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Introduction

Personality Disorders in Perspective

Katherine A. Fowler

Emory University

William O'Donohue

University of Nevada, Reno

Scott O. Lilienfeld

Emory University

The personality disorders are a complex, controversial, and fascinating class of diagnoses. Decades of clinical observations of developmentally fixated “character types” (Freud, 1916/1991), “neurotic styles” (Shapiro, 1965), and “character disorders” (e.g., Horney, 1939) preceded the formal classification “personality disorders,” which first emerged in 1980 in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association [APA], 1980). Most of the newly termed personality disorders were not new; indeed, some (e.g., schizoid personality, paranoid personality) had been included in prior editions of the DSM. In preparing the third edition, however, the DSM committee arrived at the consensus that personality disorders are a different “kind” of diagnostic category from the vast majority of disorders listed in the DSM. Thus, DSM-III was the first edition to adopt a multiaxial approach, assigning personality disorders to a separate axis (Axis II) from “clinical conditions” (Axis I). The most recent edition, DSM-IV-TR (APA, 2000), briefly states the rationale for this decision:

The listing of Personality Disorders and Mental Retardation on a separate axis ensures that consideration will be given to the possible presence of Personality Disorders and Mental Retardation that might otherwise be overlooked when attention is directed to the usually more florid Axis I disorders. (p. 28)

The above seems to imply that a diagnosis of personality disorder may provide the context for, or be overshadowed by, more “florid” Axis I diagnoses (such as depression or schizophrenia). It is interesting to speculate why personality disorders share this axis with mental retardation. Both are fairly pervasive across many situations, and both certainly bear implications for the diagnosis and treatment of Axis I disorders (e.g., cognitive therapy for depression might be contraindicated or implemented quite differently in either context); perhaps these similarities justify their placement on Axis II and explain in part why DSM-IV relegates personality disorders to a different diagnostic class from the other mental disorders. Moreover, it has been suggested that most personality disorders tend to be ego-syntonic (i.e., consistent with self-concept), whereas most Axis I disorders are ego-dystonic (i.e., inconsistent with self-concept; Grove & Tellegen, 1991).

DSM-IV-TR (APA, 2000) provides a broad definition of personality disorder:

A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. (p. 629)

This seemingly simple summary actually alludes to a complex set of properties, requiring exegesis of its key phrases. Without some clarification, we cannot make reliable and valid diagnoses and come to a shared understanding of personality disorders. For example, the following terms and phrases raise important questions:

1. *Enduring*: How long must an individual exhibit features of a personality disorder before a diagnosis is applicable?
2. *Pattern*: How consistently over time must an individual exhibit the characteristics in question? If there are periods of time when the individual does not exhibit these characteristics, how long can these time periods be?
3. *Inner experience*: Clearly, this term potentially comprises an extremely broad range of mental processes, including emotions, thoughts, impulses, fantasies, schemas, and memories. Which of these are considered most central to the conceptualization of personality disorders?

4. *Deviates markedly*: Whether a deviation is “marked” is clearly subjective. DSM-IV-TR encourages one to consider the individual’s context (e.g., family, culture) in making this determination. This is a step in the right direction, as it emphasizes that norms are not universal. However, it leads to the next point of inquiry:
5. *Individual’s culture*: Culture has many facets, including ethnicity, sexual orientation, socioeconomic status, geographic region, and gender. To which of these do we look to determine cultural norms, and what are the limits? How do we avoid confounding “cultural norms” with stereotypical perceptions?
6. *Pervasive*: How cross-situationally consistent must personality disorder features be for an individual to meet criteria? For example, can a person meet criteria for a personality disorder if he or she exhibits marked features in personal life but less marked features at work?
7. *Inflexible*: How much flexibility is allowed, and in which domains (e.g., work, school, relationships), and how pervasive must this inflexibility be?
8. *Onset in adolescence or early adulthood*: How does one discern “onset”? Must the person fully meet criteria by a certain age, or do some prodromal symptoms count? Particularly in the case of late adolescence and early adulthood, determining developmental norms is a difficult task. How do we find a balance between overpathologizing normal-range teenage behavior and overlooking true pathology? Furthermore, the age limits constituting adolescence and early adulthood are not specified.
9. *Leads to distress and impairment*: How does one establish the causal link between the symptoms and distress/impairment? What kinds of and how much distress/impairment are required?

