

# Personality Disorders & DSM-5

## Presentation for NEA-BPD Call-In Program

Sunday, December 16, 2012

### **John M. Oldham, M.D.**

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The Menninger Clinic;

Professor and Executive Vice Chair

Menninger Department of Psychiatry and Behavioral Sciences

Baylor College of Medicine;

Immediate Past President

American Psychiatric Association

“Personality and relational disorders are commonly encountered in outpatient mental health practice. Yet the **classification scheme offered by the DSM-IV** for both of these domains is **woefully inadequate** in meeting the goals of **facilitating communication among clinicians** and researchers or in **enhancing the clinical management** of those conditions.”

Michael B. First, MD  
Bruce Cuthbert, PhD  
John H. Krystal, MD  
Robert Malison, MD  
David R. Offord, MD

David Reiss, MD  
Tracie Shea, PhD  
Tom Widiger, PhD  
Katherine Wisner, MD, MS

(A Research Agenda for DSM-5, APA, 2002)



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“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.”

- Widiger and Simonsen, In: *Dimensional Models of Personality Disorders: Refining the Research Agenda for DSM-5* (APA, 2006)

# 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

# Dimensional Representation: Background

- Problems with DSM-IV PD categories:
  - Excessive co-occurrence of disorders
  - Heterogeneity within categories
  - Arbitrary distinctions between normal personality, abnormal traits, and disorders
  - Limited coverage of personality psychopathology
- No consensus yet on dimensional system and relative lack of data on clinical utility
- Need for continuity with familiar constructs to ensure that personality assessment is not further compromised



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## “Retention or Deletion of Personality Disorder Diagnoses for DSM-5: An Expert Consensus Approach”

“There is little question that the current diagnostic system for classifying personality disorders (PD) has been problematic.”

- Mullins-Sweatt et al.,  
*Journal of Personality Disorders*, October, 2012

## **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)

Research Agenda for DSM-V conferences (2000-02)

Official formation of DSM-5 Task Force and Work Groups (2006-08)

Final revisions to criteria reviewed by BOT; final text sent to APPI by year's end

Initial drafting of diagnostic criteria

Release of DSM-5

Anticipated release of ICD-11



APA/WHO/NIH Research Planning Conference series (2003-08)

Publication of research planning conference monographs (2007-10)

The DSM-5 Field Trials (2010-12)

Scientific Review Committee reviews select proposals and work groups begin drafting text (2011-12)



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## DSM5.org Web Site

- Open for public comment February-April 2010
  - More than 8,600 comments submitted
- All comments reviewed by work group members
- Comments considered in decision-making for field testing and later revisions to criteria in 2011



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## **DSM-5.org Posting #2 (5/4 – 7/15/2011)**

- 153,637 unique site visitors
- 219,483 unique site visits
- 1,063,895 pages viewed
- Visits came from 187 countries, with the largest number of visits coming from the US, Canada, Australia, the UK, and the Netherlands

## **DSM-5.org Posting #3 (5/2 – 6/17/2012)**

- 87,744 unique site visitors
- 114,324 unique site visits
- 448,957 pages viewed
- Visits came from 169 countries, with the largest number of visits coming from the US, Canada, Australia, and the UK

## 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.**”

- Kendler KS, Parnas J: Philosophical Issues in Psychiatry II, Oxford University Press, 2012



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## Personality and Personality Disorders DSM-5 Work Group

Andrew Skodol, MD, *Chair*

Renato Alarcon, MD

Carl Bell, MD

Donna Bender, PhD

Lee Anna Clark, PhD

Robert Krueger, PhD

John Livesley, MD

Leslie Morey, PhD

John Oldham, MD

Larry Siever, MD

Roel Verheul, PhD



## 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



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# Proposed DSM-5 Model for Personality Disorders

## **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

# 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.



## **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



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## **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

## **DSM-5 GCPD (continued)**

- C. The impairments in personality functioning and personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations.



