Does the Presence of One Feature of Borderline Personality Disorder Have Clinical Significance? Implications for Dimensional Ratings of Personality Disorders

Mark Zimmerman, MD; Iwona Chelminski, PhD; Diane Young, PhD; Kristy Dalrymple, PhD; and Jennifer Martinez, BA

ABSTRACT

Objective: In the draft proposal for *DSM-5*, the Work Group for Personality and Personality Disorders recommended that dimensional ratings of personality disorders replace *DSM-IV*'s categorical approach toward classification. If a dimensional rating of personality disorder pathology is to be adopted, then the clinical significance of minimal levels of pathology should be established before they are formally incorporated into the diagnostic system because of the potential unforeseen consequences of such ratings. In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we examined the low end of the severity dimension and compared psychiatric outpatients with 0 or 1 *DSM-IV* criterion for borderline personality disorder on various indices of psychosocial morbidity.

Method: Three thousand two hundred psychiatric outpatients were evaluated with semistructured diagnostic interviews for *DSM-IV* Axis I and Axis II disorders. The present report is based on the 1,976 patients meeting 0 or 1 *DSM-IV* criterion for borderline personality disorder.

Results: The reliability of determining if a patient was rated with 0 or 1 criterion for borderline personality disorder was good ($\kappa = 0.70$). Compared to patients with 0 borderline personality disorder criteria, patients with 1 criterion had significantly more current Axis I disorders ($P < .001$), suicide attempts ($P < .01$), suicidal ideation at the time of the evaluation ($P < .001$), psychiatric hospitalizations ($P < .001$), and time missed from work due to psychiatric illness ($P < .001$) and lower ratings on the Global Assessment of Functioning ($P < .001$).

Conclusions: Low-severity levels of borderline personality disorder pathology, defined as the presence of 1 criterion, can be determined reliably and have validity.

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Corresponding author: *Mark Zimmerman, MD, Bayside Medical Center, 235 Plain St, Providence, RI 02905 (mzimmerman@lifespan.org).*

The threshold to distinguish patients with and without a personality disorder is arbitrary and does not represent a well-demarcated line separating cases and noncases.[1,2] Since the publication of *DSM-III*, the potential advantages of dimensional ratings over categorical classification of personality disorders have been discussed, with some authors indicating that the question was not whether a dimensional system will replace the categorical approach but when will it happen.[3,4]

Studies comparing dimensional and categorical representations of the *DSM* personality disorder criteria have consistently found that personality disorder dimensions are more reliable, with correlation coefficients of the reliability of dimensional scores higher than κ coefficients of reliability of categorical diagnoses.[5–8] The stability of personality disorder dimensions are higher than categorical diagnoses,[9,10] and studies of the relationship between personality disorders and psychosocial morbidity have found that more variance in the dependent variables is accounted for by personality disorder dimensions than personality disorder categories.[2,11] These findings are not surprising because when transforming a continuously distributed variable into a dichotomy some information is lost. Accordingly, several researchers have advocated a dimensional approach toward evaluating personality disorders.[1,3,12–15] Recommendations for dimensional ratings have included adopting approaches grounded in the study of normal personality, converting the *DSM* personality disorders into a dimensional rating system based on the number of criteria present, converting the number of *DSM* criteria met into a uniform scaled rating, and abandoning the criteria counting approach and rating the prototypicality of personality disorder dimensions based on empirically derived clinical prototype descriptions.[1,12,13]

In the draft proposal for *DSM-5*, the Work Group for Personality and Personality Disorders recommended that 5 specific personality disorder types (antisocial, avoidant, borderline, obsessive-compulsive, schizotypal) be rated on a 5-point scale of the degree of fit with a prototypical description of the disorder.[16] Concerns have been raised about the prototype-matching approach recommended for *DSM-5*[17]; however, if a dimensional rating of personality disorder pathology is to be adopted in *DSM-5*, whether it be based on prototype matching or some other approach, an important question to consider is whether mild levels of severity have clinical significance. The real-world practical implications of indicating that a patient has slight or minimal levels of a personality disorder such as borderline personality disorder are unknown. Might a rating of slight borderline personality disorder pathology impact the acquisition of life insurance? Might there be forensic implications? The clinical significance of minimal levels of pathology should be established before their inclusion into the diagnostic system because of the potential unforeseen consequences of such ratings.[18] We are not aware of any studies that have examined the reliability and validity of ratings of mild levels of personality pathology.

