Personality Disorders
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Outline
1. Brief Historical Personality Disorders Review
2. Borderline Personality Disorder
   a. Phenomenology
   b. Neurobiology
   c. Treatment
   d. Longitudinal Course
3. DSM-5

Disclosure Statement
The speaker has no conflicts to disclose
Personality Types or Temperaments
(Bleuler, Kraepelin, Kretschmer)
- Precursors or less extreme forms of psychotic conditions
e.g.
  - Aesthenic
  - Autistic
  - Schizoid
  - Cyclothymic
  - Cycloid

Psychopathic Personalities
(Schneider)
- Separate disorders, co-occurring with other psychiatric disorders
- Similar to current DSM categorical model

DSM-I (1952)
Personality Pattern Disturbances
The most entrenched, unlikely to change, even with treatment
- Inadequate
- Schizoid
- Cyclothymic
- Paranoid

DSM-I (continued)
Personality Trait Disturbances
- Least pervasive and disabling
- Absent stress, function ok
- With stress, deterioration in functioning
- Variably motivated and amenable to treatment
  - Emotionally unstable
  - Passive-aggressive
  - Compulsive
DSM-I (continued)
Sociopathic Personality Disturbances
- Types of social deviance
  - Antisocial reaction
  - Dyssocial reaction
  - Sexual deviation
  - Addiction

DSM-II (1968)
- Earlier view that patients with PDs did not experience emotional distress was discarded
- DSM-I subcategories were discarded
- One new PD, Aesthetic PD, added

DSM-III (1980)
- Introduced multiaxial system
- Axis I = episodic, "biological" disorders characterized by exacerbations and remissions
- Axis II = personality disorders + mental retardation
  - MR = "biological" etiology
  - PDs = "psychological" etiology

DSM-III (continued)
- Inadequate PD and Aesthetic PD discontinued
- Explosive PD and Cyclothymic PD → Axis I
- Schizoid PD → Schizoid, Schizotypal, and Avoidant PDs
- Borderline PD and Narcissistic PD added
**DSM-III-R (1987)**

- Appendix = "Proposed Diagnostic Categories Needing Further Study"
- Included:
  - Self-defeating PD
  - Sadistic PD
  - Dimensional cluster system introduced

**DSM-IV (1994)**

- Dropped Self-defeating PD and Sadistic PD
- Moved Passive-aggressive PD to Appendix
- Added Depressive PD to Appendix


- No changes from DSM-IV in diagnostic terms or criteria for Axis II
- Only minimal revisions in text material for Axis II
DSM-IV Definition of Personality Disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. This pattern is manifested in two (or more) of the following areas:
   1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
   2. Affectivity (i.e., the range, intensity, ability, appropriateness of emotional response)
   3. Interpersonal functioning
   4. Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
DSM-IV Definition of Personality Disorder

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

DSM-IV Definition of Personality Disorder

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

DSM-IV-TR Personality Disorders

(A "dimensionally-flavored" categorical system)

A. Cluster A (odd/eccentric)
   1. Paranoid
   2. Schizoid
   3. Schizotypal

B. Cluster B (dramatic/emotional/impulsive)
   1. Antisocial
   2. Borderline
   3. Histrionic
   4. Narcissistic

C. Cluster C (anxious/fearful)
   1. Avoidant
   2. Dependent
   3. Obsessive-Compulsive

D. Personality Disorder Not Otherwise Specified

Brief Review of Borderline Personality Disorder
Borderline Personality Disorder (BPD)  
**APA DSM-IV Criteria**  
(At least 5 must be present)

1. Fear of abandonment
2. Difficult interpersonal relationships
3. Uncertainty about self-image or identity
4. Impulsive behavior
5. Self-injurious behavior
6. Emotional changeability or hyperactivity
7. Feelings of emptiness
8. Difficulty controlling intense anger
9. Transient suspiciousness or “disconnectedness”