## **DSM-5 GCPD (continued)**

- D.** The impairments in personality functioning and the individual's personality trait expression are relatively stable across time with onsets that can be traced back to at least adolescence or early adulthood.

## DSM-5 GCPD (continued)

- E. The impairments in personality functioning and the individual's personality trait expression are not better explained by another mental disorder.

## DSM-5 GCPD (continued)

- F. The impairments in personality functioning and the individual's personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma).

## **DSM-5 GCPD (continued)**

**G.** The impairments in personality functioning and the individual's personality trait expression are not better understood as normal for an individual's developmental stage or socio-cultural environment.



## 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



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## **Example**

# **Borderline Personality Disorder**



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## **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.

# Borderline Personality Disorder (continued)

## Criterion B:

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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## **Borderline Personality Disorder**

**Side-by-Side Comparison of DSM-IV  
Criteria and Proposed DSM-5 Criteria**

<b>Borderline Personality Disorder</b>	
<b>DSM-5</b>	<b>DSM-IV</b>
<p>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.</p>	<p>← <b>NOTE:</b> This is not part of the criteria, but is provided to orient clinicians to the main features of the diagnosis.</p>
<p>A. Moderate or greater impairment in personality functioning, manifest by characteristic difficulties in two or more of the following four areas:</p> <ol style="list-style-type: none"> <li>1. <b><u>Identity</u></b>: Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.</li> <li>2. <b><u>Self-direction</u></b>: Instability in goals, aspirations, values, or career plans.</li> <li>3. <b><u>Empathy</u></b>: 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.</li> <li>4. <b><u>Intimacy</u></b>: 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.</li> </ol>	<p>A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity as indicated by 5 (or more) of the following:</p> <ol style="list-style-type: none"> <li>3. Identity disturbance: markedly and persistently unstable self-image or sense of self.</li> <li>7. Chronic feelings of emptiness.</li> <li>9. Transient, stress-related paranoid ideation or severe dissociative symptoms</li> <li>2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation</li> </ol>

<p>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):</p>	
<p>1. <b><i>Emotional lability</i></b>: Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.</p>	<p>6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)</p>
<p>2. <b><i>Anxiousness</i></b>: 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.</p>	
<p>3. <b><i>Separation insecurity</i></b>: Fears of rejection by—and/or separation from—significant others, associated with fears of excessive dependency and complete loss of autonomy.</p>	<p>1. Frantic efforts to avoid real or imagined abandonment. <b><i>Note</i></b>: Do not include suicidal or self-mutilating behavior covered in Criterion 5.</p>
<p>4. <b><i>Depressivity</i></b>: 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.</p>	<p>5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior</p>

<p>5. <b><i>Impulsivity</i></b>: 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.</p>	<p>4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). <b>Note:</b> Do not include suicidal or self-mutilating behavior covered in Criterion 5.</p>
<p>6. <b><i>Risk taking</i></b>: 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.</p>	
<p>7. <b><i>Hostility</i></b>: Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.</p>	<p>8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)</p>
<p>C. The impairments in personality functioning and the individual’s personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations.</p>	<p>In Criterion A: “...present in a variety of contexts.” also: <u>GCPD Criterion B</u>: The enduring pattern is inflexible and pervasive across a broad range of personal and social situations. <i>(Repeated here to show parallelism; not actually repeated in DSM-IV, except for the above phrase).</i></p>
<p>D. The impairments in personality functioning and the individual’s personality trait expression are relatively stable across time with onsets that can be traced back at least to adolescence or early adulthood.</p>	<p>In Criterion A: “...beginning by early adulthood...” also: <u>GCPD Criterion D</u>. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood. <i>(Repeated here to show parallelism; not actually repeated in DSM-IV, except for the above phrase).</i></p>