Three levels of general questions surround personality disorders. First, there are *semantic questions*, such as those raised above. Second, there are *operational questions*: Once the semantics are clarified, what is the best way to gather the information we need? For example, say “enduring” is taken to mean “for at least 3 years.” Should we ask the client to self-report start dates and end dates of symptoms? Should we review records that cover this period, if available, to see if there are any corroborating or contradictory indicators? Should we use information provided by other informants who know the client well? The third problem is the *measurement question*: How does one begin to construct measures with adequate content- and criterion-related validity? This is no easy task, especially as many of these measures aim to assess complex constructs such as “impairment,” which requires historical or normative information often accessible only to the affected

individual (“inner experience”). Part of the controversy regarding personality disorders can be tied to this complexity and to what some understandably perceive to be a lack of progress on these questions.

The DSM-IV Personality Disorders

DSM-IV-TR officially recognizes 10 personality disorders (PDs) and includes three others for further study (depressive personality disorder, passive-aggressive personality disorder, and sadistic personality disorder). A brief description of each of the 10 recognized PDs follows:

Paranoid Personality Disorder is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent;

Schizoid Personality Disorder is a pattern of detachment from social relationships and a restricted range of emotional expression;

Schizotypal Personality Disorder is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior;

Antisocial Personality Disorder is a pattern of disregard for, and violation of, the rights of others;

Borderline Personality Disorder is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity;

Histrionic Personality Disorder is a pattern of excessive emotionality and attention seeking;

Narcissistic Personality Disorder is a pattern of grandiosity, need for admiration, and lack of empathy;

Avoidant Personality Disorder is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation;

Dependent Personality Disorder is a pattern of submissive and clinging behavior related to an excessive need to be taken care of;

Obsessive-Compulsive Personality Disorder is a pattern of preoccupation with orderliness, perfectionism, and control. (APA, 2000, p. 685)

The same three levels of questions noted in our discussion of PD conceptualization in general can be asked regarding individual diagnoses. Take paranoid PD,

for example: there are semantic questions (e.g., what is meant by “suspiciousness?”), operational questions (how do we go about capturing this meaning?), and measurement questions (how do we develop a test that provides a valid measure of “suspiciousness?”). When these questions are multiplied across all the criteria for all of the diagnoses, we can again see both the potential for controversy and the large amount of work that lies ahead.

The individual diagnoses are organized into three broad clusters representing presumed superordinate features that characterize each group:

Cluster A (odd/eccentric disorders):

Paranoid personality disorder
Schizoid personality disorder
Schizotypal personality disorder

Cluster B (dramatic, emotional, or erratic disorders):

Antisocial personality disorder
Borderline personality disorder
Histrionic personality disorder
Narcissistic personality disorder

Cluster C (anxious/fearful disorders):

Avoidant personality disorder
Dependent personality disorder
Obsessive-compulsive personality disorder

These clusters presumably “carve nature at its joints” better than the individual diagnoses. There are consistent findings of high co-occurrence of diagnoses within each cluster but less co-occurrence of diagnoses in different clusters (Morey, 1988; see below).

Major Questions and Controversies in Personality Disorder Research

One consistent finding is that the prevalence of personality disorders in the general population is fairly high. For example, Mattia and Zimmerman (2001) averaged data across a number of epidemiological studies and found that in community samples, 13% of individuals had at least one personality disorder.

Moreover, the prevalence of many of the individual diagnoses was relatively high; for example, obsessive-compulsive personality disorder was present in 4% of the population, while histrionic, schizotypal, and dependent personality disorders were each present in 2% of the population. This high prevalence is one reason that personality disorders remain an area of lively debate.

It is beyond the scope of this chapter to settle these contentions, as many of the issues remain unresolved in the literature. Furthermore, we do not mean to imply that these controversies are unique to personality disorders. Nevertheless, to provide a context for the remaining chapters, we give you their general flavor:

- 1. The predictive utility and perhaps even the existence of personality itself have been called into question.** For several decades, psychologists actively debated whether personality is a valid construct rather than merely a convenient summary label that we invoke to describe behaviors that happen to covary (Mischel, 1968). Personality, particularly for radical behaviorists, was a controversial construct. Skinner (1957) argued that “personality is nothing but the locus of behavior” (p. 182). He thought of personality as an “explanatory fiction” (p. 182) that often seems to involve circular reasoning. For example, imagine that someone observes Jane acting in a consistently outgoing and friendly fashion and asks, “Why does Jane behave this way?” If the answer is that she has an “extraverted personality” and if one concludes that she has an extraverted personality by observing that she is generally outgoing and friendly, this is a tautological, pseudo-explanation. Radical behaviorists would be more comfortable using personality traits as descriptive rather than explanatory concepts.