Heterogeneity of BPD
- DSM-IV - defined BPD is an extremely heterogeneous construct (Est. 256 varieties)
- Mix of unstable, stress-induced symptoms and stable personality characteristics (i.e., dimensional traits)

Comorbidity
- 84.5% of BPD patients met criteria for Axis I disorder, mean = 3.2
- Most common =
  - Mood disorders
  - Anxiety disorders
  - Substance use disorders

Patients with BPD Have Severe Impairment in Functioning
- Common history of childhood trauma
- Mistrustful of others, yet cling to others for “life support”
- High internal levels of anxiety and distress
- Stormy interpersonal relationships
- High family stress
- Difficulty keeping jobs
- Overemotional and impulsive
- Self-injurious behavior

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Lenzenweger et al., Biol Psychiatry, 2007
High Suicide Risk in Patients with BPD
8 – 10 % commit suicide
60 – 70 % make suicide attempts

Risk Factors for Suicidal Behavior in Patients with Borderline Personality Disorder
- Prior suicide attempts
- Co-morbid mood disorder
- High levels of hopelessness
- Family history of completed suicide or suicidal behavior
- Co-morbid substance abuse
- History of sexual abuse
- High levels of impulsivity and/or antisocial traits

Risk Factor - Oldham, AJP 2006

Neurobiology of BPD

Brain Structure and Function in BPD
- Review of neuroimaging studies of BPD
- Main findings:
  - ↓ volume of hippocampus, amygdala
  - ↑ amygdala activity 2º to emotion-related stimulus

Amygdala-Prefrontal Disconnection in BPD

**Normal:**
Prefrontal cortex → inhibitory control over amygdala

**BPD:**
Absence of normally tight coupling
= disconnect between orbital frontal cortex and amygdala
→ failure to downregulate amygdala in response to aversive stimuli

- New et al., 2007

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Social Baseline Theory and BPD

- Assumption: people are hardwired to assume close proximity to others, and to utilize social proximity as a baseline affect regulation strategy
- SBT principles:
  1. Early attachment = initial source of co-regulation (fostering neural links between prefrontal cortex and limbic system)
  2. These neural structures support capacity for self-control, and for attachment and maintenance of friendship bonds
  3. Frontolimbic circuits implicated in adult attachment formation, trust, affiliation, and attraction
- These crucial neural structures are impaired in patients with BPD

-Hughes et al., J Abnorm Child Psychol, 2012
Heritability of BPD
- Twin study (Torgersen et al. 2000)
- Novelty seeking (Cloninger, 2005)
- Impulsivity (New and Siever, 2002)
- Dopamine transporter polymorphism (Joyce et al., 2006; Tadic et al., 2009)
- Serotonin transporter gene (Ni et al., 2006, 2009)
- MAO-A gene (Ni et al., 2007)
- BDNF polymorphism (Wagner et al., 2010)
- Norwegian Twin Registry (Kendler, 2011)

Heritability of Psychiatric Disorders

<table>
<thead>
<tr>
<th>Heritability</th>
<th>Psychiatric Disorders</th>
<th>Other Important Familial Traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>~zero</td>
<td>Anxiety disorders, Depression, Bulimia, Personality Disorders</td>
<td>Language, Religion</td>
</tr>
<tr>
<td>20-40%</td>
<td>Alcohol and drug dependence</td>
<td>Myocardial Infarction, Normative Personality, Breast Cancer, Hip Fracture</td>
</tr>
<tr>
<td>40-60%</td>
<td>Schizophrenia, Bipolar Illness</td>
<td>Blood Pressure, Asthma, Plasma cholesterol, Prostate Cancer, Adult-onset diabetes</td>
</tr>
<tr>
<td>60-80%</td>
<td>Autism</td>
<td>Weight, Bone Mineral Density</td>
</tr>
<tr>
<td>80-100%</td>
<td>Autism</td>
<td>Height, Total Brain Volume</td>
</tr>
</tbody>
</table>

Heritability of DSM-IV PDs
- As measured by structured interview, PDs are modestly heritable
- Correcting for measurement error, however, they are at least moderately heritable
- No evidence for shared environmental effects for PDs