<p>E. The impairments in personality functioning and the individual's personality trait expression are not better explained by another mental disorder.</p>	<p><u>GCPD Criterion E:</u> The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder. <i>(Repeated here to show parallelism; not actually repeated in DSM-IV.)</i></p>
<p>F. The impairments in personality functioning and the individual's personality trait expression are not attributable to a substance (e.g., a drug of abuse, medication, exposure to a toxin) or a general medical condition (e.g., severe head trauma).</p>	<p><u>GCPD Criterion F:</u> 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) <i>(Repeated here to show parallelism; not actually repeated in DSM-IV.)</i></p>
<p>G. The impairments in personality functioning and the individual's personality trait expression are not better understood as normal for the individual's developmental stage or socio-cultural environment.</p>	<p><u>GCPD Criterion A:</u> An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. <i>(Repeated here to show parallelism; not actually repeated in DSM-IV.)</i></p>



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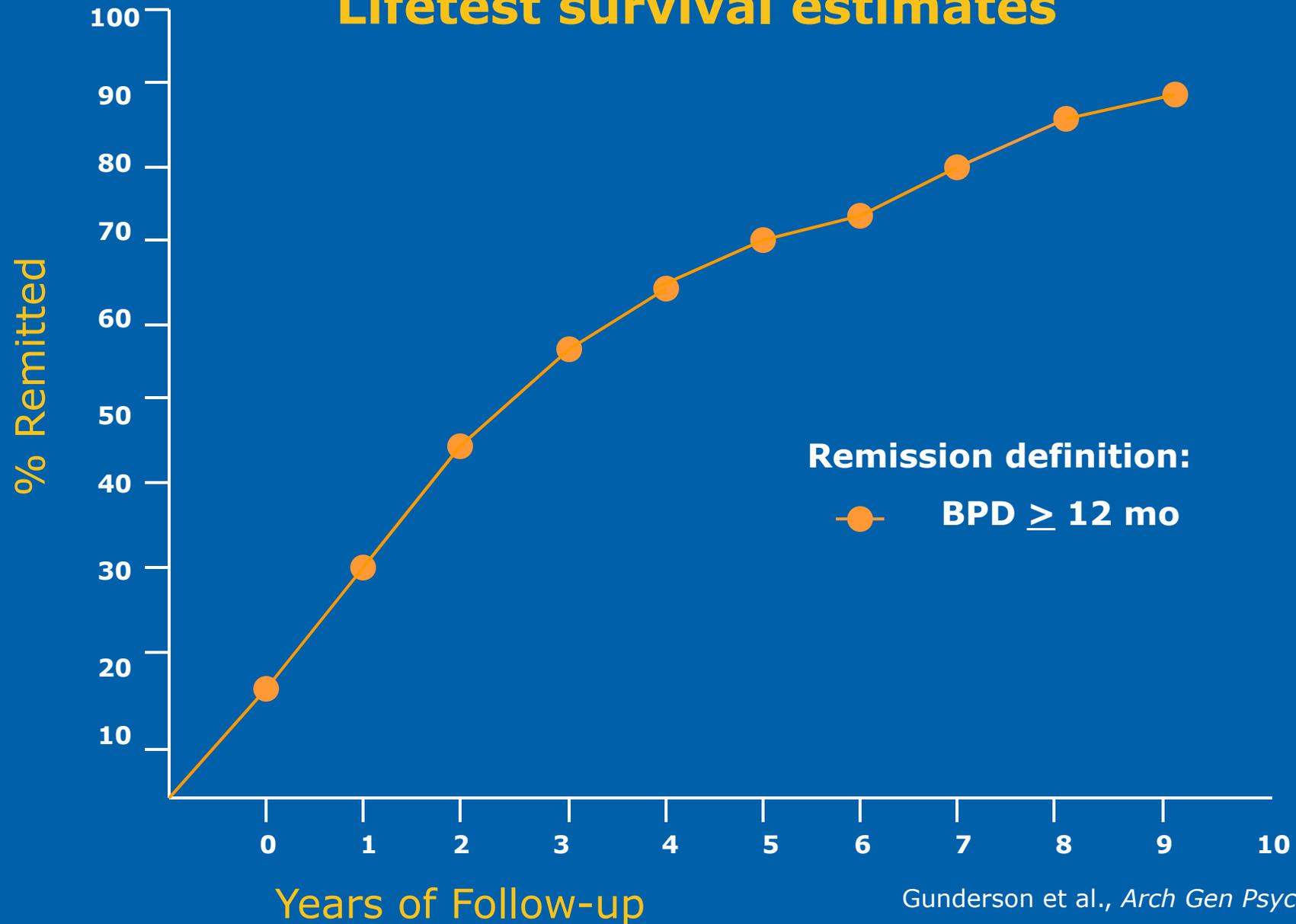
## Recent and New Data



