Impact of Deleting 5 *DSM-IV* Personality Disorders on Prevalence, Comorbidity, and the Association Between Personality Disorder Pathology and Psychosocial Morbidity

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ABSTRACT

Objective: A high rate of comorbidity among the personality disorders has been consistently identified as a problem. To address the problem of excessive comorbidity, the *DSM-5* Personality and Personality Disorders Work Group recommended reducing the number of specific personality disorder diagnoses from 10 to 5 by eliminating paranoid, schizoid, histrionic, narcissistic, and dependent personality disorders. No study has examined the impact of this change. The present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project examined the impact of eliminating these 5 personality disorders on the prevalence of personality disorders in a large sample of psychiatric outpatients presenting for treatment, comorbidity among the personality disorders, and association with psychosocial morbidity.

Method: From September 1997 to June 2008, 2,150 psychiatric patients presenting to the Rhode Island Hospital outpatient practice were evaluated with semistructured diagnostic interviews for *DSM-IV* Axis I and Axis II disorders and measures of psychosocial morbidity.

Results: More than one-quarter of the patients were diagnosed with one of the 10 *DSM-IV* personality disorders (28.6%, n = 614). When 5 personality disorders were excluded from consideration, then 25.8% (n = 555) were diagnosed with at least 1 of the 5 personality disorders proposed for retention in *DSM-5*, and the comorbidity rate dropped from 29.8% to 21.3%. Compared to patients without a personality disorder, the patients with either a retained or an excluded personality disorder had greater psychosocial morbidity. There was little difference in psychosocial morbidity between patients with a retained and an excluded personality disorder.

Conclusions: The Personality and Personality Disorders Work Group's desired goal of reducing comorbidity would be achieved by deleting 5 personality disorders, although comorbidity would not be eliminated. The reduction of comorbidity could come with a cost of false-negative diagnoses. The results therefore do not provide unambiguous support for the *DSM-5* proposed elimination of 5 personality disorders.

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When it comes to revising the official diagnostic classification system, the guiding principle should be that criteria should not be changed in the absence of research demonstrating that the new approach is superior to the old in either validity or clinical utility, preferably both. It is also preferable that the supportive research has been independently replicated. Recent revisions of the *DSM* have been preceded with assertions that changes in criteria would be grounded in empirical evidence.[1–3] Yet, despite assurances that only data-driven modifications would be made, with each new edition of the *DSM* we have witnessed repeated instances of changes being made in the absence of sufficient data demonstrating that the new criteria are superior to the prior. Certainly this is true in the personality disorder section. Criteria have been added, removed, and rewritten, and disorders have been added and removed, without evidence that the new approach would be better than the prior one. For *DSM-5*, the principles guiding revisions have been made explicit, and these principles emphasize the importance of empirically demonstrating the superiority of the proposed changes.[4]

Through the years, there have been many critiques of the *DSM-III*, *DSM-III-R*, and *DSM-IV* approaches toward classifying the personality disorders. A high rate of comorbidity among the personality disorders has been consistently identified as a problem.[5–9] High comorbidity rates among the personality disorders have been interpreted as indicating that the personality disorders do not represent unique clinical entities.[6,9] To address the problem of excessive comorbidity, one of the recommendations of the *DSM-5* Personality and Personality Disorders Work Group was to reduce the number of specific personality disorder diagnoses from 10 to 5 by eliminating paranoid, schizoid, histrionic, narcissistic, and dependent personality disorders.[10] This proposal has generated critical comment in both the scientific and nonscientific literature.[11–19] No study has examined the impact of this change.

The present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project examined 3 questions related to the proposed elimination of 5 personality disorders from *DSM-5*. First, we determined the impact on the prevalence of personality disorders in a large sample of psychiatric outpatients presenting for treatment. Second, we tested the hypothesis that among individuals with a personality disorder the rate of comorbidity would decrease when the 5 personality disorders are eliminated. Third, we compared the level of psychosocial morbidity in patients with a retained or excluded personality disorder to each other and to patients without a personality disorder.