Kendler, 2011
Cluster B
- More complex
- Two genetic factors
- Genetically, BPD and ASPD share risk factors above and beyond a general common genetic factor to cluster B disorders
- That is, BPD and ASPD have a common genetic risk factor that does not impact on Histrionic and Narcissistic PD

Kendler, 2011

Key Phenotypic Features of BPD with Identified Neural Correlates

Ecological Momentary Assessment (EMA) and BPD
- EMA = computer-based “real time” assessment of current affective states and other variables
- Heightened affective instability in BPD patients
- Stress-related dissociative and paranoid symptoms demonstrated
- Social interactions — ↑ negative and ambivalent emotions, ↓ positive emotions

Santangelo, Bohus, & Fribner-Primer, JPD, 2012

Pain-Mediated Affect Regulation in BPD
- In BPD, pain increases the inhibition of limbic activity by prefrontal areas
- Painful stimuli may enhance emotion regulation in BPD

The Rupture and Repair of Cooperation in BPD

- BPD patients → profound incapacity to maintain cooperation → impaired ability to repair broken cooperation
- Altered activity of anterior insular cortex in BPD
- Norms used in perception of social gestures are pathologically perturbed or missing altogether in BPD

- King-Casas et al., Science, 2008

Oxytocin and Trust in BPD

- Bartz, Simeon, Hamilton, Kim, Crystal, Braun, Vicens, Hollander, SCAN, 2011

Sequential Theoretical Model of BPD Pathogenesis

- Insecure Attachment
- Endophenotypes
  - Impulsive aggression
  - Affect instability

Unstable Interpersonal Relationships

- Excessive intensity
- Overvalued Expectations
- Unfounded Anxieties
- Cognitive-Perceptual Symptoms

Oldham, AJP, 2009

Theoretical Model of BPD Symptom Expression

- Heritable Risk
  - Negative Affectivity
  - Emotional sensitivity
  - Impulsivity

- Stimulus
  - Interpersonal interactions
  - Social stress

- Compensatory (?) Efforts to Control Distress
  - Self-inflicted pain
  - Dissociation
  - Rejection of / distancing from others
  - Suicide

- Highly Symptomatic State
  - Emotional distress
  - Paranoid thinking
  - Suicidal ideation / behavior
  - Impulsive behavior

Oldham, 2013
APA Practice Guidelines Work Group on Borderline Personality Disorder

John Oldham, M.D. (Chair)
Glen Gabbard, M.D.
Marcia Goin, M.D., Ph.D.
John Gunderson, M.D.
Paul Soloff, M.D.
David Spiegel, M.D.
Michael Stone, M.D.
Katherine Phillips, M.D.

APA Treatment Recommendations for Patients with Borderline Personality Disorder

Evidence-based Treatment Strategies for BPD

Psychotherapy (core treatment)
Pharmacotherapy (adjunctive, symptom-targeted)

Types of Psychotherapy for BPD (published RCTs)

1. Mentalization-Based Therapy (MBT)
2. Dialectical Behavior Therapy (DBT)
3. Schema-Based Therapy (SBT)
4. Transference-Focused Therapy (TFT)
5. Generalized Psychiatric Management (GPM)
6. Cognitive Behavioral Therapy (CBT)
7. Systems Training for Emotional Predictability and Problem Solving (STEPPS)
U.K. National Institute for Health and Clinical Excellence (NICE)

NICE Clinical Guideline #78
Borderline Personality Disorder
January 2009
• Psychotherapy
  1. ≥ 3 months
  2. Recommended twice weekly
• Pharmacotherapy
  • Do not use “specifically for BPD”

Australian Draft Clinical Practice Guideline (CPG) for the Management of Borderline Personality Disorder

National Health and Medical Research Council
Australian Government

(Open for comment until May 14, 2012)