Personality researchers responded to these criticisms. In particular, they demonstrated that many personality trait measures predict laboratory and biological indices that cannot merely be derived from the behaviors subsumed by the trait labels themselves (Kenrick & Funder, 1988). Nevertheless, some critics justifiably continue to argue that some personality disorders (e.g., dependent personality disorder) are little more than summary labels for behaviors that merit clinical attention.

Mischel re-ignited this controversy in the late 1960s in his book *Personality and Assessment* (1968), in which he pointed to the cross-situational inconsistency of personality traits and thereby called into question the traditional assumption of traits as pervasive behavioral dispositions. Once again, researchers responded to this criticism in a variety of ways. Some suggested that the sample of studies Mischel used to bolster his claim was unrepresentative and demonstrated how a review of different studies did not support his claim (e.g., Block, 1977), while others suggested that examination of moderator variables, such as tendency to “self-monitor” (Snyder, 1974) and prediction of aggregated behaviors (i.e., trends) rather than single behaviors,

yield considerably higher estimates of cross-situational consistency (Bem & Allen, 1974; Epstein, 1979).

Although many consider these controversies resolved when it comes to personality in general, they bear repeating with respect to personality disorders. Personality disorder researchers should meet these challenges as personality researchers did by demonstrating that these conditions predict important external criteria (e.g., natural history, laboratory findings).

2. **It is not clear whether personality disorders are underpinned by categories or by dimensions.** The DSM-IV-TR adopts a categorical system for the diagnosis of personality disorders, as it does with all other disorders. Some have argued (e.g., Trull, 2005) that a dimensional system is better suited to the diagnosis of personality disorders. Categorical discriminations are made when constructs have or are thought to have clear boundaries in nature (tall or short, for example). Dimensional ratings, in contrast, simply provide a value on a continuum (such as 5' 10"). In general, categorical approaches presume that natural discontinuities exist, whereas dimensional approaches presume the existence of natural continua. Although dimensional systems seem to have the advantage of precision, they raise questions about which dimensions of personality and/or psychopathology ought to be used in conceptualizing personality disorders. Is the use of cutoffs on dimensions for a particular disorder ever justified for pragmatic or social purposes? And, finally, can we measure a dimension accurately? For example, we can measure height, but can we measure extraversion with the same reliability and validity?
3. **If personality disorders are better conceptualized dimensionally, it is not clear which system (e.g., Big Five, Big Three) is the most useful for doing so.** Several dimensional models have been investigated as alternatives to the current DSM categorical conceptualization of personality disorders. Of these, the model necessitating the least departure from the current system adopts the approach of rating match to a prototypical description of each disorder. Although some have found that this approach may increase reliability (e.g., Heumann & Morey, 1990), others have noted that it does not necessarily increase validity for two reasons: (1) the validity of the prototypes is still dependent on the validity of the conceptualizations found in the DSM, and (2) this approach does not address the problem of symptom heterogeneity found within most personality disorders (Clark, 1999).

A different dimensional approach examines the possibility that personality disorders are best expressed as constellations of normal-range personality traits. Of these alternative conceptualizations, the five-factor model of personality (FFM) has received the most research attention. The FFM was derived from lexical studies of the English

language, in which an overinclusive list of colloquial trait adjectives was factor-analyzed, yielding five separable dimensions: (1) extraversion (social potency, positive affectivity); (2) agreeableness (desire to get along with others); (3) conscientiousness (constraint, self-discipline); (4) neuroticism (anxiety, irritability); and (5) openness (intellect, unconventionality). Widiger, Trull, Clarkin, Sanderson, and Costa (1994) give an example of the characterization of a personality disorder within this framework:

From the perspective of the FFM avoidant personality disorder involves: a) introversion, particularly the facets of low gregariousness (no close friends, avoids significant interpersonal contact, and unwilling to get involved with others; APA, 1987); low excitement-seeking (exaggerates potential dangers, difficulties, or risks in doing anything outside of normal routine); and low activity (avoidance of social and occupational activities, and canceling of social plans) . . . and b) neuroticism, particularly the facets of vulnerability, self-consciousness, and anxiety (e.g., easily hurt by criticism and disapproval, reticent in social situations because of fear of saying something foolish, fears being embarrassed, and afraid of being disliked). (p. 49)