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Clinical Points

- The deletion of 5 personality disorders, as recommended by the *DSM-5* Personality and Personality Disorders Work Group, does not eliminate diagnostic comorbidity.
- The deletion of 5 personality disorders may result in increased rates of personality disorder not otherwise specified diagnoses, signaling a problem with the nosology that was not adequately solved by removing these disorders.
- Comorbidity rates may decline by virtue of classification of fewer disorders; however, without empirical evidence supporting such changes, the removal of disorders may lead to false-negative diagnoses.

METHOD

The MIDAS project represents an integration of research methodology into a community-based outpatient practice affiliated with an academic medical center.[20] 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.

A comprehensive diagnostic evaluation is conducted upon presentation for treatment. During the course of the MIDAS project, the assessment battery has changed. The assessment of all *DSM-IV* personality disorders was not introduced until the study was well underway and the procedural details of incorporating research interviews into our clinical practice had been well established. The present report is based on the 2,150 patients who presented to the Rhode Island Hospital outpatient practice and were interviewed with the full Structured Interview for *DSM-IV* Personality (SIDP-IV)[21] from September 1997 to June 2008. The data in Tables 1 and 2 show the demographic and diagnostic characteristics of the sample. The majority of the subjects were white, female, and married or single and had some college education. The mean age of the sample was 38.5 years (SD = 12.8). The most frequent current *DSM-IV* diagnoses were major depressive disorder, social phobia, generalized anxiety disorder, and panic disorder.

Patients were interviewed by a diagnostic rater who administered the Structured Clinical Interview for *DSM-IV* (SCID)[22] and SIDP-IV. 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 the course of training, the senior author met with each rater to review the interpretation of every item on the SCID and SIDP-IV. Also during training, every interview was reviewed on an item-by-item basis by the senior rater who observed the evaluation and by the principal investigator who reviewed the case with the interviewer. 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

Table 1. Demographic Characteristics of 2,150 Psychiatric Outpatients[a]

Characteristic	n	%
Gender		
Female	1,310	60.9
Male	840	39.1
Education		
Less than high school	178	8.3
Graduated high school	1,343	62.5
Graduated college or greater	629	29.3
Marital status		
Married	869	40.4
Living with someone	127	5.9
Widowed	36	1.7
Separated	112	5.2
Divorced	325	15.1
Never married	681	31.7
Race		
White	1,952	90.8
Black	95	4.4
Hispanic	58	2.7
Asian	21	1.0
Other	24	1.1

[a]Mean (SD) age = 38.5 (12.8) years.

Table 2. Current *DSM-IV* Axis I Diagnoses of 2,150 Psychiatric Outpatients[a]

DSM-IV Diagnosis	n	%
Major depressive disorder	925	43.0
Bipolar disorder	111	5.2
Dysthymic disorder	179	8.3
Generalized anxiety disorder	415	19.3
Panic disorder	381	17.7
Social phobia	576	26.8
Specific phobia	225	10.5
Obsessive-compulsive disorder	138	6.4
Posttraumatic stress disorder	247	11.5
Adjustment disorder	149	6.9
Schizophrenia	8	0.4
Eating disorder	143	6.7
Alcohol abuse/dependence	207	9.6
Drug abuse/dependence	103	4.8
Somatoform disorder	167	7.8
Attention-deficit disorder	138	6.4
Impulse-control disorder	123	5.7
Paranoid personality disorder	69	3.2
Schizoid personality disorder	18	0.8
Schizotypal personality disorder	10	0.5
Histrionic personality disorder	17	0.8
Borderline personality disorder	204	9.5
Antisocial personality disorder	41	1.9
Narcissistic personality disorder	40	1.9
Dependent personality disorder	39	1.8
Obsessive-compulsive personality disorder	147	6.8
Avoidant personality disorder	285	13.2

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

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the raters consisted of weekly diagnostic case conferences involving all members of the team. In addition, the item ratings of every case were reviewed by the senior author. The institutional review committee of Rhode Island Hospital approved the research protocol, and all patients provided informed, written consent.