In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we examined the low end of the severity dimension and compared psychiatric outpatients with 0 or 1 *DSM-IV* criterion for borderline personality disorder on various

Clinical Points

- Low-severity levels of borderline personality disorder can be assessed reliably.
- Psychiatric outpatients with 1 borderline personality disorder criterion have greater psychosocial morbidity than patients with 0 criteria.
- The results support suggestions to rate borderline personality disorder dimensionally because low severity levels of such pathology are clinically significant.

indices of psychosocial morbidity. We tested the hypothesis implicit in recommendations to rate personality disorders dimensionally that patients with low-severity levels of personality disorder pathology would have greater psychosocial morbidity than patients with no evidence of personality disorder pathology.

METHOD

Three thousand two hundred outpatients were evaluated with semistructured diagnostic interviews in the Rhode Island Hospital Department of Psychiatry outpatient practice. This private-practice group predominantly treats individuals with medical insurance (including Medicare but not Medicaid) on a fee-for-service basis, and it is distinct from the hospital's outpatient residency training clinic that predominantly serves lower-income, uninsured, and medical-assistance patients. All participants of this study were 18 years or older and provided informed written consent. Participants who displayed difficulties in communicating in the English language or who had a history of developmental disabilities were excluded from the study.

During the course of the study the assessment battery was changed. The evaluation of borderline personality disorder did not begin until after the project began and the first 90 patients had been evaluated. Also, due to time constraints, the complete evaluation was sometimes not conducted, and 41 patients were not administered the personality disorder interview. Of the 3,069 psychiatric outpatients evaluated, 1,093 met 2 or more criteria for borderline personality disorder. The focus of this report is the 1,976 patients who met 0 or 1 *DSM-IV* criterion for borderline personality disorder. The majority of the patients were female, white, and high school graduates (Table 1). The mean age of the sample was 40.5 years (SD = 13.6). The most frequent current *DSM-IV* Axis I disorders were major depressive disorder, social phobia, panic disorder, and generalized anxiety disorder (Table 2).

The patients were interviewed by a trained diagnostic rater who administered the borderline personality disorder section of the Structured Interview for *DSM-IV* Personality[19] and a modified version of the Structured Clinical Interview for *DSM-IV* (SCID).[20] The Rhode Island Hospital institutional review committee approved the research protocol, and all patients provided informed, written consent. Only a minority of patients evaluated in the practice received the SCID and Structured Interview for *DSM-IV* Personality because of the lack of available diagnostic raters or patients' preference for a less time-consuming standard clinical evaluation. Patients who did and did not participate in the study were similar in gender, education, marital status, and scores on self-administered symptom questionnaires.[21]

Table 1. Demographic Characteristics of 1,976 Psychiatric Outpatients With 0 or 1 *DSM-IV* Borderline Personality Disorder Criterion

Characteristic	n	%
Gender		
Female	1,145	57.9
Male	831	42.1
Education		
Less than high school	147	7.4
Graduated high school	1,156	58.5
Graduated college or greater	673	34.1
Marital status		
Married	925	46.8
Living with someone	103	5.2
Widowed	46	2.3
Separated	96	4.9
Divorced	270	13.7
Never married	536	27.1
Race		
White	1,814	91.8
Black	77	3.9
Hispanic	45	2.3
Asian	17	0.9
Other	23	1.2
Age, y	Mean = 40.5	SD = 13.6

We integrated into the SCID interview the item from the Schedule for Affective Disorders and Schizophrenia (SADS)[22] on the amount of time missed from work due to psychiatric reasons during the past 5 years. The SCID/SADS interview also included assessments of prior psychiatric hospitalizations, current suicidal ideation (rated on a 0 to 6 scale on the SADS), and lifetime history of suicide attempts. Based on the results of the SCID/SADS and Structured Interview for *DSM-IV* Personality interviews, the Global Assessment of Functioning (GAF) was rated.

The diagnostic raters were highly trained and monitored throughout the project to minimize rater drift. Diagnostic raters included PhD-level psychologists and research assistants with college degrees in the social or biological sciences. Research assistants received 3 to 4 months of training, during which they observed at least 20 interviews, and they were observed and supervised in their administration of more than 20 evaluations. Psychologists observed only 5 interviews; however, they, too, were observed and supervised in their administration of 15 to 20 evaluations. During training, every interview was reviewed on an item-by-item basis by the senior rater who observed the evaluation. At the end of the training period, the raters were required to demonstrate exact, or near exact, agreement with a senior diagnostician on 5 consecutive evaluations. Throughout the MIDAS project, ongoing supervision of the raters consisted of weekly diagnostic case conferences involving all members of the team. Written reports of all cases were reviewed by M.Z., who also reviewed the item ratings of every case.