They further raise the still unresolved question of whether using this model to describe personality disorders is superior to the current DSM system. Part of the argument for doing so is that the FFM may provide an overarching and parsimonious model that accommodates all of the personality disorders on Axis II. Moreover, such a model could underscore trait commonalities that both underlie these disorders and account for their extensive covariation (see #4 below). Currently, several research groups are examining these questions (e.g., Bagby, Costa, Widiger, Ryder, & Marshall, 2005; Miller, Bagby, Pilkonis, Reynolds, & Lynam, 2005). Alternative dimensional models to the FFM, such as three-factor models (e.g., Clark, 1999; Cloninger, 1987), have been proposed and continue to be an active source of investigation.

4. **The rampant comorbidity among many personality disorders calls into question their validity and/or existence as independent syndromes.** Fiester, Ellison, Docherty, and Shea (1990) reported two kinds of comorbidity among PDs. First, they found that individuals diagnosed with one personality disorder are likely to be diagnosed with at least one other. In four samples of individuals diagnosed with a personality disorder, Widiger and Rogers (1989) found that the average proportion of patients who met criteria for at least one additional personality disorder was 85%, with a range of 76% for dependent personality disorder to 100% for paranoid personality disorder. Second, they found that many persons diagnosed with a personality disorder are also diagnosed with a mood disorder, anxiety disorder, or schizophrenia.

They concluded that “the fundamental relationships of these disorders to one another remains a puzzle” (p. 111). Moreover, they proposed some potential explanations for this second type of comorbidity, such as: (1) one personality disorder causes another disorder; (2) the other disorder causes the personality disorder; (3) the personality disorder and the other disorder influence and affect each other; and (4) the personality disorder and the other disorder are etiologically separable and unrelated coeffects of some other disturbance. More research is needed to investigate these possibilities.

5. **There are serious problems with the reliability of personality disorders.** The DSM personality disorders suffer from problems of internal consistency, test-retest reliability, and interrater reliability. Morey (1988) found that the internal consistency among diagnostic features for the DSM-III personality disorders as revealed by the median correlation among the criteria within each disorder ranged from $r = .10$ to $r = .34$. Loranger et al. (1988) studied the test-retest reliability of personality disorder diagnoses over a 1-week to 6-month interval. The median kappa for the presence or absence of the disorder on both occasions ranged between .52 and .57, except in the case of compulsive personality disorder (now called obsessive-compulsive personality disorder), in which it was only .26. Overall, there was a trend toward fewer observed diagnoses and traits over time. With regard to interrater reliability, in the DSM-III field trials the kappa coefficient for the presence or absence of any personality disorder was .61 based on a joint-interview design. The interrater reliability evidence for later versions of the DSM is scarcely more promising (see Zimmerman, 1994, for a review).
6. **There is a paucity of evidence for the construct validity of most personality disorders, including their natural history and laboratory correlates.** The chapters that follow will reveal that much information about the course, family history, and laboratory and physiological correlates of personality disorders is lacking. Of course, this criticism must be tempered by the fact that many other groups of disorders in the DSM-IV also lack this sort of information (e.g., sexual dysfunctions and paraphilias). This paucity of evidence leaves the DSM vulnerable to the radical behaviorists' criticism that these disorders are little more than tautological summary labels for covarying thoughts, emotions, and behaviors.
7. **The best means of assessing personality disorders is unclear.** Currently, there are a number of omnibus instruments for the assessment of personality disorders, such as the Personality Disorders Examination (Loranger, 1988), the Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II; Spitzer, Williams, & Gibbon, 1987), and the Personality Disorders Questionnaire-4+ (PDQ-4+; Hyler & Rieder,

1994). In a thorough review of the extant measures, Perry (1992) found that although several instruments showed moderate to high levels of interrater and test-retest reliability for some diagnoses, many showed poor levels. Perry also found little agreement among the measures (median kappa = .25), calling into question the convergent validity of commonly used personality disorder measures.

Moreover, Zimmerman (1994) has suggested that most of the following fundamental questions regarding personality disorder assessment remain unresolved: (1) Who should provide information (e.g., client, relatives, both)? (2) What instruments should be used? and (3) When should the assessment be conducted (e.g., when the patient is free of Axis I symptoms, or when he or she is experiencing them)?