We integrated into the SCID the item from the Schedule for Affective Disorders and Schizophrenia (SADS)[23] 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, lifetime history of suicide attempts, current suicidal ideation (rated on a 0-to-6 scale on the SADS), and social functioning during the past 5 years (rated on a 1-to-7 scale on the SADS). Based on the results of the SCID/SADS and SIDP-IV interviews, the Global Assessment of Functioning (GAF) was rated.

The SIDP-IV focuses on the individual's "usual self" over the past 5 years. Each *DSM-IV* criterion is rated 0 (criterion not present), 1 (subthreshold; some evidence of the trait but not sufficiently pervasive or severe to be considered present), 2 (criterion present; clearly evident for the last 5 years at least 50% of the time), or 3 (criterion strongly present). The questions on the SIDP-IV are grouped thematically into similar content areas, such as interpersonal relationships, interests and activities, social conformity, and emotions. Such an interview is less prone to halo effects in which ratings of individual criteria are influenced by how close the individual is to meeting the criteria for a particular disorder.

The full SIDP-IV assesses the 10 *DSM-IV* personality disorders, 2 personality disorders listed in the Appendix of *DSM-IV* as disorders requiring further study (depressive and passive-aggressive personality disorder), and *DSM-III-R* self-defeating personality disorder. The present report focuses on the 10 *DSM-IV* personality disorders.

Reliability of personality disorder diagnoses was examined in 47 patients. A joint-interview design was used in which one rater observed another conducting the interview and both raters independently made their ratings. The reliabilities of any personality disorder ($\kappa = 0.90$) and any cluster A ($\kappa = 0.79$), B ($\kappa = 0.79$), or C ($\kappa = 0.93$) personality disorder were good to excellent. Too few patients were diagnosed with individual personality disorders to calculate κ coefficients. However, intraclass correlation coefficients (ICCs) of criterion count dimensional scores were high (paranoid, ICC = 0.92; schizoid, ICC = 0.95; schizotypal, ICC = 0.82; antisocial, ICC = 0.95; borderline, ICC = 0.95; histrionic, ICC = 0.91; narcissistic, ICC = 0.91; avoidant, ICC = 0.96; dependent, ICC = 0.97; obsessive-compulsive, ICC = 0.90).

Data Analysis

We subdivided the patients who met the *DSM-IV* criteria for a personality disorder into 2 groups on the basis of whether they were diagnosed with a disorder to be retained in *DSM-5*. Patients diagnosed with antisocial, avoidant, borderline, schizotypal, or obsessive-compulsive personality disorder were included in the *retained personality disorder* group. Patients diagnosed with dependent, histrionic, narcissistic, paranoid, or schizoid personality disorder, and who were not diagnosed with any of the retained personality disorders, were included in the *excluded personality disorder* group.

We compared the level of psychosocial morbidity in 3 groups: no personality disorder, retained personality disorder, and excluded personality disorder. The dependent variables were examined categorically as well as continuously. We a priori defined as indicators of severe illness 3 or more current 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 unemployed due to psychiatric reasons for at least 2 years in the past 5 years. Analyses of variance were used to compare the 3 groups on continuously distributed variables, whereas categorical variables were compared by the χ^2 statistic. Tukey honestly significant difference follow-up tests were conducted for the 2-group comparisons of no personality disorder versus retained personality disorder and no personality disorder versus excluded personality disorder. Regression analyses were conducted comparing the excluded and retained personality disorder groups with the total number of *DSM-IV* personality disorders entered into the model before entering the measure of psychosocial morbidity.

