

CHAPTER 14

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THE PERSONALITY DISORDERS

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INTRODUCTION

"Personality disorders" as an official diagnostic category did not exist before the creation in 1980 of the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III; American Psychiatric Association [APA], 1980) and its multiaxial system. The Axis II personality disorders are conditions created by committees who attended most to the research on personality attributes of relatives of schizophrenics (in reference to schizotypal personality disorder) and antisocial behaviors (in reference to antisocial personality disorder), psychodynamic formulations of other behaviors (in reference to narcissistic, borderline, passive-aggressive personality disorder), and the personality theories of Millon (1981).

Starting with the concept of personality traits, the architects of Axis II defined personality "disorders" as traits so inflexible and maladaptive that they result in either subjective personal distress or interpersonal difficulties. Conceptually, the

committees began with the history and background of the psychological research on personality traits. However, the history of research on personality traits and related concepts is minimally utilized in the personality diagnostic categories and criteria.

Axis II is at the crossroads of clinical phenomena that can be conceptualized either as a "disease" or as variants on normally distributed traits. The disease model as applied to mental disorders has been articulated differently by various authors and is not a uniform concept across even Axis I disorders (Blashfield, 1984). It is likely that Axis II is composed of phenomena that have diverse etiologies and mixes of biological/environmental causes. Schizotypal personality disorder may represent the outer boundaries of thought disorder related to schizophrenia, a mental disorder/illness in the strict sense. This is in contrast to other traits/behaviors on Axis II. How one conceptualizes these "disorders" or traits will guide one's research, both in content and in priority.

We will begin this chapter by reviewing some

of the diverse conceptions of the personality disorders, from psychodynamic, behavioral, interpersonal, and biological perspectives. The various approaches to the personality disorders each have some unique contribution that is valuable at this beginning stage of our knowledge. Much of this information is at a theoretical and preempirical stage but should not be ignored. This will be followed by a substantial discussion of the controversial aspects of Axis II due to the primitive level of development of this axis. Although Axis I disorders are relatively well defined and have led to treatment studies, longitudinal studies, and family studies, there are basic definitional (i.e., construct validity) issues that must be addressed on Axis II before further development can take place. Although there is little empirical substantiation for the three clusters in which the personality disorders have been grouped in DSM-III-R, for consistency we will use this organization in presenting the disorders themselves. In each of the three clusters of personality disorders, we will discuss key issues, such as the definition of the disorders (including diagnostic criteria from DSM-III and DSM-III-R, their internal consistency, and overlap with other disorders), historical background, and nature of the disorder (etiology, epidemiology, family studies, biological correlates). Unfortunately for the advance of research, the diagnostic criteria have changed rapidly from DSM-III to DSM-III-R (APA, 1987), and DSM-IV is anticipated. The careful reader will be cautious about interpreting research results, as some use the DSM-III criteria and the later studies often use DSM-III-R.

CONTRASTING ORIENTATIONS TO THE PERSONALITY DISORDERS

Human behavior can be conceptualized at many levels of organization, and the personality disorders are no exception. Although admittedly our coverage is less than exhaustive, we will consider four predominant orientations to the personality traits and disorders. Because the very definition of personality disorders involves disruption in interpersonal behavior, we will begin with

the interpersonal tradition, historically related to the writings of Harry Stack Sullivan (1953) and the Leary (1957) interpersonal circle.

The interpersonal approach has been espoused by many authors, most notably Kiesler (1986), Benjamin (1986), and the biosocial learning point of view of Millon (1981). In contrast to the uneven mixture of interpersonal, behavioral, and symptomatic criteria in DSM-III-R Axis II with no unifying theoretical structure, the interpersonal circle (Leary, 1957; Wiggins, 1982; Kiesler, 1982) provides a theoretically derived taxonomy of interpersonal behavior that can be used for guiding therapeutic intervention. Based on two axes of control (dominant to submissive) and affiliation (hostile to friendly), the interpersonal circle defines 16 segments of interpersonal behavior. Comparison of the theoretically derived interpersonal circle with the atheoretical committees of DSM-III and DSM-III-R reveal several important points (Kiesler, 1986). First of all, the DSM-III disorders are classified almost exclusively in the hostile half of the circle, with relative inattention to the submissive and dramatically dominant octants. Second, while the interpersonal circle systematically specifies the level of functional disruption, the DSM-III categories provide no systematic attention to level of functional impairment. The DSM-III categories range from an extreme level of functional disruption (e.g., narcissistic personality disorder) to a mild-moderate level of disruption (e.g., avoidant personality disorder). Finally, there is little correspondence of the three clusters of personality disorders in DSM-III to the interpersonal system.

