Title

Commentary on "The Challenge of Transforming the Diagnostic System of Personality Disorders".

Journal

Journal of Personality Disorders, 34(Supplement C)

ISSN

0885-579X

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Publication Date

2020-12-01

DOI

10.1521/pedi_2019_33_00

Peer reviewed

Journal of Personality Disorders, 1-4, 2019

EDITOR'S NOTE:

In the October 2017 issue, the Journal of Personality Disorders *published a paper reviewing some issues relating to the draft classification proposal for personality disorders for ICD-11 (Herpertz et al., 2017). To some degree, this paper was in response to a paper also addressing concerns related to the ICD-11 work in progress (Hopwood et al., 2018). A brief response by the Hopwood group to the paper by the Herpertz group was then submitted to* JPD. *Since* JPD *does not have a "Letters to the Editor" section, I have chosen to publish this submission on* JPD*'s website as an online-only document, available to interested parties.*

At the September 2017 meeting of the International Society for the Study of Personality Disorders in Heidelberg, a panel of speakers summarized the position being considered for the ICD-11. A new development was presented, that an agreement had been provisionally reached to include "borderline" as a personality disorder diagnostic specifier, in the forthcoming system, which was generally well received.

—John M. Oldham, MD

COMMENTARY ON "THE CHALLENGE OF TRANSFORMING THE DIAGNOSTIC SYSTEM OF PERSONALITY DISORDERS"

Christopher J. Hopwood, Robert F. Krueger, David Watson, Thomas A. Widiger, Robert R. Althoff, Emily B. Ansell, Bo Bach, R. Michael Bagby, Mark A. Blais, Marina A. Bornovalova, Michael Chmielewski, David C. Cicero, Christopher Conway, Barbara De Clerq, Filip De Fruyt, Anna R. Docherty, Nicholas R. Eaton, John F. Edens, Miriam K. Forbes, Kelsie T. Forbush, Michael P. Hengartner, Masha Y. Ivanova, Daniel Leising, Mark R. Lukowitsky, Donald R. Lynam, Kristian E. Markon, Joshua D. Miller, Leslie C. Morey, Stephanie N. Mullins-Sweatt, Johan Ormel, Christopher J. Patrick, Aaron L. Pincus, Camilo Ruggero, Douglas B. Samuel, Martin Sellbom, Jennifer L. Tackett, Katherine M. Thomas, Timothy J. Trull, David D. Vachon, Irwin D. Waldman, Monika A. Waszczuk, Mark H. Waugh, Aidan G.C. Wright, Mathew M. Yalch, David H. Zald, and Johannes Zimmermann

We write in response to a paper by Herpertz et al. (2017) regarding the proposal for diagnosing personality disorders in the *ICD-11*, written as a collaboration among certain board members from the International, European, and North American Societies for the Study of Personality Disorders

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(ISSPD/ESSPD/NASSPD). Herpertz and colleagues provided a letter to the World Health Organization (WHO) objecting to the proposals for the *ICD-11* personality disorders section. We felt that this original letter was not sufficiently accurate and potentially even misleading. We therefore provided a commentary on this letter, and we understood that both would be published in *Personality and Mental Health*. Herpertz and colleagues, however, did not submit their letter to *Personality and Mental Health*, submitting instead a substantially revised article to the *Journal of Personality Disorders* that included remarks about our commentary. In our previous article, we argued in favor of a dimensional approach to personality disorder classification. We maintain this position but do not elaborate upon it. Here we focus on two issues: (a) specific responses to the four instances in which Herpertz et al. (2017) cite our previous commentary and (b) two suggestions for a more productive and transparent process.