RESULTS

More than one-quarter of the patients were diagnosed with one of the 10 *DSM-IV* personality disorders (28.6%, n = 614). When schizoid, paranoid, histrionic, narcissistic, and dependent personality disorders were excluded from consideration, then 25.8% (n = 555) of the patients were diagnosed with at least 1 of the retained personality disorders. Overall, 7.8% (n = 168) of the patients were diagnosed with at least 1 of the excluded personality disorders, 109 of whom were also diagnosed with a retained personality disorder and included in the retained personality disorder group. Thus, the excluded personality disorder group consisted of the 59 patients who were diagnosed with an excluded personality disorder only.

In the sample of 614 patients with any of the 10 *DSM-IV* personality disorders, 29.8% (n = 183) were diagnosed with at least 1 other personality disorder. The mean number of *DSM-IV* personality disorders in the patients with a *DSM-IV* personality disorder was 1.5 (SD = 0.8). In the subsample of 555 patients with a retained personality disorder, 21.3% (n = 118) were diagnosed with another retained personality disorder. The mean number of retained personality disorders in the patients with a retained personality disorder was 1.2 (SD = 0.5).

The mean number of *DSM-IV* personality disorders was significantly higher in the group with a retained personality disorder compared to the group with an excluded personality disorder (1.5 ± 0.8 vs 1.0 ± 0.1, $t = 4.4$, $P < .001$); therefore,

Table 3. Psychosocial Morbidity in Patients With No Personality Disorder (n = 1,536), One of the 5 Personality Disorders Recommended for Retention in *DSM-5* (n = 555), and One of the 5 Personality Disorders Recommended for Exclusion in *DSM-5* (n = 59)

Indicator of Psychosocial Morbidity	Patient Group: No Personality Disorder, Mean (SD)	Patient Group: Personality Disorder Recommended for Retention in *DSM-5*,[a] Mean (SD)	Patient Group: Personality Disorder Recommended for Exclusion in *DSM-5*,[b] Mean (SD)	3-Group Test: *F*	3-Group Test: *df*	*P* Value: 3-Group Significance	*P* Value: Retained vs None	*P* Value: Excluded vs None	*P* Value: Retained vs Excluded[c]
No. of current Axis I disorders	1.6 (1.2)	3.0 (1.7)	2.3 (1.7)	169.5[d]	2,148.4	.001	.001	.001	.05
Global Assessment of Functioning rating	55.8 (9.1)	48.8 (8.4)	50.7 (10.0)	127.1	2,2145	.001	.001	.001	NS
Suicidal ideation[e]	0.7 (1.1)	1.3 (1.4)	0.9 (1.3)	56.0[d]	2,149.5	.001	.001	NS	NS
No. of suicide attempts	0.3 (1.5)	1.1 (5.0)	0.2 (0.5)	8.2[d]	2,245.3	.001	.001	NS	NS
No. of psychiatric hospitalizations	0.4 (1.0)	0.7 (1.4)	0.6 (1.1)	12.0[d]	2,150.8	.001	.001	NS	NS
Time unemployed in past 5 years, y[f]	2.2 (1.7)	3.1 (2.2)	2.8 (2.0)	33.9[d]	2,137.7	.001	.001	.05	NS
Social functioning[g]	2.8 (1.0)	3.6 (1.2)	3.4 (1.4)	109.9[d]	2,149.2	.001	.001	.001	NS

[a]Patients in the *DSM-5* retained group were diagnosed with schizotypal, borderline, antisocial, avoidant, or obsessive-compulsive personality disorder.
[b]Patients in the *DSM-5* excluded group were diagnosed with schizoid, paranoid, histrionic, narcissistic, or dependent personality disorder and were not diagnosed with any of the 5 disorders defining the *DSM-5* retained group.
[c]The retained and excluded groups were compared after controlling for the total number of personality disorders.
[d]The assumption of homogeneity was not met; therefore, the Welch *F* ratio is reported and the degrees of freedom are adjusted.
[e]Measured on a 0-to-6 scale from the Schedule for Affective Disorders and Schizophrenia; a higher score indicates greater suicidal ideation.
[f]Those not expected to work (ie, retired, student, housewife, physically ill) were excluded from the analysis; thus, the sample sizes were 1,362 for the group with no personality disorder, 511 in the retained group, and 54 in the excluded group.
[g]Measured on a 1-to-7 scale from the Schedule for Affective Disorders and Schizophrenia; a higher score indicates worse social functioning.