Millon's biosocial-learning theory (1981, 1986) posits three dimensions in formulating a theory of personality psychopathology, arguing that these three dimensions have been utilized by major American and European personality theorists. These three dimensions — active-passive, subject-object, pleasure-pain — pertain to an individual's coping strategies, sources of reinforcement, and the manner in which the person seeks reinforcement. For example, narcissistic patients would be described in this system as utilizing a passive-independent coping strategy; their source of reinforcement belies an independence from

others as a means of pleasure, and they learn to distance themselves from others to minimize pain. Further, they seek reinforcement passively, overvaluing their abilities and assuming that others will do likewise. Millon describes each of the DSM-III personality disorders within this three-dimensional framework, and his conceptualizations have significantly influenced the content of the current psychiatric nosology. His self-report inventory, the Millon Clinical Multiaxial Inventory (MCMI), purports to measure the DSM-III-R personality disorders, although it is clear that Millon's criteria and those of the manual do not always overlap (Widiger, Frances, Spitzer, & Williams, 1988).

The behavioral orientation emphasizes the overt behaviors that are observable and accessible for reliable measurement. The aim is not to "diagnose" individuals by these behaviors but, rather, to classify the behaviors in logical, content categories (Marshall & Barbaree, 1984). It is within this tradition that a major debate has occurred concerning the degree of consistency that the individual manifests across environmental situations (Mischel, 1968). The debate has lessened in intensity over the years, and the present approach is to recognize both the influence of the environment on behavior and interindividual consistency (Carson, 1989), consistency that may be most evident in disturbed individuals (Bowers, 1973). It has been cogently argued that for behavioral intervention, one needs a case formulation that goes much beyond "diagnosis" and includes behavioral analysis and hypotheses about specific problem behaviors (Turner & Turkat, 1988).

Rather than emphasizing overt behaviors, psychodynamic thinkers concentrate on the motivations and attitudes that characterize the individual's typical behavior and interactions with others. The concept of defense mechanisms (that is, the characteristic ways the individual defends himself or herself from anxiety) is central to the psychodynamic understanding of the personality disorders (Shapiro, 1965). This approach is rich in description of individual patients and hypotheses that led to Axis II diagnostic criteria.

The biological approach involves an attempt to isolate key biological systems that relate to characteristic behavioral patterns. There is grow-

ing evidence that both normal (Bourchard, Lykken, McGue, Segal, & Tellegen, 1990) and abnormal personality conditions (Plomin, DeFries, & McClearn, 1990) are related to genetic factors. In a speculative but very interesting schema, Cloninger (1987) has suggested that key biological systems are related to certain personality traits. He isolates three dimensions of personality: novelty seeking, harm avoidance, and reward dependence.

Novelty seeking (exploratory pursuit, repetitive approach, and active avoidance and escape) is hypothesized to be related to the dopamine neuromodulator system. A second system of behavioral inhibition and harm avoidance is hypothesized as related to the serotonin neuromodulator system and is related behaviorally to passive avoidance and extinction. A third neuromodulator system, that of norepinephrine, is hypothesized as relating to behavioral maintenance and reward dependence. It is thought that this brain system plays a crucial role in learning and memory of new paired associations and increases resistance to extinction of previously rewarded behavior. Some of the Axis II personality disorders can be considered in terms of these three dimensions. For example, antisocial personality disorder is characterized by high novelty seeking with low harm avoidance and reward dependence. In direct contrast, the passive-dependent personality disorder is characterized by low novelty seeking and high harm avoidance and reward dependence.

CONTROVERSIAL AREAS

The DSM-III decision to utilize specific diagnostic criteria and to separate the personality disorders (Axis II) from the symptom constellations (Axis I) was beneficial to both clinical practice and research. However, many aspects of the DSM Axis II system are problematic and deserve research attention and alternative approaches.

Reliability and Validity

The assessment of the Axis II disorders yields the lowest reliability figures for the whole diagnostic system. For example, in one study (Mellsop, Varghese, Joshua, & Hicks, 1982) comparing

diagnoses assigned by three psychiatrists, kappa coefficients ranging from .01 to .49 for specific personality disorders were found. With the use of semistructured interviews, however, reliability reaches respectability (Reich, 1987).

Very little has been written about the validity of the personality disorders. When validity is mentioned in the psychiatric literature (e.g., Oldham, 1991), the emphasis is on the documentation of the distinctness of the separate disorders. There is a basic question about the most optimal process in defining and organizing personality pathology into valid constructs.

