# DSM-5 and Personality Disorders: Where Did Axis II Go?

Robert L. Trestman, PhD, MD

The past decade has seen a period of extensive research into the etiology, pathophysiology, assessment, and treatment of personality disorders. Concomitantly, a group of experts in the field were brought together to form the Personality and Personality Disorder Work Group for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), charged with the responsibility of updating the diagnostic approach to personality disorders. This article is a review of some of the history of the American Psychiatry Association's approach to the recognition and diagnosis of personality disorders over the past half century, the process of developing the recommendations for a DSM-5 personality disorder diagnosis and the elimination of the multiaxial system, and how DSM-5 has left us with essentially no changes of relevance to the practice of forensic psychiatry in the process for diagnosing personality disorders or in the specific diagnoses of personality disorder.

**J Am Acad Psychiatry Law 42:141–5, 2014**

Many psychiatrists who practice at the interface with the law recognize that there is an apparent overrepresentation of people with personality disorders (PDs) in civil and criminal cases and in correctional settings. The data show them to be correct.[1,2] Facets of functional impairment, associated with emotional regulation, interpersonal relationships, distrust of others, a distorted sense of entitlement, and impulse management, which are each an aspect of the various personality disorders, relate directly to increased risk of legally problematic behavior. Codifying and diagnosing those personality disturbances have for over half a century been the domain of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). In this article, I review some of the history, its relevance to forensic psychiatric practice, and the implications of the changes in DSM-5.[3]

Initially, a few key summary points are in order. First, distinct from any specific functional impairments that may be present, PD diagnoses themselves are not accepted as a mitigating factor in criminal cases in the United States, but may enter into consideration in other jurisdictions.[4] Second, there are no meaningful changes in the clinical diagnosis of personality disorder in DSM-5. The story behind this outcome is enlightening, as it reflects the evolution of our understanding of personality disorders.

Dr. Trestman is Professor of Medicine, Psychiatry and Nursing, University of Connecticut Health Center, Farmington, CT. Address correspondence to: Dr. Robert L. Trestman, PhD, MD, University of Connecticut Health Center, 263 Farmington Avenue, Farmington CT 06070. E-mail: trestman@uchc.edu.

Disclosures of financial or other potential conflicts of interest: None.

## The Evolution of the Personality Disorder Diagnosis Over 60 Years

Although personality and its dysfunction have been discussed for millennia, the modern era of personality disorders can be said to have begun in 1952 with the publication of the first DSM [5] by the American Psychiatric Association (APA). In this initial version, personality disorders had brief descriptions and included a very broad diagnosis labeled sociopathic personality disorder. This diagnosis included multiple subtypes: antisocial, sexual deviations, alcoholism, drug addiction, and dissocial reaction. It was well over a decade later, in 1968, that DSM-II[6] was published. It expanded coverage of personality disorders by devoting all of three pages (Ref. 6, pp 41–4) to their description. One short paragraph descriptor of each of 10 named personality disorders was provided: paranoid, cyclothymic, schizoid, explosive, obsessive compulsive, hysterical, asthenic, antisocial, passive-aggressive, and inadequate. It also included a variant labeled other personality disorders of specified types. The introductory comments defined personality disorders as "deeply ingrained maladaptive patterns of behavior. . . . Generally, these are lifelong patterns, often recognizable at the time of ado-

lescence or earlier" (Ref. 6, p 41). Neither the first nor the second edition of DSM was supported by any research evidence, epidemiology, or discussion of the potential pathophysiology of personality disorder diagnoses.

Some of these shortcomings were addressed in DSM-III[7] and its revision, DSM-IIIR.[8] DSM-III elaborated for the first time a criterion-based, ostensibly atheoretical categorical diagnostic system consistent with contemporary medical diagnoses. It also incorporated a multiaxial model that placed personality disorders in the newly created Axis II, thus separating them from the major syndromes reflected in Axis I. These personality disorders were delineated by 3 clusters totaling 11 PDs plus personality disorder-not otherwise specified (PD-NOS). This model was created for at least two specific reasons. One was to focus clinicians on the potential presence of the chronic, lifelong conditions that were less acute than the more dramatic major syndrome presentations of Axis I. A second explicit reason was to help generate more research, and more was clearly needed: a search of PubMed (accessed on July 15, 2013) yielded only 257 clinical studies on personality disorders published before December 31, 1987.