Table 2. Current *DSM-IV* Axis I Diagnoses of 1,976 Psychiatric Outpatients With 0 or 1 *DSM-IV* Borderline Personality Disorder Criterion[a]

DSM-IV Diagnosis	n	%
Major depressive disorder	771	39.0
Bipolar disorder	43	2.2
Dysthymic disorder	123	6.2
Generalized anxiety disorder	313	15.8
Panic disorder	278	14.1
Social phobia	384	19.4
Specific phobia	156	7.9
Obsessive-compulsive disorder	101	5.1
Posttraumatic stress disorder	136	6.9
Adjustment disorder	173	8.8
Schizophrenia	6	0.3
Eating disorder	83	4.2
Alcohol abuse/dependence	136	6.9
Drug abuse/dependence	56	2.8
Somatoform disorder	123	6.2
Attention-deficit disorder	118	6.0
Impulse control disorder	128	6.5

[a]Individuals could be given more than 1 diagnosis.

Previous reports from the MIDAS project have documented high levels of interrater reliability.[23] Of relevance to the present report is the reliability of rating individuals with 0 or 1 criterion. There are 2 different ways of selecting the sample for this analysis. One approach is to include only those individuals who were rated as having 0 or 1 criterion by at least 1 of the 2 raters. The other approach is to include all patients in whom reliability was examined (n = 47). The problem with the inclusion of all patients is that this includes patients who would not be included in the validity analyses. Moreover, inclusion of patients in the reliability analysis who have several borderline personality disorder features would bias the findings in favor of greater reliability because, if both raters determined that patients had multiple borderline personality disorder criteria, their rating would be counted as agreement that the patient had more than 0 criteria. Thus, we chose the more conservative approach and included only the 33 patients with 0 or 1 criterion according to at least 1 of the 2 raters. The reliability of determining if a patient was rated with 0 or 1 criterion for borderline personality disorder was good ($\kappa = 0.70$).

Before comparing the groups on indicators of psychosocial morbidity, we compared the 2 groups on demographic variables. *t* Tests were used for continuously distributed variables, whereas categorical variables were compared by the χ^2 statistic. Variables that were significantly different between the groups were controlled in regression analyses. We compared patients with 0 or 1 borderline personality disorder criterion on the following variables: number of current *DSM-IV* Axis I disorders, lifetime psychiatric hospitalizations, lifetime suicide attempts, suicidal ideation at the time of the evaluation, GAF ratings, and amount of time unemployed during the past 5 years due to psychiatric reasons. We defined indicators of severe illness a priori as 3 or more Axis I disorders, 3 or more psychiatric hospitalizations, 3 or more suicide attempts, a rating of 3 or higher on the SADS suicidal ideation item, a GAF rating of 50 and below, and unemployment due to psychiatric reasons for at least 2 years in the past 5 years.

Table 3. Frequency of Individual *DSM-IV* Borderline Personality Disorder Criteria in 589 Psychiatric Outpatients With 1 Borderline Personality Disorder Criterion

DSM-IV Borderline Personality Disorder Criterion	n	%
Frantic efforts to avoid abandonment	7	1.2
Unstable and intense interpersonal relationships	31	5.3
Identity disturbance	24	4.1
Impulsivity in at least 2 areas that are self-damaging	114	19.4
Recurrent suicidality or self-mutilating behavior	24	4.1
Affective instability	86	14.6
Chronic feelings of emptiness	170	28.9
Inappropriate anger	113	19.2
Stress-related paranoid ideation or dissociation	20	3.4

RESULTS

Approximately two-fifths of the 3,069 patients (43.3%, n = 1,387) had 0 borderline personality disorder criteria and one-fifth (18.4%, n = 589) had 1 criterion. In the 589 patients with 1 criterion, the 9 *DSM-IV* borderline personality disorder criteria were not equally represented (Table 3), with chronic feelings of emptiness the most frequent criterion and frantic efforts to avoid abandonment the least frequent. Compared to the patients with 0 criteria, the patients with 1 criterion were significantly more likely to be male (47.2% vs 39.9%, $\chi^2 = 9.1$, $P < .01$) and less likely to have graduated from college (27.5% vs 36.8%, $\chi^2 = 17.8$, $P < .001$). Patients with 1 criterion were significantly younger (mean ± SD age = 37.5 ± 12.2 vs 41.8 ± 13.9 years, $t = 6.5$, $P < .001$).