For research to progress, establishing construct validity of the diagnostic system (Skinner, 1986) is of central importance. Livesley, Jackson, and Schroeder (1989) have taken a multistep path to arriving at a factorial structure of personality pathology. First, the major features of personality malfunction were identified from the clinical literature. As a second step, clinicians were surveyed and asked to identify systematically the most salient features of each disorder. Third, these descriptive features were organized into sets of mutually exclusive trait categories. Next, behavioral items were developed to assess each dimension. In the next step psychometric criteria were used to establish a homogeneous and distinctive set of items in order to assess each dimension. Finally, factor analysis was used in order to identify the basic dimensions underlying the personality pathology.

Axis I and Axis II

The arbitrary distinction between Axis I and Axis II is helpful in emphasizing the difference between transient symptoms and enduring behaviors, attitudes, and orientations. In the prototypic case, an Axis I disorder is a time-limited episode that the individual suffers, an episode of disturbance that can be distinguished from the person. Personality disorders, in contrast, are disabilities that endure as an integral part of the individual's behavioral repertoire over time. This prototypic distinction is less clear when the symptom picture becomes chronic (e.g., schizophrenia and schizotypal personality disorder; anxiety dis-

order and avoidant personality disorder; depression and self-defeating personality disorder). The theoretical relationship between symptom patterns and personality traits/disorders is a complex one as seen in a longitudinal framework (Doherty, Fiester, & Shea, 1986).

Since depression is a prevalent symptom pattern/Axis I diagnosis, the relationship between depression and personality disorders is theoretically and clinically important (Farmer & Nelson-Gray, 1990). Personality disorders may be primary and predispose the individual to depression (characterological predisposition hypothesis). Alternatively, depression may result in personality disorders (complication hypothesis). The personality disorders may be an attenuated or alternative expression of the process that underlies depression (attenuation hypothesis). Depression and personality disorder, though having separate causes, may occur together because of a common third factor, such as traumatic childhood experiences (coeffect hypothesis). Depression and personality disorder may independently cause but co-occur only because of chance (orthogonal hypothesis). The diagnosis of both depression and a personality disorder may be due simply to the overlap of criteria sets in the diagnostic system (overlapping symptomatology hypothesis). This argument has been explored concerning depression and borderline personality disorder (see Kroll & Ogata, 1987, for a review). Finally, depression and personality disorders may arise from different sources (genetic, constitutional, and environmental factors) resulting in heterogeneous populations, some of which manifest both depression and personality disorders (heterogeneity hypothesis). Ultimately, only longitudinal designs will provide data to address these hypotheses.

The arbitrary distinction between Axis I and Axis II prompts debate about the proper placement of certain of these disorders. For example, there is current discussion about the movement of schizotypal personality disorder from Axis II to the Axis I schizophrenia section because the personality characteristics are related to the schizophrenia spectrum. Another controversy concerns the overlap between avoidant personality disorder on Axis II and generalized social phobia on Axis

I (Williams, Goldman, Gruenberg, Mezzich, & Skodol, 1990).

Boundaries within Axis II

The 11 personality disorders are arbitrarily grouped into three clusters by the originators of the personality disorder criteria. Unfortunately, there are few data to substantiate this tripartite grouping made on the grounds of content. One direct research investigation concerning the grouping found not three but two major groups, composed of anxious, nervous disorders and the more acting-out, behavioral disorders (Morey, 1988). Although we will use the three clusters in organizing this chapter, the clustering itself is arbitrary and needs further investigation.

The DSM system has been criticized for having an undefined border between a trait that is normal and one that is maladaptive. Tyrer (1988) has suggested that the diagnosis of a personality disorder be made only when there are behavioral data to indicate that the attitudes, thoughts, and motivations of the individual are causing interpersonal distress and malfunctioning. There is a need for data on the personality disorders and their associated functional disabilities.

The categories in Axis II are polythetic in nature; that is, the patient must meet a predetermined number of criteria less than the number in the total set (e.g., at least 5 of the 8 criteria) to be called borderline personality disorder). This is in contrast to a classical categorization system in which one must meet *all* the criteria to be classified as a member of that set. There are many implications of this way of assigning people to a diagnostic category (Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983). One direct result is that individuals will meet the diagnostic category in different ways, thus ensuring that the members of the category will be heterogeneous even on the diagnostic criteria themselves. Such heterogeneity must be recognized and addressed for treatment planning and research.