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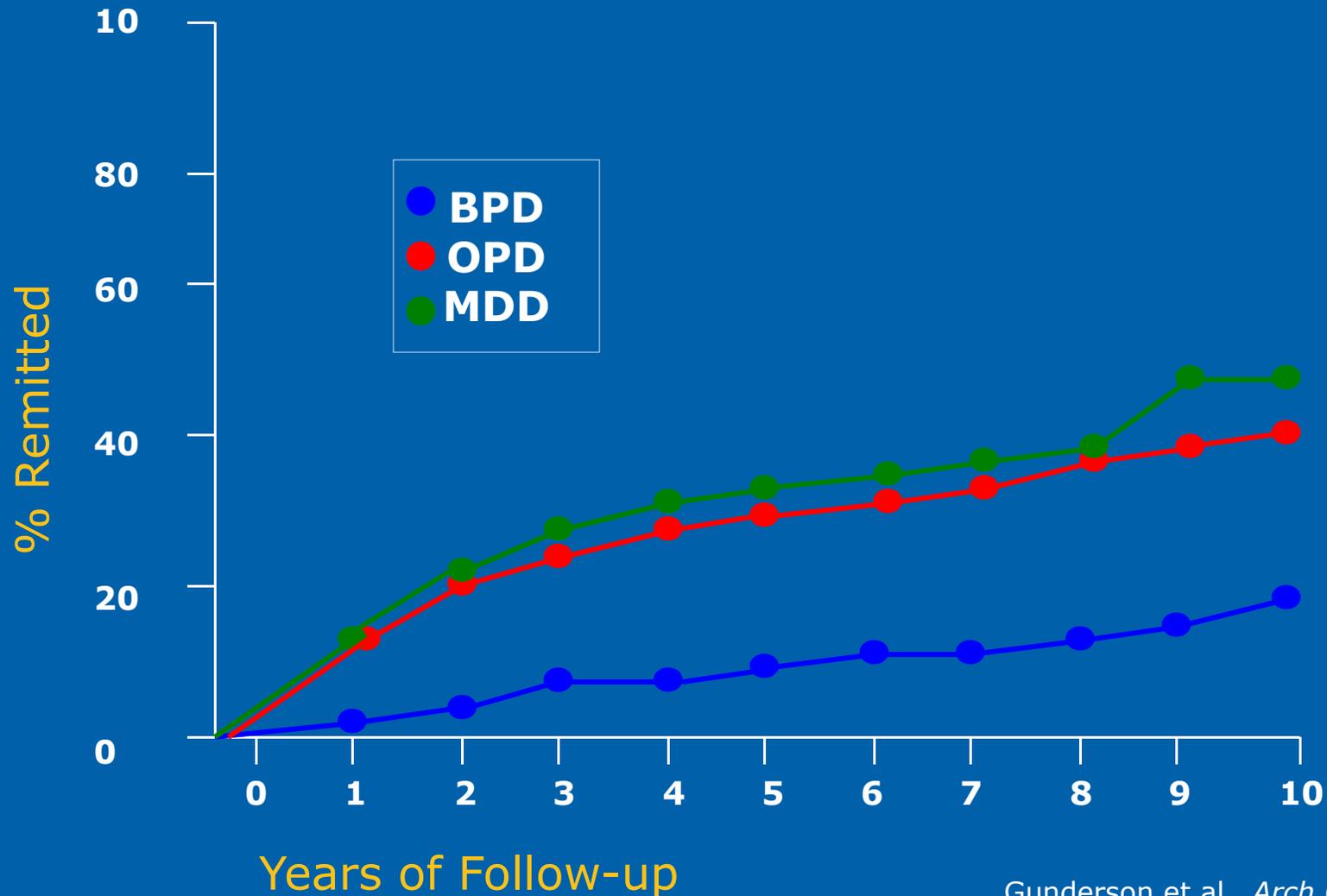
# DSM-IV BPD Stability Over Time