The focus on the need for personality disorder research yielded results. By the time DSM-IV[9] was published in 1994, 489 new studies had been conducted on personality disorders (PubMed search on July 15, 2013). DSM-IV and DSM-IV-TR[10] provided incremental changes from DSM-III, with 10 personality disorders, as in DSM-III, plus personality disorder-NOS; passive aggressive personality disorder was renamed negativistic personality disorder and moved to the Appendix. The basic criterion-driven, categorical approach to diagnosis was left unchanged, although many experts in the field acknowledged that the categorical diagnostic method was less than satisfactory.[11,12]

By the time DSM-5 was published, no fewer than 2,338 additional studies about personality disorders had been conducted (PubMed search on July 15, 2013). Although this plethora of research yielded a great deal of knowledge regarding phenotypic presentations, prevalence estimates, treatment benefits, lifetime trajectories, and so forth, it became clear that there was no consensus on underlying neuropathology or the optimum approach to diagnosis. That lack of consensus played out in the DSM-5 Personality and Personality Disorder Work Group, the committee charged by the APA with the responsibility for formulating the new diagnostic nosology for personality disorders. The work group, comprising 10 members plus a text coordinator, reviewed the literature and research findings, conducted selected focus groups, and reviewed trials of diagnostic models. The work group attempted to select only the personality disorders with a solid research basis for inclusion in DSM-5. The primary focus was ultimately the diagnostic model: categorical or dimensional. Categorical, criterion-based diagnosis is the foundation of most medical models and is inherent in the preceding editions of the DSM. It is also the basis for the diagnosis of all other major syndromes in DSM-5. Clinical practitioners have grown comfortable with it, even though multiple studies have demonstrated that clinicians frequently diagnose by impression rather than by criteria. Moreover, even when criteria are used, the inter-rater reliability is inconsistent.[13]

Dimensional approaches to personality disorder diagnosis have long been advocated by many prominent researchers and clinical psychologists.[11,14,15] With the use of several nosologies, dimensional approaches may capture far more information about affective lability, impulse dyscontrol, degree of perceptual and conceptual distortions, interpersonal relatedness, and stability of self-concept. This rich information, however, does not easily boil down to single-phrase diagnoses.[16] In the end, the work group proposed a hybrid model incorporating elements of both categorical diagnoses and dimensional characteristics.

Which personality disorder diagnoses to retain from DSM-IV-TR or to add in DSM-5 became an issue of substantial process and debate.[17–20] Originally, only six diagnoses were proposed for inclusion as personality disorders: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive and schizotypal personality disorders (Ref. 20; Ref. 3, pp 763–4). The process, which extended over more than five years, was contentious enough to generate ongoing active and vociferous challenges to its implementation,[22] and two of the committee members resigned in protest.[23] The APA Board of Trustees ultimately decided to keep all 10 personality disorders from DSM-IV-TR unchanged (with only minor text updating). This decision was based on the perception that, ". . . the transition from a categorical diagnostic system of individual disorders to one based on the relative distribution of personality traits has not been

widely accepted" (Ref. 3, p xliii). The debate and dissent were, in this author's opinion, caused by the following factors: we do not know the underlying pathophysiology of personality disorders; there is a great deal of passion and commitment to strongly held attitudes about personality disorders and how best to approach diagnosis and treatment; and many psychiatrists find it easier and more consistent with all other diagnoses to make categorical decisions. The final product of the work group was included as an alternative model in Section III of DSM-5, "Emerging Measures and Models" (Ref. 3, pp 761–82).

Another change of note is the elimination of the multi-axial system. All development disorders, personality disorders, and general medical conditions are now listed together, consistent with the approach used by the International Classification of Diseases.[24]

## The Final Product: Implications for Practice in North America

### *The Cautionary Statement*

The DSM-5 contains an expanded Cautionary Statement of explicit relevance to forensic psychiatry. It states in part that, "In most situations, the clinical diagnosis of a DSM-5 mental disorder . . . does not imply that an individual meets legal criteria for the presence of a mental disorder or a specified legal standard. . . ." It goes on to state that, "a diagnosis does not carry any necessary implications regarding the . . . individual's degree of control over behaviors that may be associated with the disorder" (Ref. 3, p 25). For example, in regard to antisocial personality disorder (ASPD), DSM-5 does not address the often-troubling tautology about illegal behavior, in either civil or criminal matters. Specifically, four of seven Criterion A diagnostic criteria for ASPD include illegal behavior: "Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest"; "deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure"; "irritability and aggressiveness, as indicated by repeated physical fights or assaults"; and "consistent irresponsibility, as indicated by repeated failure to . . . honor financial obligations" (Ref. 3, p 659). It may therefore prove challenging to offer in testimony that ASPD should be considered a mitigating factor in the commission of a crime.