Australian BPD CPG

1. Psychotherapy
• There is a range of structural psychological therapies that are effective in the treatment of BPD, compared to treatment as usual:
  • CBT
  • DBT
  • EBT (Emotive Regulation Training)
  • MACT (Manual-Assisted Cognitive Therapy)
  • MBT
  • MOTR (Motive-Oriented Therapeutic Relationship)
  • SFP
  • STEPPS
  • TFP

2. Pharmacotherapy
• “Overall, pharmacotherapy did not appear to be effective in altering the nature and course of the disorder”
• “Evidence does not support the use of pharmacotherapy as a first-line or sole treatment for BPD”
Collaborative Longitudinal Personality Disorders Study (CLPS)

- 5 Collaborative Sites
  Brown (Shea), Columbia (Skodol), Harvard (Gunderson), Yale (McGlashan), Texas A&M (Morey)
- 668 Patients Recruited Originally (+65)
  STPD (N= 86), BPD (N=175), AVPD (N= 138), OCPD (N= 154), MDD and no PD (N= 95)
- Followed Longitudinally for >14 Years
  To determine the stability of symptoms, diagnoses, dimensions, and functioning and to determine the predictors of clinical course

BPD Remission (cumulative): Lifetest survival estimates

Functional Remission (GAF > 70 for 12 months): Lifetest survival estimates

Remission definition:
- BPD ≥ 12 mo
“Ten Year Rank-order Stability of Personality Traits and Disorders in a Clinical Sample”

• “...corrected stability estimates were generally in the range of .60-.90 for traits and .25-.65 for personality disorders.”
• “In summary, this study showed that personality traits were substantially more consistent than PDs in a clinical sample followed over ten years.”

- Hopwood CJ et al., Journal of Personality, 2012

Stability of BPD Remission: A 16-year Prospective Follow-up Study

• BPD patients slower to remit or recover than Axis II comparison subjects
• By year 16, high rates of remission by both groups, but less so for BPD recovery (defined as good social and vocational functioning)
• Sustained remission and recovery substantially more difficult for BPD than other PDs

Zanarini et al., AJP, 2012

DSM-5 Proposed PD Diagnostic System

“Well-informed clinicians and researchers have suggested that variation in psychiatric symptomatology may be better represented by dimensions than by a set of categories, especially in the area of personality traits...”

- Bruce J. Rounsaville, MD
- Renato D. Alarcon, MD
- Gavin Andrews, MD
- James S. Jackson, PhD
- Robert E. Kendell, MD
- Kenneth Kendler, MD

(A Research Agenda for DSM-5, APA, 2002)
Alternative Dimensional Models of Personality Disorders: Finding a Common Ground

“The limitations of the categorical model of personality disorder classification are well recognized.”


“The Diagnosis of Mental Disorders: The Problem of Reification”

“Disorders in which evidence favors a dimensional approach include major depression (Kendler & Gardner 1998), obsessive-compulsive disorder (Mataix-Cols et al. 2005), autism (Qi Martino et al. 2009, Hoekstra et al. 2007), attention deficit hyperactivity disorder (ADHD; Hudziak et al. 2005), and personality disorders (Skodol et al. 2002a,b). For all these diagnoses, symptoms listed in their criterion sets are also normally distributed in the general population. The dimensional nature of personality disorders has long been argued (Skodol et al. 2002a,b; Widiger & Mullins-Sweatt 2009).”

-Hyman, Steven E

Recent Wisdom

“Generally, our approach to modifying psychiatric diagnoses is like a small mutation. We consider adding a criterion...simplifying criteria...or changing duration. These small changes are like the small steps of an iterative evolutionary process. But maybe the place we started with a diagnosis is like an evolutionary box canyon. Small changes cannot fix it. We need a big re-design. According to some experts, this is the position in which personality disorders in DSM-IV finds itself.”

DSM-5 PDs

- Personality and Personality Disorders Work Group took its APA charge seriously, and it was not easy!
- Challenges included:
  - Factor-analytic trait psychology research is extensive, and terms are often unfamiliar to clinicians
  - Vested interests of various research groups, clinical experts, and educators

Elements of Personality Functioning

**Self**

1. **Identity**: Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.
2. **Self-direction**: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively.