## Diagnostic Remission (cumulative): Lifetest survival estimates



Gunderson et al., *Arch Gen Psych*, 2011

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





## “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*, in press



## **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

## 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. WG Study (continued)

This study also found that the DSM-5 PD approach was empirically demonstrated to be **more strongly related to clinical decision-making** than DSM-IV in areas of:

- Global functioning
- Risk assessment
- Recommended treatment type and intensity
- Prognosis

## Morey et al. WG Study (continued)

- Clinicians were asked to mark all PD criteria that apply to real patients in their practice, from randomized lists of DSM-IV and DSM-5 criteria
- Correlations between endorsed DSM-5 criteria and endorsed DSM-IV criteria for all patients (N=334) were calculated.



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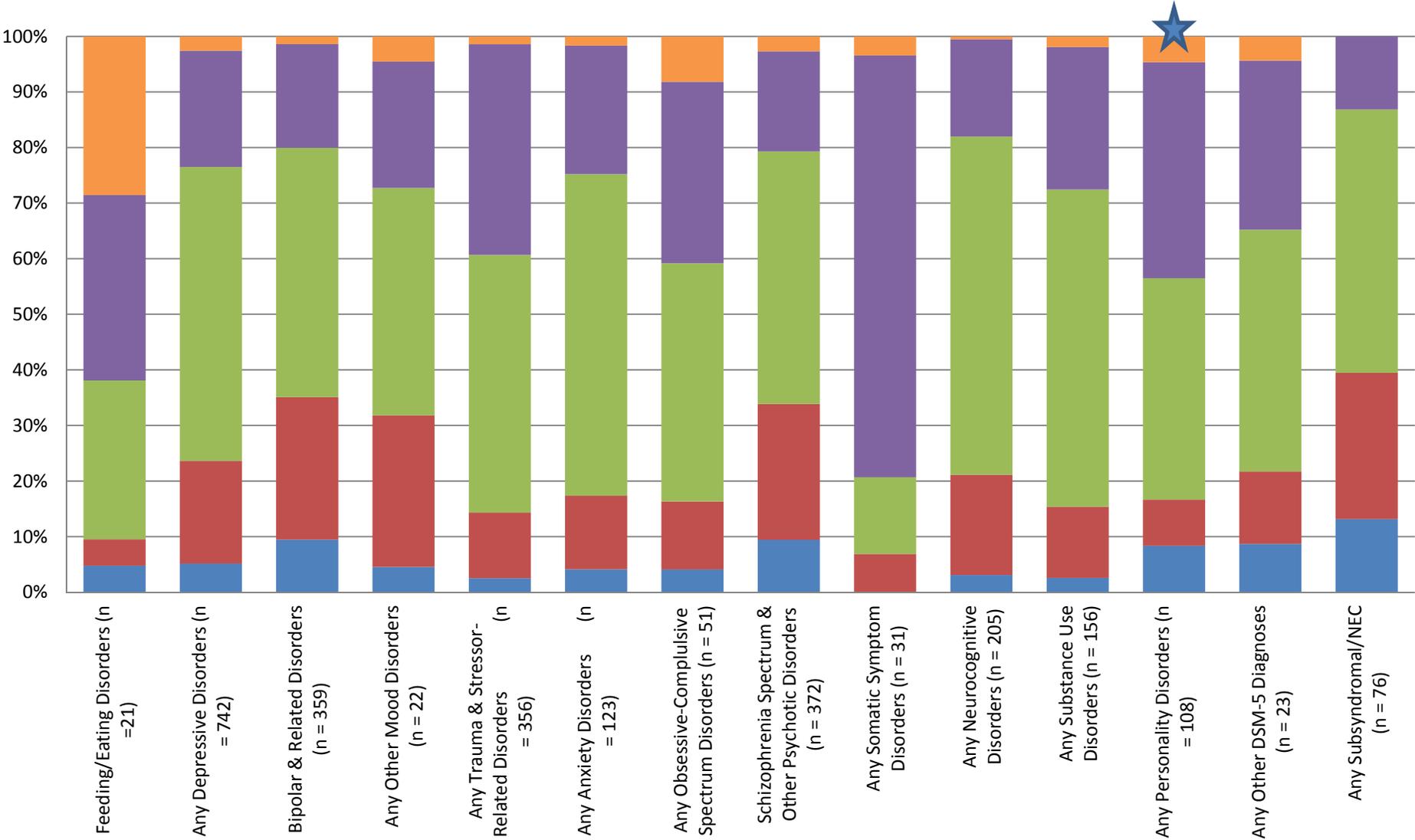
# Field Trials Data