Table 4. Indicators of Severe Illness in Patients With No Personality Disorder (n = 1,536), One of the 5 Personality Disorders Recommended for Retention in *DSM-5* (n = 555), and One of the 5 Personality Disorders Recommended for Exclusion in *DSM-5* (n = 59)

Indicator of Severe Morbidity	Patient Group: No Personality Disorder, (%) n	Patient Group: Personality Disorder Recommended for Retention in *DSM-5*,[a] (%) n	Patient Group: Personality Disorder Recommended for Exclusion in *DSM-5*,[b] (%) n	3-Group Test, χ^2	*P* Value: 3-Group Significance	*P* Value: Retained vs None	*P* Value: Excluded vs None	*P* Value: Retained vs Excluded[c]
3+ Current Axis I disorders	20.6 (317)	57.5 (319)	40.7 (24)	262.9	.001	.001	.001	NS
Global Assessment of Functioning rating ≤ 50	29.4 (452)	61.8 (342)	52.5 (31)	185.8	.001	.001	.001	NS
Serious suicidal ideation[d]	7.4 (114)	20.7 (115)	13.6 (8)	73.9	.001	.001	NS	NS
History of 3+ suicide attempts	2.9 (44)	10.3 (57)	0.0 (0)	52.9	.001	.001	NS	NS
History of 3+ psychiatric hospitalizations	5.4 (83)	10.5 (58)	6.8 (4)	16.5	.001	.001	NS	NS
Unemployed 2+ years in past 5 years[e]	7.5 (102)	19.8 (101)	13.0 (7)	57.9	.001	.001	NS	NS
Poor social functioning[f]	5.1 (79)	23.1 (128)	16.9 (10)	147.3	.001	.001	.001	NS

[a]Patients in the *DSM-5* retained group were diagnosed with schizotypal, borderline, antisocial, avoidant, or obsessive-compulsive personality disorder.
[b]Patients in the *DSM-5* excluded group were diagnosed with schizoid, paranoid, histrionic, narcissistic, or dependent personality disorder, and were not diagnosed with any of the 5 disorders defining the *DSM-5* retained group.
[c]The retained and excluded groups were compared after controlling for the total number of personality disorders.
[d]Rating of 3 or higher on the Schedule for Affective Disorders and Schizophrenia suicidal ideation item.
[e]Those not expected to work (ie, retired, student, housewife, physically ill) were excluded from the analysis; thus, the sample sizes were 1,362 for the group with no personality disorder, 511 in the retained group, and 54 in the excluded group.
[f]Rating of 5 or higher on the Schedule for Affective Disorders and Schizophrenia social functioning item.

the number of personality disorders was controlled in analyses comparing the retained and excluded personality disorder groups. The data in Table 3 show that the patients with a retained personality disorder had significantly more current Axis I disorders than the patients who only had an excluded personality disorder, although there was no difference on the other indicators of psychosocial morbidity. There was no difference between the retained and excluded personality disorder groups on any indicator of severe illness (Table 4).

Compared to patients without a personality disorder, the patients with an excluded personality disorder had significantly more Axis I disorders, missed more time from work, had poorer social functioning, and were rated lower on the GAF (Tables 3 and 4). Compared to the no personality disorder group, the patients with a retained personality disorder also had significantly more Axis I disorders, missed more time from work, had poorer social functioning, and were rated lower on the GAF, as well as had an increased rate of psychiatric hospitalizations and suicide attempts.