### *Intended Use of the Alternative Model*

The hybrid personality disorder model developed by the work group and included in Section III of DSM-5 is explicitly intended to support a research agenda (Ref. 3, p 645). This model might be useful if it were the only initiative guiding advances in our understanding of the etiology, phenomenology, and treatment of personality disorders. However, even that role is contested.

The National Institute of Mental Health (NIMH) has proposed a very divergent diagnostic approach to advancing psychiatric research, labeled the Research Domain Criteria (RDoC). This criteria set is intended to be guided by data from genetics, cognitive science, and the search for potential biological markers.[25] This approach has created a certain amount of tension between the framers of DSM-5 and researchers at NIMH, as the former have maintained a phenomenological and descriptive nosology, whereas the latter argue for one based on a conceptualization of mental illnesses as disorders of brain function.[25] This contentious environment may be quite fruitful for the generation of novel ideas and research approaches, but meanwhile, it is likely to limit the forensic credibility of the current personality disorder diagnostic framework.

### *Use of Personality Disorder Diagnoses in Expert Opinions and in Court*

Despite the political disagreements, the use of personality disorder diagnoses in expert opinion reports is unlikely to be affected. Given the current state of our knowledge, the relevance of asserting a diagnosis of a personality disorder is not the disorder *per se*, but rather its cognitive, affective, behavioral, and interpersonal manifestations.[1] For example, the diagnosis of borderline personality disorder requires that an individual satisfy at least five of nine specific criteria. Two different individuals may therefore both carry a diagnosis of borderline personality disorder, but share in common only one of the nine criteria. In that context, a matter of relevance to the court regarding a child custody matter may not be a parent's diagnosis of borderline personality disorder, but perhaps the parent's severe emotional instability, impulsivity, and high risk for repeated suicide attempts. A judge may be swayed by the potential of exposing a child to parental instability and likely suicide, but not to a parent with only a diagnosed personality disorder. Similar problems of functionality and behavior hold

in the context of disability evaluations or fitness-for-duty examinations.

Although some psychiatric illnesses may serve as mitigating factors in the sentencing phase of a trial (e.g., acute psychosis associated with schizophrenia), personality disorders are not among them.[4] Given the lack of substantive changes in personality disorder diagnosis in DSM-5, this situation is unlikely to change.

One consideration is whether a forensic psychiatrist might use aspects of the alternative model as part of an evaluation. The hybrid model includes a newly developed assessment of five broad areas of pathological personality traits: the Personality Inventory for DSM-5 (PID-5).[26] Consistent with any of the components of a forensic evaluation, the validity and reliability would have to be adequate to survive scrutiny. Initial data support the validity of PID-5[26] and its convergence with existing measures of psychopathology.[27,28] The degree to which these evolving data demonstrate enhanced value in the assessment of personality disorders will determine its ultimate value in a forensic evaluation.

Another interesting potential situation is a challenge to the overall credibility of the diagnostic schema of personality disorders. Such an assertion may reasonably be based on both the contentious process that relegated the recommendation of the work group to alternative model status and the broader rejection of DSM-5 (at least for purposes of research) by the NIMH.

### *Clinical Management of Patients with Personality Disorder Diagnoses*

Finally, nothing in the DSM-5 criteria for personality disorders suggests changes in the approach to treatment of individuals with a diagnosed personality disorder. The field of personality disorder research is growing at a rapid rate, as reflected in the expanding clinical research portfolio. Outcome studies reflect that treatment, both psychotherapeutic and pharmacologic, is beneficial, and there is growing optimism among clinical researchers and clinicians for functional improvement and enhanced quality of life in this population.[29] Targeted research may also assist in defining interventions that substantially reduce many of the problematic behaviors of individuals with personality disorders and ultimately in developing preventive interventions targeting at-risk populations.

## Conclusion

In part because of the very different views of experts in the field of personality disorders and the rapidly changing nature of our understanding of the etiology, pathophysiology, and treatment of these disorders, DSM-5 presents us with DSM-IV-TR redux. For the practical purposes of forensic psychiatry, DSM-5 requires that we change essentially nothing as it relates to assessing, diagnosing, and treating individuals with personality disorders. Furthermore, DSM-5 will have little immediate impact on opinion writing, depositions, or courtroom testimony as it relates to individuals given a diagnosis of personality disorder. It may, however, open up further contentious debate over the value of the DSM-5 personality disorder diagnoses, given the disagreements among the members of the DSM-5 Personality and Personality Disorder Work Group and the ultimate decision to relegate the work of the committee to the "Emerging Measures and Models" section.

