it would be antithetical to the scientific truth that resided in some form within the dimensional system. To others, the truth lay in further refinement of DSM-IV’s criteria-based diagnoses because those criteria were simply translations of many of the psychodynamic and object relations “facts” that had been known for close to a half a century. Ironically, each side seemed to harden its position even while the committee itself was working hard to make the overall changes much more palatable to those in the PD research and clinical community. The PPDWG wanted its proposal to be viewed as a relatively small step away from DSM-IV, and in actuality it was. But the disagreements, especially outside the PPDWG, nonetheless seemed to devolve at times into each side feeling that they occupied not only the “right” position but the only “true” position.⁶

The idea persists that if we could get the diagnostic system correct, we would be much closer to how these various disorders actually are in nature; this is the old idea of carving nature at its joints.¹⁷ But such a putative classification, if it exists at all, appears to be an elusive goal. The mind has so

many connections with so many different neurotransmitters and neuroendocrinological compounds, each impinging on the other, that it seems that these reductionistic attempts are doomed to fail. And often when we think that we have succeeded, the research and laboratory successes have not translated readily into clinical success. Take, for example, the concept that impulsivity or impulsive aggression is related to low serotonin levels. That idea has been proven over and over again with respect to many different types of behavior, from fire setting to male aggressive impulses.¹⁸ We have neuroimaging studies and pharmacologic challenge studies that reinforce those findings.^{18–20} Yet, when we translate those findings into a pharmacologic treatment that is known to increase the amount of serotonin available at the neural junction, we find that, while the theory works in the lab, *in vitro*, it does not always or often work very well in people, *in vivo*.^{21,22} Most researchers who work in the field of PDs would agree that we know too little about the brain and its complexities to know how nature did carve, if it actually did carve, at the joints (or even if there are joints).²³ Some of the words and positions taken in the commotion around how best to diagnose PDs suggest the intellectual hubris on both sides.²⁴ At present, there is no truth here. The truth may eventually emerge, but at present we have primarily theoretical constructs and individuals who more or less strongly defend and research those various and differing constructs.

Despite all the emphasis on changing the prevailing DSM system only if there was empirical support for the change, the APA failed to fund a PPDWG-proposed field trial that would have, among other things, evaluated the “internal consistency, discriminant validity, structural relationships, and relationships to adaptive functioning” of the proposed model relative to DSM-IV.³ The DSM-5 leadership decided against funding this trial even though it was designed to address exactly the question that the DSM-5 leadership wished to answer. The trial would have evaluated whether clinicians accepted this DSM-5 diagnostic schema, whether the schema was user friendly, and whether it would identify more or less of the same patients that DSM-IV identified. In their rush to publish DSM-5 by the promised date, the DSM Task Force refused to gather from appropriate clinical field trials the very data needed to decide whether the proposed changes met the criteria for change as outlined prior to the formation of the PPDWG.²⁵ A pared-down version of the PPDWG’s rejected request for a field trial was submitted to the NIMH, but despite the proposal’s fine priority score, it was denied funding because the NIMH felt that the APA should be responsible for funding tests regarding DSM-5.³ Since the APA reiterated that it did not have monies to fund the trial, the trial was not conducted; in drafting its final proposal on PDs, the PPDWG had insufficient data available (though some data were available) to persuade the DSM-5 review committees that more radical change was justified.

THE FUTURE

This commentary is a personal one. Most of the issues and disagreements around how best to diagnose PDs now seem to have been elucidated and are out in the open. Both sides represented in the Appendix—the PPDWG and the PD research and clinical community—should join together to develop and implement studies that not only might lessen the disagreements but also provide us with data that will help move the profession and this field forward.

John Gunderson, who was the “lead” author of two letters that opposed the course, manner, and overall process that the PPDWG was undertaking, also wrote an article “Seeking Clarity for Future Revisions of the Personality Disorders in DSM-5.”⁹ In the article he enumerates a number of the benefits or perhaps new insights that arose from the PPDWG DSM-5 process even though the diagnostic revisions were not accepted. To summarize, he stated that awareness of the strengths and weaknesses of our current way of considering PDs and their relationship to normal personality was increased. New information about the other side of the argument was introduced to each side and can no longer be ignored. Defining PDs in terms of self and interpersonal relationships, which Gunderson felt was premature, brought the concept of personality back to object relations and object relations theory—which is where many of the ideas about how to conceptualize PDs originally took hold.²⁶

In this author’s opinion, reemphasizing patients’ interpersonal styles in relating to others could force people who are evaluating patients for PDs to sit back and listen to the patient. The interviewer can then try to decipher how the patient is relating to the interviewer and how that relating may or may not be characteristic of the patient’s interpersonal relationships and also of the patient’s way of thinking about himself or herself. The introduction of the trait system, along with the consideration of a patient’s personality in terms of traits—whether in addition to, or as a replacement for, specific criteria—will allow us to better define our patients and fill in the gaps with trait descriptions. Dimensions might be more scientifically valid than arbitrary cutoffs in a polythetic, criteria-based system. Such an approach would potentially diminish the amount of lost clinical data. We need more research to explore this dimensional approach and more empirical studies to determine at what threshold a person should be defined as having a disorder—in lieu of the random cutoffs that were put in place for DSM-III and DSM-IV.^{11,12}

Gunderson further suggests that establishing structures, procedures, and processes for consideration of these issues would not only help to guide future change but also improve the likelihood that the needed changes would be accepted. In addition, he suggests a review process that is inclusive of those people who have been involved in the treatment and study of patients with PDs. In addition to raising and vetting issues thought to be relevant, such a process would help to achieve buy-in from different theoretical points and would enable presenting a unified face to the rest of psychiatry and psychology.

Needless to say, all of the suggestions, data, and theories should also be informed by field trials that are expressly designed to unravel the issues raised by a particular diagnostic grouping and the proposed changes in that grouping.⁹ These goals are admirable, to be sure, though they were not achieved in drafting either previous editions or the present edition of the DSM. The struggles and conflicts and disagreements that swirled around the DSM-5 PPDWG have led, however, to new studies attempting to answer some of the particular questions that many hoped would have been settled prior to the publication of DSM-5.

CONCLUSION

If we are to move forward and to continue to have civil interchanges that bring together the best minds from all over the world who are struggling to understand these perplexing conditions that we still label PDs, we cannot let ourselves be split apart by disagreements over diagnosis or by the academic hubris attendant to our own research and opinions. It is important not only to figure out the specific diagnostic issues but also how to approach diagnosis in general. Ultimately, the bottom line should be the delivery of good treatment to our patients with PDs. Have the DSM-5 processes and struggles led to better treatment for patients with PDs, or have they been distractions from the need to develop and produce more clinicians with greater knowledge and comfort in delivering effective treatments to those patients?²⁷ If we think we are right and already know all the answers, and if we simply set out to prove we are right, then curiosity and inquiry cease. We stop moving forward. And while we ultimately may be right about the facts—whatever that means—our patients will continue to suffer.

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APPENDIX

**Key Articles from Special Issues of Psychiatry and Psychology Journals Addressing
DSM-5 Issues Regarding Personality Disorders**

Journal of Personality Assessment, Volume 93, Number 4 (2011):

Krueger RF, Eaton NR, Derringer J, Markon KE, Watson D, Skodol AE. Personality in DSM-5: helping delineate personality disorder content and framing the metastructure. *J Pers Assess* 2011;93:325–31.

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