Herpertz et al. (2017) make four statements about our previous article. First, they claim that we "argu[e] for accepting the ICD-11 proposal in its current form" (p. 582). We do not make this argument; in fact, we are quite clear that we believe that "there are multiple potential pathways for moving toward a more evidence-based and clinically useful scheme for classifying personality dysfunction" and simply "urge the *ICD-11* PD work group to remain committed to an evidence-based revision of PD diagnosis." Many of us do not agree with one another about the best way to diagnose PDs, and most of us would probably do it differently from the *ICD-11* proposal. This diversity reflects the general state of the field. There are appropriate channels for individuals and groups to express their views to WHO, and we do not believe it is our place (or anyone else's) to interfere with the process established by WHO to assert how the *ICD-11* should diagnose PDs in a way that is as specific as Herpertz et al. imply.

Second, Herpertz et al. correctly cite our statement that a "majority of clinicians and researchers support a transition to a more dimensional, evidence-based framework," but say that the statement is "inaccurate" (p. 582). They go on to say that a recent article by Nelson, Huprich, Shankar, Sohnleitner, and Paggeot (2017) seems to support the comprehensiveness of the Psychodynamic Diagnostic Manual framework, which, to the best of our knowledge, is not on the table for the *ICD-11*. In fact, the data in Nelson et al. (2017) indicated that the *DSM-5* dimensional trait model was deemed more clinically useful than all the other models for 11 of the 13 clinical utility variables examined, including for ratings of comprehensiveness. Additionally, Herpertz et al. use the Nelson el al. (2017) results to make an inference regarding the views of "practicing clinicians with many years of experience" (p. 582), even though the results reported in that article are based on data from a survey of doctoral trainees. We again acknowledge that there is not unanimity in the field, but stand by our statement that the majority of clinicians and researchers support evidence-based dimensions because the statement is consistent with several published surveys (Bernstein, Iscan, Maser, &

Boards of Directors , 2007; Keeley et al., 2016; Morey, Skodol, & Oldham, 2014; Nelson et al., 2017), as described in our initial commentary.

Third, in a footnote Herpertz et al. (2017, p. 582) assert that the findings of a study by Morey et al. (2014) were more mixed than what we reported. Morey et al. (2014) found in a survey of 337 clinicians an unequivocal preference for *DSM-5* Alternative Model Criterion B traits over *DSM-IV* categories among both psychiatrists and psychologists, but more equivocal evidence with respect to Alternative Model Criterion A level of personality functioning and the Alternative Model hybrid disorder criteria. These results are entirely consistent with our statement that clinicians and researchers support the transition to a more dimensional, evidence-based system, even if they challenge certain specific elements of the *DSM-5* Alternative Model. If anything, these results would seem to conflict rather directly with the suggestion by Herpertz et al. (2017) that that the *ICD-11* should adopt the *DSM-5* Alternative Model.

Fourth, Herpertz et al. (2017) correctly cite our statement that existing *DSM* PD categories are "clinically problematic," but challenge this view based on the large body of research on PD categories. There is indeed a large body of research on PD categories, but the size of this literature does not speak to the degree to which PD categories are clinically useful or problematic. Our view is more in line with the statement in the first section of the Herpertz et al. (2017) article that "there are several well-founded arguments that categorical diagnoses are not sufficiently empirically grounded and do not provide a reliable enough means for individual treatment planning" (p. 579).

Whatever the outcome in the *ICD-11*, we remain concerned about the process. We therefore conclude with two recommendations regarding the role of representatives from professional societies in influencing bodies such as WHO. First, *advocacy by professional societies should be transparent*. In this specific case, we believe that all correspondence between individuals acting as representatives of the ISSPD, ESSPD, and/or NASSPD and WHO should be made public. We call on Herpertz et al. to publish their original letter and any other correspondence with WHO. Second, *representatives of a scientific society should be obligated to accurately represent that society's views*. Although the authors of the Herpertz et al. (2017) article may be board members of professional societies such as the ISSPD, ESSPD, and/or NASSPD, not all of these societies have elected board members, and there is clearly diversity of opinion among the membership of such societies. We underscore the need for any advocacy by board members of professional societies to accurately represent the views of the broader membership. Specifically, any future claims to speak for a scientific society should be based on direct representation (i.e., by elected officials) or data (i.e., membership surveys such as Bernstein et al., 2007, whose results played an important role in the formulation of the *DSM-5* Alternative Model).

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