## Clinicians in Academic vs. RCP FT

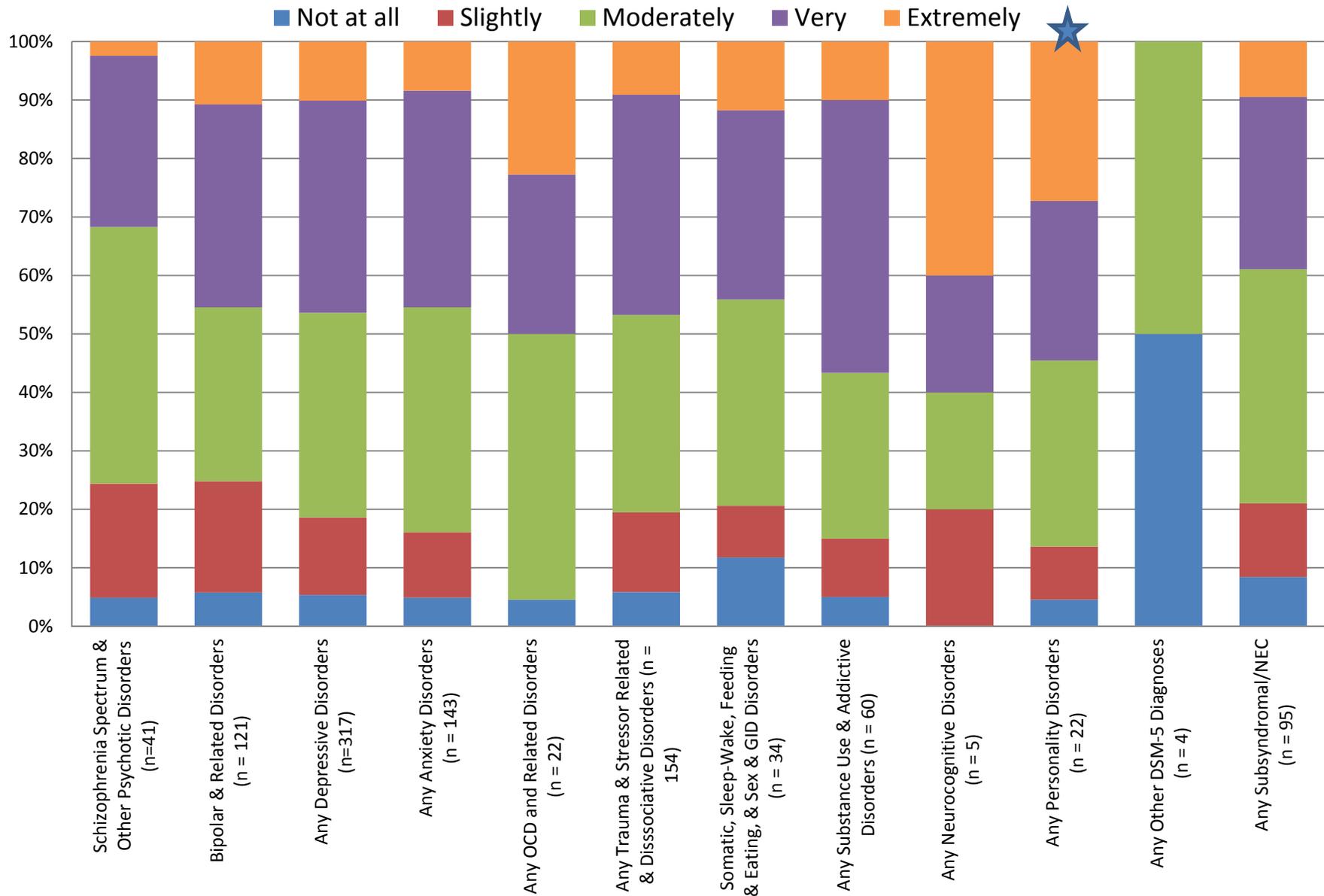
- Over 80% of clinicians in the Academic & RCP field trials found the new PD criteria “moderately” to “extremely” useful compared to DSM-IV.
- A larger proportion of “extremely” useful reporting for the new PD criteria was observed from clinicians in the RCP (~27%) than academic FTs (~5%)
- In the RCP FT, the rating of “extremely” useful was greater for PDs than most diagnostic groupings, e.g., schizophrenia spectrum & other psychotic disorders (~2%) and substance use disorders (~10%) **BUT** the criteria for PDs had more substantial changes 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**