DISCUSSION

The *DSM-5* Personality and Personality Disorders Work Group made several recommendations to change the approach toward diagnosing personality disorders, including the adoption of dimensional ratings of prototypes and trait ratings and the deletion of 5 personality disorders. The deletion of 5 personality disorders is intended to reduce the level of comorbidity among the personality disorders. No data were cited describing the impact this deletion had, or might have, on the overall prevalence of personality disorders, nor were data cited indicating how much lower the rate of comorbidity would drop. The results of the present study of a large, heterogeneous sample of psychiatric outpatients found that approximately 10% of the patients with a personality disorder would no longer have a personality disorder because they had been diagnosed only with 1 (or more) of the 5 disorders recommended for deletion. The desired goal of reducing comorbidity would be achieved by deleting 5 personality disorders, although comorbidity would not be eliminated. Psychosocial morbidity was greater in patients with an excluded diagnosis than patients without a personality disorder. Moreover, there was little difference in morbidity between patients with an included and excluded diagnosis. One interpretation of this finding is that the reduction of comorbidity will come with a potential cost of false-negative diagnoses. On the other hand, it can be argued that no false-negatives will occur because the *DSM-5* system allows for such pathology to be identified in the trait ratings. However, even ardent proponents of dimensional trait approaches toward personality disorder assessment acknowledge that the dimensional trait approach is likely to be ignored in clinical practice.[24]

The findings of the present study highlight our concerns about adopting changes in the diagnostic manual without adequate empirical evaluation beforehand. To be sure, there are problems with the classification of personality disorders. However, the identification of a problem is simply the first step of a process resulting in a change in diagnostic criteria. As part of the process, it is imperative that the new diagnostic approach is compared to the previous one to ensure that the new approach is superior in its reliability, validity, or clinical utility or, ideally, all 3. Moreover, sufficient research needs to be conducted to examine all 3 of these constructs to ensure that an improvement in one area is not offset by a worsening in another. For example, the classification of personality disorders (or any other diagnostic category) would not be improved if the new criteria or diagnostic approach were more clinically useful but less reliable and valid. We are not aware of other examples in contemporary medicine in which a large number of disorders were eliminated from a nosology in the absence of solid scientific evidence demonstrating that the proposed, alternative, classification was superior. Miller et al[17] described the proposed elimination of half of the personality disorders as a "gutting" of the personality disorder section of the diagnostic manual. Analyses similar to the one conducted in the present study could be done with other large data sets. In fact, we believe that before having embarked on the field trials for *DSM-5* such analyses should have been done to examine whether unforeseen consequences such as false-negative diagnoses might occur as a result of recommending the deletion of 5 disorders.[25]

In previewing the possible changes to the personality disorder section of *DSM-5*, Skodol and Bender[26] indicated that comorbidity among the personality disorders was "excessive" and one of the primary reasons for making substantive changes. Unstated was the level of comorbidity that would be deemed acceptable. Zimmerman[27] recently raised the question of whether comorbidity rates among the personality disorders are, in fact, too high. Zimmerman noted that the high comorbidity rates identified by critics of the *DSM-IV* approach are based on studies of psychiatric patients, in which Berkson's bias might be responsible for inflated estimates of comorbidity rates. A review of 7 community-based epidemiologic studies found that comorbidity rates were approximately half the level found in patient studies.[27] Perhaps the comorbidity rates found in general population surveys of the *DSM* personality disorders are also excessive. It is difficult to be more definitive because the Work Group did not indicate what an acceptable level of comorbidity might be. Admittedly, a high rate of comorbidity among the personality disorders in individuals seeking psychiatric treatment remains a problem for the treating clinician; however, this may be more a product of Berkson's bias than limitations of the nosology. Because the diagnostic system has multiple purposes, including facilitating the identification of valid disease/disorder entities and allocation of public health resources, the *DSM-5* Work Group's recommendation that 5 disorders be deleted in order to reduce comorbidity rates in patient samples could result in a less valid diagnostic system.