**Interpersonal**

1. **Empathy**: Comprehension and appreciation of others’ experiences and motivations; tolerance of differing perspectives; understanding the effects of own behavior on others.
2. **Intimacy**: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

DSM-5 General Criteria for Personality Disorder (GCPD)

The essential features of Personality Disorder are:

A. Moderate or greater impairment in personality (self / interpersonal) functioning AND
B. Pathological personality traits

Criterion A:

*Level of Impairment in Personality Functioning*

Moderate or greater impairment in personality functioning, manifest by characteristic difficulties in two or more of the following four areas:

1. Identity
2. Self-direction
3. Empathy
4. Intimacy
Guidance in estimating “moderate or greater impairment”:

Level of Impairment Scale

0 - Little or No Impairment
1 - Some Impairment
2 - Moderate Impairment
3 - Severe Impairment
4 - Extreme Impairment

Criterion B:
(Patterns of Pathological Personality Traits)

Trait Domains

- Negative Affectivity
- Detachment
- Antagonism
- Disinhibition
- Psychotism

Personality Disorder Types

References to DSM-IV Personality Disorders in Scientific Literature 1994-2010
Personality Disorders
- Antisocial
- Avoidant
- Borderline
- Narcissistic
- Obsessive-Compulsive
- Schizotypal
- PD – Trait Specified

Personality Disorder – Trait Specified

**Criterion A:** Moderate or greater impairment in personality functioning, manifest by characteristic difficulties in two or more of the following four areas:
1. Identity
2. Self-direction
3. Empathy
4. Intimacy

** Criterion B:** One or more pathological personality trait domains OR specific trait facets within domains, considering **ALL** of the following domains:
1. Negative Affectivity
2. Detachment
3. Antagonism
4. Disinhibition
5. Psychoticism

**Negative Affectivity (vs. emotional stability)**
Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, anger, etc.), and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations.
1. Emotional lability
2. Anxiousness
3. Separation insecurity
4. Submissiveness
5. Hostility
6. Perseveration
7. Depressivity
8. Suspiciousness
9. Restricted affectivity

**Detachment (vs. extraversion)**
Avoidance of socio-emotional experience, including both withdrawal from interpersonal interactions ranging from casual, daily interactions to friendships to intimate relationships as well as restricted affective experience and expression, particularly limited hedonic capacity.
1. Withdrawal
2. Intimacy avoidance
3. Anhedonia
4. Depressivity
5. Restricted affectivity
6. Suspiciousness
**Antagonism (vs. agreeableness)**

Behaviors that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both unawareness of others’ needs and feelings, and a readiness to use others in the service of self-enhancement.

1. Manipulativeness
2. Deceitfulness
3. Grandiosity
4. Attention seeking
5. Callousness
6. Hostility

**Disinhibition (vs. conscientiousness)**

Orientation towards immediate gratification, leading to impulsive behavior driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences; the opposite pole of this domain reflects excessive constraint of impulses, risk avoidance, hyperresponsibility, hyperperfectionism, and rigid, rule governed behavior.

1. Irresponsibility
2. Impulsivity
3. Distractibility
4. Risk taking
5. (lack of) Rigid perfectionism

**Psychoticism (vs. lucidity)**

Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception, dissociation) and content (e.g., beliefs).

1. Unusual beliefs and experiences
2. Eccentricity
3. Cognitive & perceptual dysregulation

**Example**

**Borderline Personality Disorder**
Borderline Personality Disorder

Typical features of Borderline Personality Disorder are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk-taking, and/or hostility. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domain of Negative Affectivity, and also Antagonism and/or Disinhibition.

Borderline Personality Disorder (continued)

Criterion A:
Moderate or greater impairment in personality functioning, manifest by characteristic difficulties in two or more of the following four areas:

1. **Identity**: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
2. **Self-direction**: Instability in goals, aspirations, values, or career plans.
3. **Empathy**: Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
4. **Intimacy**: Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between over-involvement and withdrawal.