Not at all   Slightly   Moderately   Very   Extremely



Clinicians in DSM-5 Field Trials in **solo & small group practices** found the new diagnostic criteria for personality disorders moderately to extremely useful, compared to DSM-IV, when diagnosing **their new and/or existing patients**.



# DSM-5 Field Trials: Test – Retest Reliability

Data from 11 Academic Centers

<b>Pooled Test – Retest Reliability</b>		
DSM-5 Diagnosis	Intraclass Kappa	Interpretation
Major Neurocognitive Disorder	0.78	Very Good
Posttraumatic Stress Disorder	0.67	Very Good
Bipolar I Disorder	0.56	Good
<b>Borderline Personality Disorder</b>	<b>0.54</b>	<b>Good</b>
Schizophrenia	0.50	Good
Mild Neurocognitive Disorder	0.48	Good
Major Depressive Disorder	0.28	Questionable
Mixed Anxiety-Depressive Disorder	0.004	Unacceptable

- Regier et al., *AJP*, 2012



## Procedural Complications

- WG submitted FT protocol to compare DSM-IV and DSM-5. TF implemented standard reliability protocol for all WGs instead.
- WG submitted grant to NIMH. Good score, NIMH said APA should fund.
- Midstream revision from prototype to criteria-based and trait-based model
- WG submitted summary proposal to SRC
- WG submitted extensive data to CPHC



## Procedural Complications (continued)

- SRC and CPHC submitted reports to TF
- Assembly Committee reviewed CPHC report
- TF reviewed modified proposal after receiving SRC, CPHC, and Assembly input, and TF approved the main framework of the proposal for Section 2

## 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”



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## **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



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# 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



## DSM-5 Table of Contents

### 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



## **DSM-5 Table of Contents**

### **Section II (continued)**

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

## **DSM-5 Table of Contents**

### **Section III**

1. Introduction
2. Conditions for Further Study
3. Alternative DSM-5 Model for Personality Disorders
4. DSM-5 Dimensional Measures
5. Other Conditions that May Be a Focus of Clinical Attention
6. Cultural Formulation
7. Technical Glossary
8. Highlights of Changes from DSM-IV

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DIAGNOSTIC AND STATISTICAL  
MANUAL OF  
MENTAL DISORDERS

FIFTH EDITION

DSM-5

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AMERICAN PSYCHIATRIC ASSOCIATION



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**DSM-5: A Work Now Complete**  
**DSM-5.1: A Work in Progress**

**Thank you for your interest**