8. **The distinction between Axis I and Axis II psychopathology is frequently unclear and seemingly arbitrary.** The rationale for these two axes has never been entirely clear or grounded in solid evidence (Harkness & Lilienfeld, 1997). For example, some Axis I problems, such as schizophrenia and cyclothymic disorder, can last at least as long as Axis II disorders, particularly if they are left untreated. In addition, the DSM's placement of Axis II disorders has often been inconsistent. For example, cyclothymic disorder appears to be a subsyndromal form of bipolar disorder and is located on Axis I, whereas schizotypal personality disorder appears to be a subsyndromal form of schizophrenia and is located on Axis II. Additionally, as mentioned previously, the way in which Axis I and Axis II pathology interact remains unclear. Thus one can raise potentially interesting questions, such as, does dysphoria set the stage for the perhaps more florid histrionic personality disorder, or is it the other way around? That is, although the DSM seems to view personality disorders as a distinct class of disorders, it has not clearly elucidated the distinctive properties of this class.
9. **The diagnosis of certain personality disorders may be compromised by gender bias.** According to DSM-IV-TR (APA, 2000), some personality disorders are diagnosed more frequently in men (e.g., antisocial personality disorder, narcissistic personality disorder, obsessive-compulsive personality disorder, and the Cluster A disorders), whereas others are diagnosed more frequently in women (e.g., borderline personality disorder, histrionic personality disorder, and dependent personality disorder). However, there have been inconsistent findings: for example, Golomb, Fava, Abraham, and Rosenbaum (1995) found no significant gender differences for borderline, histrionic, and dependent personality disorders.

Some have argued that the DSM unfairly pathologizes individuals who are extreme examples of stereotypical sex roles (both male and female), and that the conformity of many healthy individuals to these roles accounts for the observed pattern of sex differences in personality

disorder diagnosis (e.g., Caplan, 1987; Landrine, 1989). Moreover, a widely cited study by Warner (1978) reported that clinicians tended to diagnose males with antisocial personality disorder and females with histrionic personality disorder when they were given identical patient profiles that were supposed to describe a patient with histrionic personality disorder. Taken together, these points raise questions of sex bias in both the diagnostic decision-making process and in the criteria themselves.

In a 1991 review, Widiger and Spitzer examined several potential sources of sex bias in PD diagnosis: (1) social-cultural sex bias (in which differences result from differences in child rearing, social opportunities, etc.), (2) sampling sex bias (in which sex differences are caused by data collection at sites where one sex with a disorder happens to be more represented than the other), and (3) diagnostic sex bias (in which either the assessment instruments or the diagnostic criteria cause false positives or false negatives that misrepresent true prevalence for one sex). They concluded that for questions of gender bias to be properly examined, the DSM must first clarify the threshold at which behaviors become maladaptive (to protect against false positives). They further emphasized that differential prevalence rates do not necessarily indicate bias and may instead reflect appropriate attention to the base rates of disorders in the real world.

10. **There is a marked paucity of well-conducted research examining effective treatments for most personality disorders.** As the chapters that follow will underscore, beyond a few treatments for borderline personality disorder that have promising empirical support, there are few documented effective interventions for personality disorders. Furthermore, clinical lore regarding the intractability of some personality disorders (e.g., antisocial personality disorder; see Fowler & Lilienfeld, 2006) has led to marked pessimism surrounding therapeutic intervention, possibly further contributing to this inertia. These observations highlight the importance of further well-conducted treatment outcome studies for personality disorders.
11. **There is disagreement regarding specific diagnostic criteria for most personality disorders.** As will be discussed in greater detail within several chapters, there have been numerous changes in personality disorder diagnostic criteria across the DSM revisions. These changes reflect a lack of consensus in the field surrounding these criteria. For example, there has been particular controversy surrounding antisocial personality disorder. Some argue that this diagnosis should be modified to include dispositional criteria (e.g., lack of empathy, superficial charm), which were largely eliminated in DSM-III (APA, 1980) in an attempt to increase reliability, but which may have decreased validity (Lykken, 1995).

12. **There is marked symptom heterogeneity within diagnoses.** Since its third edition (DSM-III; APA, 1980), the DSM has employed a largely polythetic classification system—that is, one that lists a number of characteristics, of which the individual is required to possess only a subset to meet the diagnosis. As a result, it is possible for there to be little to no overlap in symptoms among patients with the same diagnosis. This problem is not limited to personality disorders but is a consequence of the DSM's classification method, which some criticize as a “Chinese menu” approach.
13. **Many personality disorders appear to be heterogeneous in etiology.** Recent findings suggest that some personality disorders (e.g., antisocial personality disorder, borderline personality disorder) subsume distinct variants that differ in etiology, course, and treatment response (Bradley, Conklin, & Westen, 2005; Skeem, Poythress, Edens, Lilienfeld, & Cale, 2003). These results raise concerns regarding the construct validity of some current personality disorder conceptualizations, because such diagnoses may comprise multiple syndromes.