Borderline Personality Disorder (continued)

Criterion B:
Four or more of the following seven pathological personality traits (including at least one of the following: #5 Impulsivity, #6 Risk taking, or #7 Hostility):

1. **Emotional lability** (an aspect of Negative Affectivity): Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
2. **Anxiousness** (an aspect of Negative Affectivity): Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
3. **Separation insecurity** (an aspect of Negative Affectivity): Fears of rejection by—and/or separation from—significant others, associated with fears of excessive dependency and complete loss of autonomy.
4. **Depressivity** (an aspect of Negative Affectivity): Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.
5. **Impulsivity** (an aspect of Disinhibition): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.
**Borderline Personality Disorder (continued)**

**Criterion B:**

6. **Risk taking** (an aspect of **Disinhibition**): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one’s limitations and denial of the reality of personal danger.

7. **Hostility** (an aspect of **Antagonism**): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

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**Clinical Usefulness of the DSM-5 Diagnostic Criteria for Personality Disorders**

- Research from the WG Morey et al. study
- Results from the DSM-5 Field Trials in Academic Centers and Routine Clinical Practices

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**Morey et al. WG Study**

A recent empirical study involving 334 clinicians found that in 14 of 18 comparisons, **DSM-5 is perceived as more clinically useful** than DSM-IV with respect to:

- Ease of use
- Communication of clinical information to other professionals
- Communication of clinical information to patients
- Comprehensiveness in describing pathology
- Treatment planning

Morey et al., 2012

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**Field Trials Data**
Clinicians in Academic vs. RCP FT

Over 80% of clinicians in the Academic and Routine Clinical Practice (RCP) field trials found the new PD criteria “moderately” to “extremely” useful compared to DSM-IV.

Clinicians in DSM-5 Field Trials in Academic Centers found the new diagnostic criteria for personality disorders moderately to extremely useful, compared to DSM-IV, when diagnosing patients seen for the first time for a single diagnostic interview.

- Regier et al., AJP, 2012
DSM-5 PDs

- **Frequently heard concerns** – “It’s too complex, and clinicians won’t use it.”
- **“Reality check”** - DSM-5 proposed 25 traits, compared to 94 criteria in DSM-IV (43% reduction)
- **Interpretation** – “It’s more complicated than what I now do”

### Final PD Proposal Presented to DSM-5 Task Force in October, 2012

Strongly and unanimously endorsed and approved

However,

- Review groups had concern that proposal too complex and unfamiliar, objected to by many leaders in the PD field
- Board of Trustees voted to approve PD proposal for Section III, not Section II
Final DSM-5 Table of Contents

DSM-5 Table of Contents

Section I
1. Task Force on DSM-5
2. Work Groups on DSM-5
3. Preface (includes Acknowledgments)
4. Introduction
5. Use of DSM-5 (includes Cautionary Statement)
6. DSM-5 Classification

Section II
1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma- and Stressor-Related Disorders
8. Dissociative Disorders
9. Somatic Symptom and Related Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse Control, and Conduct Disorders
16. Substance Related and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilic Disorders
20. Other Mental Disorders
New features and enhancements make DSM-5 easier to use across all settings:

The chapter organization reflects a lifespan approach, with disorders typically diagnosed in childhood (such as neurodevelopmental disorders) at the beginning of the manual, and those more typical of older adults (such as neurocognitive disorders) placed at the end. Also included are age-related factors specific to diagnosis.

Boyce N: “The First Flight of DSM-5”
The Lancet 377(9780), 1816-1817, May 28, 2011

“...The proposed structure is broadly in line with the human life-cycle, a sort of psychiatric seven ages of man... It is, however, disappointing that the proposed structure breaks its own rules in placing personality disorders after neurocognitive disorders. Surely an aetiological, chronological approach should lead to their appearance at a far earlier stage in the text?”
DSM-5: A Work Now Complete
DSM-5.1: A Work in Progress

Thank you for your interest