After controlling for age, sex, and education, we found that, compared to patients with 0 criteria, the patients with 1 borderline personality disorder criterion had more current Axis I disorders, more frequently attempted suicide, reported more suicidal ideation at the time of the evaluation, more frequently were hospitalized, missed more time from work due to psychiatric illness, and were rated significantly lower on the GAF (Table 4). The patients with 1 criterion were significantly more likely to have severe illnesses as indicated by having 3 or more current Axis I disorders, a history of 3 or more suicide attempts, a history of 3 or more psychiatric hospitalizations, and missing 2 or more years from work in the past 5 years (Table 5).

DISCUSSION

DSM-IV already includes a limited number of dimensional ratings. For example, severity is rated as mild, moderate, or severe in patients diagnosed with a major mood disorder. However, the severity specifier applies only to patients who already meet the diagnostic criteria for the syndrome. In setting a research agenda for *DSM-5*, one of the initial recommendations was to examine the feasibility of developing a dimensional rating system to either complement or replace some existing diagnoses, and the personality disorder section was considered a good place to start because personality dimensional ratings had already been discussed and studied for several years.[24] Research comparing dimensional and categorical representations of the *DSM* personality

Table 4. Differences in Illness Severity Between Psychiatric Outpatients With 0 or 1 *DSM-IV* Borderline Personality Disorder Criterion

	No. of Borderline Personality Disorder Criterion			
Illness Severity Indicator, mean (SD)	0 (n = 1,387)	1 (n = 589)	β (SE)[a]	*P* Level
No. of current Axis I disorders	1.4 (1.1)	1.8 (1.3)	0.4 (0.06)	< .001
Global Assessment of Functioning	56.7 (9.2)	53.9 (9.0)	−2.8 (0.5)	< .001
Suicidal ideation	0.5 (1.0)	0.7 (1.1)	0.2 (0.05)	< .001
No. of suicide attempts	0.1 (0.7)	0.5 (4.5)	0.4 (0.1)	< .01
No. of psychiatric hospitalizations	0.3 (0.8)	0.5 (1.0)	0.2 (0.04)	< .001
Time unemployed in past 5 years[b]	2.0 (1.6)	2.3 (1.8)	0.4 (0.09)	< .001

[a]Analyses controlled for age, gender, and education.
[b]Those not expected to work (ie, retired, student, housewife, physically ill) were excluded from the analysis: thus, the sample sizes were 1,212 for the group with 0 criteria and 528 in the group with 1 criterion.

Table 5. Differences in Indicators of Severe Illness Between Psychiatric Outpatients With 0 or 1 *DSM-IV* Borderline Personality Disorder Criterion

	No. of Borderline Personality Disorder Criterion		Odds Ratio	
Indicator of Severe Illness, % (n)	0 (n = 1,387)	1 (n = 589)	(95% CI)[a]	*P* Level
3+ current Axis I disorders	15.2 (210)	28.7 (169)	2.2 (1.7–2.7)	< .001
Global Assessment of Functioning score ≤ 50	25.2 (348)	33.6 (198)	1.5 (1.2–1.9)	< .001
Serious suicidal ideation	5.5 (76)	7.6 (45)	1.4 (1.0–2.1)	NS
History of suicide attempt	9.5 (131)	17.7 (104)	2.1 (1.6–2.8)	< .001
History of 3+ suicide attempts	0.8 (11)	3.2 (19)	4.6 (2.1–9.9)	< .001
History of psychiatric hospitalization	15.8 (218)	23.8 (140)	1.7 (1.4–2.2)	< .001
History of 3+ psychiatric hospitalizations	2.5 (35)	6.5 (38)	2.9 (1.8–4.8)	< .001
Unemployed 2+ years in past 5 years[b]	5.6 (68)	8.3 (44)	1.7 (1.1–2.5)	< .01

[a]Analyses controlled for age, gender, and education.
[b]Those not expected to work (ie, retired, student, housewife, physically ill) were excluded from the analysis: thus, the sample sizes were 1,212 for the group with 0 criteria and 528 in the group with 1 criterion.
Abbreviation: NS = nonsignificant.

disorders has favored the dimensional approach in its reliability, temporal stability, and validity.[25]

One component of the *DSM-5* Work Group's proposed revision for the personality disorders is the inclusion of 5-point dimensional ratings of how closely the patient matches a prototype description. According to this system, a rating of 0 indicates that the patient does not match the prototype and a rating of 1 indicates a slight match. That is, a rating of 1 confers the presence of some pathology, albeit at a low level of severity. The results of the present study indicate that low-severity levels of borderline personality disorder pathology, based on a criterion count method and defined as the presence of 1 criterion, can be determined reliably and have validity. That is, compared to patients with 0 borderline personality disorder criteria, patients with 1 criterion had more Axis I disorders, more suicide attempts, more suicidal ideation at the time of the evaluation, more psychiatric hospitalizations, and more time missed from work.