Despite myriad surrounding controversies, personality disorder diagnoses are frequently associated with important social and clinical outcomes. For example, individuals with paranoid personality disorder are disproportionately likely to become involved in litigation (see Chapter 3), and individuals with borderline personality disorder have a high rate of suicide attempts (see Chapter 7).

Findings such as these bring us full circle in our delineation of current controversies surrounding personality disorders as we return to questions of predictive validity. Because many personality disorders show associations with important real-world outcomes, the controversies outlined in this chapter are more than discouraging theoretical musings or armchair debates. Instead, they should be considered potentially fruitful and interesting lines of inquiry that may improve our understanding of important clinical phenomena.

Purpose and Outline of This Volume

We intend this handbook to be a widely used resource that will appeal to a broad audience, including researchers, beginning and advanced graduate students, and practitioners in a variety of mental health settings. We asked that our contributors minimize the use of technical terms, supplying a user-friendly summary and integration of major trends, findings, and future directions.

The book is organized by two broad sections: (1) an opening section (including this chapter) that reviews basic theoretical and methodological controversies in personality disorder research and practice and highlights proposed alternatives to DSM-IV Axis II conceptualizations, and (2) a section in which the DSM-IV personality disorders, organized by cluster, as well as the

three personality disorders designated for further research, are discussed and critically evaluated. Each of these chapters includes a summary and thoughtful integration of the best available scientific evidence bearing on the etiology, assessment, diagnosis, and (where relevant) treatment of the disorder. Further, chapters include discussion of any relevant psychobiological models and correlates. Wherever possible, case examples are offered as illustrations of each disorder's clinical presentation. Finally, each chapter includes explicit recommendations for further research, with a focus on unresolved conceptual and methodological issues. This includes a thoughtful review and evaluation of alternative conceptualizations (e.g., dimensional, interpersonal, behavior analytic) of each disorder, with an eye toward the publication of DSM-V. You will notice that the controversies outlined in the previous section provide the scaffolding for the chapters that follow.

By now, you have read most of Chapter 1, which is framed on the current state of personality disorder research and practice issues. In Chapter 2, Widiger further discusses problems with current Axis II conceptualizations, such as pejorative connotations of its nomenclature, seemingly arbitrary diagnostic boundaries, and inadequate coverage of clinical phenomena. He then provides a thorough review of proposed alternative models, including dimensional models, prototype matching approaches, and possible reconfigurations of the Axis I/Axis II distinction.

In Chapter 3, Bernstein and Useda present and discuss paranoid personality disorder (PPD). They highlight important differential diagnostic challenges, such as distinguishing between the extreme suspiciousness that characterizes PPD and the paranoid delusions that characterize paranoid schizophrenia. They present the history of paranoia in the psychiatric literature and critique the current DSM conceptualization, which they argue may overrepresent cognitive features of the condition. Further, they note potentially important social consequences for individuals affected by PPD, such as relationship difficulties and involvement in unnecessary litigation, as they underscore the need for effective treatments for PPD. As of now, they add, the treatment literature is unfortunately composed solely of case studies. Although some of these have shown promising results, they point to the need for larger-scale treatment studies as well as further construct validation efforts as an important future direction for PPD research.

In Chapter 4, Mittal, Kalus, Bernstein, and Siever present and discuss schizoid personality disorder (SCD). They outline the historical conceptualization of "schizoid character" as first described by Bleuler, its subsequent revisions, and the present DSM conceptualization, in which it mirrors a subsyndromal variant of the "negative" symptoms associated with schizophrenia. They discuss the extremely low prevalence of SCD in clinical settings, describe psychometric problems regarding low internal consistency of the diagnosis, and critically evaluate the sensitivity and specificity of the individual criteria. Additionally, they discuss differential diagnostic challenges in distinguishing SCD from avoidant personality disorder and Asperger's

syndrome. Last, they discuss the difficulties inherent in drawing individuals with SCD into treatment, due to their characteristic social isolation, and the resulting lack of treatment outcome studies. They conclude with recommendations regarding potential treatment strategies as well as recommended changes for DSM-V.