In the present article, we focused on only 1 of the problems identified by the Work Group with the *DSM-IV* personality disorders classification approach—the problem of diagnostic comorbidity. The recommended overhaul of the personality disorders section for *DSM-5* is also based on other professed limitations of *DSM-IV,* such as the high rates of personality disorder not otherwise specified, evidence of the continuous nature of the personality disorder constructs, and incomplete coverage of personality pathology. However, the recommendation of deleting 5 personality disorders, among the most controversial of the Work Group's suggestions,[11–19] was explicitly linked to the goal of reducing diagnostic comorbidity.[26,28]

In the present study, we used a semistructured interview to diagnose the *DSM-IV* disorders. This is at variance with the proposed change for *DSM-5* in which specific personality disorders will be diagnosed according to the degree of fit to a prototype. It is possible that in clinical practice, in which clinicians are not as comprehensive in their assessment of all diagnostic criteria, the decrement in rate of comorbidity when fewer disorders are available for diagnosis would be greater. On the other hand, multiple studies of clinicians' diagnostic practice have found that patients are much less

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likely to be diagnosed with multiple disorders during a routine clinical evaluation versus a semistructured diagnostic interview.[29–31] Thus, it is likely that the deletion of 5 disorders in *DSM-5* would not result in lower rates of comorbidity in clinical practice.

The present study examined the impact of the *DSM-5* proposal as it was initially presented on the *DSM-5* Web site. On June 21, 2011, after this article had been submitted for publication and reviewed and was about to be resubmitted after revision in response to reviewers' comments, a modified proposal was presented on the *DSM-5* Web site. In the original draft of the resubmission, we wrote, "It is possible that some of the disorders currently recommended for exclusion will ultimately be retained, and a new set of analyses would be required to determine the impact of the revised proposal." In fact, this has proven to be the case. Narcissistic personality disorder is no longer recommended for exclusion. We chose not to redo the analyses because it is possible that further changes will occur. Again, we urge the *DSM-5* Work Group to collaborate with researchers possessing large clinical and epidemiologic data sets to examine the impact of alternative proposals.

We examined the impact of disorder deletion on comorbidity rates based on the *DSM-IV* definitions of the disorders. A change in the disorders' definitions could alter comorbidity rates and the impact of disorder exclusion on comorbidity rates.

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 psychiatric hospitalization. The study was conducted in a single clinical practice in which the majority of the patients were white, were female, and had health insurance. A strength of the study is the use of highly trained diagnostic interviewers to reliably administer a semistructured diagnostic interview. Replication of the results in other clinical samples with different demographic characteristics and in general population epidemiologic samples is warranted.