The analysis in the present report was prompted by the proposed revision of the personality disorder section for *DSM-5*, though we do not consider the present report as directly bearing on the *DSM-5* draft proposal because we followed the *DSM-IV* criterion counting approach toward assessment rather than the *DSM-5* prototype matching approach. The *DSM-5* Work Group's proposal has been criticized by several personality disorder researchers,[18,26–29] and the reliability and validity of the proposal have not yet been studied. The prototype-matching approach of the *DSM-5* proposal has been one of the aspects that has raised concern.[17] At this point, it is unclear which, if any, components of the draft proposal will be retained in *DSM-5*. Thus, our focus is on the broader issue of the clinical importance of dimensional ratings of personality disorders at the low end of the severity spectrum. If a prototype-matching approach is adopted for *DSM-5*, the reliability and validity of prototype ratings of low severity warrant study because of the aforementioned concerns regarding possible unforeseen consequences of such ratings. We would predict, however, that a similar pattern of differences exists between patients judged to not match a prototype and those who slightly match the prototype.

Our finding of clinically significant differences between patients with 0 and 1 borderline personality disorder criterion contrasts with a previous report[30] from our group in which we found that, among patients who met *DSM-IV* criteria for borderline personality disorder, the number of criteria met was not associated with GAF scores, psychiatric hospitalizations, number of Axis I disorders, or current social functioning. In that report, it was concluded that, once the *DSM-IV* threshold was met, a dimensional representation of pathology accounted for little variance in clinical indices of severity. On the other hand, the results of the present study suggest that, at the mild end of the severity continuum, important information is lost. Thus, a dimensional representation of personality pathology may be most important at subthreshold levels of severity.

Several factors should be considered when interpreting the results of this study. The ratings of the borderline personality disorder criteria were based on a semistructured interview. Zimmerman and Mattia[31] compared such interviews to unstructured clinical interviews conducted by clinicians during intake evaluations and found that a greater number of patients were given a diagnosis of borderline personality disorder using a semistructured interview such as the Structured Interview for *DSM-IV* Personality. We would hypothesize that unstructured interviews generally result in underrecognition of personality disorder pathology and that this result is not limited to making a diagnosis but would also extend to the milder end of the severity spectrum. If our hypothesis is true, and false-positive ratings are less of a problem with clinical ratings than false-negative ratings, then we would expect that a clinician's rating of slight borderline personality disorder pathology would be at least as

clinically meaningful as the results based on a semistructured interview.

A potential confounding of dependent and independent variables was present because one of the borderline personality disorder criteria is recurrent suicidal behavior, and this was also one of the validating variables examined. However, removing the patients who met this criterion from the group who met 1 borderline personality disorder criterion did not change the results. Similarly, Axis I pathology might have contributed to some of the borderline personality disorder ratings. For example, substance use and eating disorders are examples of self-damaging impulsivity, and suicidal behavior is characteristic of depressive disorders. However, most of the borderline personality disorder criteria are not characteristic features of Axis I disorders.

More generally, we did not compare patients who met each of the 9 borderline personality disorder criteria to the 0-criteria group because we were interested in addressing the broader nosologic issue of the clinical implications of low-severity ratings on a dimension of the disorder rather than the more specific question of which of the borderline personality disorder criteria, when occurring alone, are associated with increased psychosocial morbidity.

The findings of the present study reinforce the importance of routinely inquiring about and considering the presence of personality disorder pathology, even for those patients who might not have an obvious personality disorder. However, in routine clinical practice, clinicians struggle to find a balance between comprehensiveness and time efficiency. While several studies have demonstrated that more Axis I and Axis II disorders are diagnosed when semistructured interviews are used rather than unstructured clinical evaluations,[21,31–34] the use of such interviews are not the standard of care.

The present report was based on a sample of patients presenting for outpatient treatment. However, almost one-quarter of the patients evaluated in the MIDAS project had a history of at least 1 hospitalization. The study was conducted in a single clinical practice in which the majority of the patients were white, female, and had health insurance. Replication of the results in other clinical samples with different demographic characteristics and in general population epidemiologic samples is warranted. Strengths of the study are the large sample size and the use of highly trained diagnostic interviewers to reliably administer a semistructured diagnostic interview.

Author affiliations: Department of Psychiatry and Human Behavior, Brown University School of Medicine, Rhode Island Hospital, Providence.
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