In Chapter 5, Bollini and Walker present and discuss schizotypal personality disorder (SPD). From the outset, they emphasize SPD as an Axis II condition for which there is a good deal of empirical support. They address the history of SPD as a condition conceptualized as a reflection of biological liability for schizophrenia rooted in Meehl's (1962) concept of "schizotaxia." They discuss the extension of this conceptualization into the diathesis-stress model of schizophrenia spectrum disorders, which for decades has been the dominant etiologic model of schizophrenia. They present evidence establishing genetic links between SPD (the criteria for which describe positive and negative subsyndromal features of schizophrenia) and schizophrenia. Further, they discuss the evidence for environmental factors (e.g., obstetrical complications) that may be important in the etiology of SPD. Additionally, they discuss brain and psychophysiological abnormalities common to both SPD and schizophrenia. They conclude by noting the lack of controlled treatment studies of SPD, a target for future research.

In Chapter 6, Patrick presents and discusses antisocial personality disorder (APD) and a related syndrome, psychopathy. He first describes the history of psychopathy as a construct that evolved into the more behavior-based APD diagnosis now found in the DSM. He then presents recent empirical findings regarding APD, with an emphasis on APD's place in a broader context of impulse control disorders. This is followed by a discussion of contemporary conceptualizations of psychopathy, a construct that many agree provides a richer picture of personality features often associated with chronic criminal behaviors, and that possesses a somewhat paradoxical mix of behavioral and personality pathology and adaptive personality features. Finally, Patrick discusses the lack of well-controlled APD treatment studies and offers suggestions for future treatment efforts based on work with other externalizing conditions.

In Chapter 7, Bradley, Conklin, and Westen present and discuss borderline personality disorder (BPD). They first examine the history of the borderline construct, from its roots in Kernberg's assertion that these patients' personality organization lies on the borderline between neurosis and psychosis to more contemporary views of BPD as a disorder of emotion dysregulation. They then introduce contemporary biological findings, including behavior genetics support for subsyndromal markers (i.e., endophenotypes) of BPD and neuroimaging studies. Further, they discuss literature regarding life events potentially etiologically relevant to BPD, such as separation from caretakers and childhood abuse. Additionally, they review findings related to the course and outcome of BPD, including high suicide rates and symptom reduction in middle age. They present findings regarding the most widely discussed contemporary therapy for BPD, which has shown promising

empirical support: dialectical behavior therapy (DBT; Linehan, 1993). They discuss other interventions for which there are encouraging preliminary findings. They conclude with a discussion of future directions for BPD research, including improvement of diagnostic criteria and procedures and further examination of recent findings of subtypes of BPD.

In Chapter 8, Blagov, Fowler, and Lilienfeld present and discuss histrionic personality disorder (HPD). First they trace its historical roots, from ancient concepts of “wandering womb,” through its early psychiatric examination by Charcot, and finally to the present, where it has been separated from somatization symptoms and now describes a personality pattern of excessive attention seeking. They then discuss the considerable overlap between HPD and other Cluster B disorders, as well as findings related to associations between HPD and Axis I conditions. This is followed by a discussion of the impact of gender and culture on HPD diagnosis and prognosis and a review of theories that posit antisocial personality disorder and HPD as gender-typed manifestations of the same underlying construct. They then present the extant treatment literature for HPD, which consists primarily of treatments under development, awaiting empirical support. They conclude with a discussion of future directions for HPD research, including elucidating its real-world impact, identifying endophenotypic markers that might differentiate it from other Cluster B disorders, and conducting controlled treatment studies.

In Chapter 9, Levy, Reynoso, Wasserman, and Clarkin present and discuss narcissistic personality disorder (NPD). First, they present the history of narcissism, from its roots in Greek mythology and Freudian theory to current DSM conceptualizations. They follow with a discussion of the extensive literature on subtypes of NPD and the disorder's co-occurrence with a number of Axis I and Axis II conditions, including its frequent comorbidity with substance abuse. Although there are no controlled treatment studies of NPD, they briefly discuss findings from case studies. They then present the extant data regarding its course and outcome, including reports of symptom remittance over time and some evidence of increased suicide risk in NPD patients. Additionally, they discuss the relation between features of NPD and contemporary Western culture. They conclude with recommendations for future research, including more research on course and outcome and well-done treatment studies.