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REFERENCES

1. Frances A, Pincus HA, Widiger TA, et al. *DSM-IV*: work in progress. *Am J Psychiatry*. 1990;147(11):1439–1448.
2. Widiger TA, Frances AJ, Pincus HA, et al. Toward an empirical classification for the *DSM-IV*. *J Abnorm Psychol*. 1991;100(3):280–288.
3. Kupfer DJ, Regier DA, Kuhl EA. On the road to *DSM-V* and *ICD-11*. *Eur Arch Psychiatry Clin Neurosci*. 2008;258(suppl 5):2–6.
4. Kendler KS, Kupfer DJ, Narrow WE, et al. Guidelines for Making Changes to *DSM-V*. American Psychiatric Association Web site. http://www.psych.org/MainMenu/Research/DSMIV/DSMV/DSMRevisionActivities/Guidelines-for-Making-Changes-to-DSM_1.aspx. Revised October 21, 2009.
5. Clark LA. Assessment and diagnosis of personality disorder: perennial issues and an emerging reconceptualization. *Annu Rev Psychol*. 2007;58(1):227–257.
6. Trull TJ, Durrett CA. Categorical and dimensional models of personality disorder. *Annu Rev Clin Psychol*. 2005;1(1):355–380.
7. Blashfield RK, Breen MJ. Face validity of the *DSM-III-R* personality disorders. *Am J Psychiatry*. 1989;146(12):1575–1579.
8. Shedler J, Westen D. Refining personality disorder diagnosis: integrating science and practice. *Am J Psychiatry*. 2004;161(8):1350–1365.
9. Westen D, Shedler J. Revising and assessing Axis II, Part I: developing a clinically and empirically valid assessment method. *Am J Psychiatry*. 1999;156(2):258–272.
10. American Psychiatric Association. *Personality and Personality Disorders*. Washington, DC: American Psychiatric Association; 2010.
11. Bornstein RF. Reconceptualizing personality pathology in *DSM-5*: limitations in evidence for eliminating dependent personality disorder and other *DSM-IV* syndromes. *J Pers Disord*. 2011;25(2):235–247.
12. Gunderson JG. Revising the borderline diagnosis for *DSM-V*: an alternative proposal. *J Pers Disord*. 2010;24(6):694–708.
13. Ronningstam E. Narcissistic personality disorder in *DSM-V*—in support of retaining a significant diagnosis. *J Pers Disord*. 2011;25(2):248–259.
14. Zimmerman M. A critique of the proposed prototype rating system for personality disorders in *DSM-5*. *J Pers Disord*. 2011;25(2):206–221.
15. Zanor C. A fate that narcissists will hate: being ignored. *New York Times*. November 30, 2010. http://www.nytimes.com/2010/11/30/health/views/30mind.html.
16. Shedler J, Beck A, Fonagy P, et al. Personality disorders in *DSM-5*. *Am J Psychiatry*. 2010;167(9):1026–1028.
17. Miller JD, Widiger TA, Campbell WK. Narcissistic personality disorder and the *DSM-V*. *J Abnorm Psychol*. 2010;119(4):640–649.
18. Pies R. How to eliminate narcissism overnight: *DSM-V* and the death of narcissistic personality disorder. *Innov Clin Neurosci*. 2011;8(2):23–27.
19. Clarkin JF, Huprich SK. Do *DSM-5* personality disorder proposals meet criteria for clinical utility? *J Pers Disord*. 2011;25(2):192–205.
20. Zimmerman M. Integrating the assessment methods of researchers in routine clinical practice: the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project. In: First M, ed. *Standardized Evaluation in Clinical Practice*. Washington, DC: American Psychiatric Publishing, Inc; 2003:29–74.
21. Pfohl B, Blum N, Zimmerman M. *Structured Interview for DSM-IV Personality*. Washington, DC: American Psychiatric Press, Inc; 1997.
22. First MB, Spitzer RL, Gibbon M, et al. *Structured Clinical Interview for DSM-IV Axis I Disorders-Patient Edition (SCID-I/P, version 2.0)*. New York, NY: Biometrics Research Department, New York State Psychiatric Institute; 1995.
23. Endicott J, Spitzer RL. A diagnostic interview: the Schedule for Affective Disorders and Schizophrenia. *Arch Gen Psychiatry*. 1978;35(7):837–844.
24. Widiger TA. A shaky future for personality disorders. *Pers Disord Ther Res Treat*. 2011;2:54–67.
25. First MB, Frances A. Issues for *DSM-V*: unintended consequences of small changes: the case of paraphilias. *Am J Psychiatry*. 2008;165(10):1240–1241.
26. Skodol AE, Bender DS. The future of personality disorders in *DSM-V*? *Am J Psychiatry*. 2009;166(4):388–391.
27. Zimmerman M. Is there adequate empirical justification for radically revising the personality disorders section for *DSM-5*? [published online ahead of print April 18, 2011] *Pers Disord Ther Res Treat*.
28. Skodol AE, Bender DS, Morey LC, et al. Personality disorder types proposed for *DSM-5*. *J Pers Disord*. 2011;25(2):136–169.
29. Ramirez Basco M, Bostic JQ, Davies D, et al. Methods to improve diagnostic accuracy in a community mental health setting. *Am J Psychiatry*. 2000;157(10):1599–1605.
30. Shear MK, Greeno C, Kang J, et al. Diagnosis of nonpsychotic patients in community clinics. *Am J Psychiatry*. 2000;157(4):581–587.
31. Zimmerman M, Mattia JI. Psychiatric diagnosis in clinical practice: is comorbidity being missed? *Compr Psychiatry*. 1999;40(3):182–191.