### References


1. Reid WH: Borderline personality disorder and related traits in forensic psychiatry. J Psychiatr Pract 15:216–20, 2009
2. Trestman RL, Ford JD, Zhang W, *et al*: Current and lifetime psychiatric illness among inmates not identified as acutely mentally ill at intake in Connecticut's jails. J Am Acad Psychiatry Law 35:490–500, 2007
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA: American Psychiatric Association, 2013
4. Sparr LF: Personality disorders and criminal law: an international perspective. J Am Acad Psychiatry Law 37:168–81, 2009
5. American Psychiatric Association: Diagnostic and Statistical Manual, Mental Disorders, First Edition. Washington DC: American Psychiatric Association, 1952
6. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Second Edition. Washington DC: American Psychiatric Association, 1968
7. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington DC: American Psychiatric Association, 1980
8. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised. Washington DC: American Psychiatric Association, 1987
9. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington DC: American Psychiatric Association, 1994
10. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: American Psychiatric Association, 2000
11. Widiger TA, Simonsen E, Sirovatka PJ, *et al*: Dimensional Models of Personality Disorders: Refining the Research Agenda for DSM-V. Arlington, VA: American Psychiatric Association, 2006
12. Bernstein DP, Iscan C, Maser J: Opinions of personality disorder experts regarding the DSM-IV personality disorders classification system. J Personal Disord 21:536–51, 2007

13. Harford TC, Chen CM, Saha TD, *et al*: An item response theory analysis of DSM-IV diagnostic criteria for personality disorders: findings from the national epidemiologic survey on alcohol and related conditions. Personal Disord 4:43–54, 2013
14. McRae RR, Costa PT: Personality in Adulthood: a Five-Factor Theory Perspective (ed 2). New York: The Guilford Press, 2003
15. Tyrer P: Diagnostic and Statistical Manual of Mental Disorders: a classification of personality disorders that has had its day. Clin Psychol Psychother 19:372–4, 2012
16. Pilkonis PA, Hallquist MN, Morse JQ, *et al*: Striking the (Im) proper balance between scientific advances and clinical utility: commentary on the DSM-5 proposal for personality disorders. Personal Disord 2:68–82, 2011
17. Kendler K, Kupfer D, Narrow W, *et al*: Guidelines for making changes to DSMV. Washington DC; APA, revised October 21, 2009. Available at http://www.dsm5.org/ProgressReports/Documents/Guidelines-for-Making-Changes-to-DSM_1.pdf. Accessed July 20, 2013
18. Pull C: Too few or too many?—reactions to removing versus retaining specific personality disorders in DSM-5. Curr Opin Psychiatry 26:73–8, 2013
19. Zimmerman M, Chelminski I, Young D, *et al*: Which DSM-IV personality disorders are most strongly associated with indices of psychosocial morbidity in psychiatric outpatients? Compr Psychiatry 53:940–45, 2012
20. Bornstein RF: Reconceptualizing personality pathology in DSM-5: limitations in evidence for eliminating dependent personality disorder and other DSM-IV syndromes. J Pers Disord 25:235–47, 2011
21. Skodol AE: Personality disorders in DSM-5. Annu Rev Clin Psychol 8:317–44, 2012
22. Frances A: Two Who Resigned From DSM-5 Explain Why, Psychology Today, Blog: DSM-5 in Distress. July 11, 2012. Available at http://www.psychologytoday.com/blog/dsm5-in-distress/201207/two-who-resigned-dsm-5-explain-why
23. Livesley WJ: Disorder in the proposed DSM-5 classification of personality disorders. Clin Psychol Psychother 19:364–8, 2012
24. World Health Organization: ICD-10 Classifications of Mental and Behavioral Disorder: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization, 1992
25. Insel T, Cuthbert B, Garvey M, *et al*: Research Domain Criteria (RDoC): toward a new classification framework for research on mental disorders. Am J Psychiatry 167:748–51, 2010
26. Fossati A, Krueger RF, Markon KE, *et al*: Reliability and validity of the Personality Inventory for DSM-5 (PID-5): predicting DSM-IV personality disorders and psychopathy in community-dwelling Italian adults. Assessment 20:689–708, 2013
27. Sellbom M, Anderson JL, Bagby RM: Assessing DSM-5 Section III Personality Traits and Disorders with the MMPI-2-RF. Assessment 20:709–22, 2013
28. Few LR, Miller JD, Rothbaum AO, *et al*: Examination of the Section III DSM-5 diagnostic system for personality disorders in an outpatient clinical sample. J Abnorm Psychol 122:1057–69, 2013
29. Oldham J: Guideline watch: practice guideline for the treatment of patients with borderline personality disorder. American Psychiatric Publishing, Inc., 2010