In Chapter 10, Herbert presents and discusses avoidant personality disorder (APD). He begins by reviewing the extensive literature examining the extent to which APD can be considered a distinct syndrome above and beyond the sum of its clinical features (shyness, social anxiety, and interpersonal avoidance). In his discussion of overlap between APD and Axis I and II pathology, he particularly highlights findings pertaining to the overlap between APD and the condition that presents the greatest differential diagnostic challenge: social anxiety disorder (SAD). Due to their high degree of overlap and the greater body of research on SAD, Herbert then reviews literature on the etiology, cognitive and social skills deficits, and assessment of APD and SAD together. He adds that there is little literature regarding

interventions specifically for APD, whereas there is a large literature supporting interventions for SAD, particularly social skills training and pharmacotherapy. He concludes with recommendations for future research, such as clarifying whether APD should be considered a subtype of SAD rather than a personality disorder and carrying out further treatment research.

In Chapter 11, Bornstein presents and discusses dependent personality disorder (DPD). He traces its history from early diagnosticians' mentions of exaggerated dependency needs to current DSM conceptualizations of DPD. He then reviews findings from behavior genetics studies and studies of parenting styles as they relate to DPD. Adding to his discussion of possible etiologic factors, Bornstein reviews cultural factors that may influence the perception of dependency as pathological. He then discusses epidemiological findings, which indicate that DPD is one of the most prevalent personality disorders in clinical settings and has a higher prevalence in women. Further, he discusses controversies over potential gender bias of DPD criteria and diagnosis. Bornstein then reviews the sparse treatment literature regarding DPD symptom reduction (for which there are conflicting results) and the impact of DPD on treatment outcome. He concludes with recommendations for future research, including criteria revision, careful evaluation of the temporal stability of DPD, and testing of different conceptual frameworks, such as those that incorporate symptom intensity and adaptiveness (as dependence on others can at times be an adaptive strategy).

In Chapter 12, Bartz, Kaplan, and Hollander present and discuss obsessive-compulsive personality disorder (OCPD). They first review the history of OCPD as one of the few personality disorders that have appeared in some form in every edition of the DSM, with few changes to its criteria over time. They then present a major diagnostic controversy surrounding OCPD: its relation to obsessive-compulsive disorder (OCD). They discuss psychoanalytic, cognitive, and interpersonal conceptualizations of OCPD. Following this, they review recent proposals of an obsessive-compulsive spectrum, which some have argued may be mediated by biological mechanisms (e.g., serotonergic dysfunction) that result in varied but related clinical manifestations (e.g., OCD, OCPD, body dysmorphic disorder). Further, they present etiologic theories of OCPD as an adaptation to Axis I pathology such as anxiety disorders, with which it demonstrates a high degree of overlap. The literature regarding treatment of OCPD lacks well-controlled studies, but Bartz and her colleagues present and discuss different treatment models (psychodynamic, cognitive, pharmacotherapeutic) and present case study results when available. Last, they highlight more rigorous treatment studies and more research on the possible conceptualization of OCPD as an obsessive-compulsive spectrum disorder as key areas for future research.

Finally, in Chapter 13, Morey, Hopwood, and Klein present and discuss the three personality disorders designated for further research: depressive personality disorder (DPD), passive-aggressive personality disorder (PAPD), and sadistic personality disorder (SPD). They cite the high prevalence of PDNOS

(personality disorder not otherwise specified) diagnoses in clinical settings as a rationale for examining other potential personality disorders that have been identified in prior clinical and research literature but excluded from the current DSM. They first discuss PAPD (also called negativistic personality disorder) and review theories regarding its etiology, such as dramatic shifts in parenting style in childhood and cognitive mechanisms such as overfocus on authority and power. Next, they discuss historical and current conceptualizations of SPD, including its differentiation from sexual sadism. They underscore the potential importance of SPD if it accompanies a diagnosis of antisocial personality disorder (APD), as it adds information not found in the criteria for APD and would uniquely characterize those predisposed to cruelty and violence as well as criminality. Last, they discuss DPD and its roots in German phenomenological literature on “depressive temperament.” They review long-standing controversies regarding the relationship of DPD with Axis I mood disorders (particularly cyclothymia) as well as behavior genetics studies that have indicated higher rates of mood disorders in relatives of probands with DPD. Morey, Hopwood, and Klein offer suggestions for future research on each of the three disorders.

We hope you will find that the 13 issues raised within this chapter come into sharper focus as you read through the volume. In many cases, however, there are a number of unanswered questions pertaining to these controversies, and we therefore further hope that these chapters will help stimulate your thought and interest and raise new questions toward the future of personality disorder research.

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