Another related difficulty is that the cutoff score in the polythetic system has been arbitrarily set by the committee. Scant theoretical or research attention has been paid to the development of pro-

cedures for optimization of the decision rules. For example, the decision to use a cutoff of at least 5 of 8 criteria for the diagnosis of bipolar disorder (BPD) was based on limited empirical data, but whether this cutoff point is, in fact, optimal can be questioned. One can question whether any 5 of the 8 criteria are equally optimal and whether any particular combination of criteria is more useful than others. We used data from four independent studies of BPD to illustrate a strategy for the optimization of psychodiagnostic decision rules that rely on polythetic criteria (Hurt et al., 1990). The strategy capitalized on the relationship among the criteria and the joint conditional probability structure of criteria combination in optimizing the decision rule for the diagnoses.

The categorical nature of Axis II presents still another controversy. Some would say that Axis II should be dimensional rather than categorical. The most useful approach to this controversy is to identify the advantages and disadvantages of both the categorical and dimensional systems for various purposes. Certainly for research and treatment planning the dimensional approach is more useful. With lack of construct validity, such extensive overlap and comorbidity on Axis II, it seems shortsighted to hold onto a categorical approach alone. It has been argued (Morey, 1988) that the categorical system can be improved by using a hierarchical scheme that would reduce diagnostic overlap.

The Purpose of Classification

Classification is at the heart of the scientific enterprise (Blashfield, 1984; Skinner, 1986), and classification of psychopathology can serve a number of important functions (Blashfield & Draguns, 1976). A classification system provides a consistent and defined set of terms. Second, the classification system becomes a structure for information retrieval by organizing both clinical experience and research results around its scaffold. Third, a classification system highlights the important similarities and differences between individual patients. This differentiation enhances knowledge about the symptoms that are likely to be seen in individual patients. In this regard, it is

important for the categories to be homogeneous but not identical. It has been argued that a polythetic classification is in fact more useful than a monothetic one. Another purpose of a classification system is the prediction of outcome over natural course and/or prognosis related to particular treatments and treatment response. Finally, a classification system provides basic concepts that assist in the formulation of adequate theories of various psychopathologies.

Judged against these functions of classification, Axis II has not been very successful. It does provide a consistent set of criteria that have improved reliability. It has also provided a structure for organizing clinical experience and research results, but because of its lack of construct validity, this is probably premature at best and misleading at worst. Only at a macro level does it point out differences between individual patients, as many of these diagnoses overlap to a great extent. Due to Axis II's lack of construct validity, it is premature to use Axis II categories for studies of natural course, prognosis, and treatment response. The architects of the system disclaim its use as a classification system for treatment planning. They rightfully point out that additional information not contained in the criteria set is needed for treatment planning.

Because the purpose in the initial construction of DSM-III was not well defined, it may be more informative to explore what purposes the classification has served subsequently. In terms of research, Axis II has spawned a number of assessment instruments of both self-report and semi-structured interview nature. Although reliability is variable, the criteria do provide a fairly reliable standard to diagnose Axis II pathology. Once the Axis II disorders have been assessed in a reliable fashion, there has been subsequent research on the phenomenology, family history, and treatment effects. In terms of treatment planning, the Axis II categories are of little use. This is due to many factors: the arbitrary cutoff scores of the categorical disorders, the rampant "comorbidity" of the personality disorders, the fact that most patients receive a diagnosis of mixed personality disorder (what is the treatment of a mixed personality disorder?), and the lack of construct

validity for the disorders. Clinicians do not treat a poorly defined category but, rather, symptoms and problem areas in the context of the patient's assets and social supports (Beutler & Clarkin, 1990).

CLUSTER A PERSONALITY DISORDERS

Serious personality disorders such as paranoid, schizoid, and schizotypal personality disorder are included in this cluster. These disorders are grouped together because of the central relationship to thought disorder and schizophrenia.

Schizoid

Definition of the Disorder

Patients with schizoid personality disorder have an extensive and pervasive indifference to interpersonal and social relationships. Lack of attachment to others is accompanied by a general emotional flatness. The DSM-III-R schizoid criteria set was expanded and provided indicators for social indifference, blunted affect, and anhedonia. The DSM-III-R revision added an item for odd, eccentric, or peculiar behavior. The schizoid personality disorder criterion set yields a very low coefficient alpha and, in fact, three of the seven criteria yield convergent correlations below .30 (Morey, 1988). The overlap of schizoid with other personality disorders is relatively unknown because of the infrequency of the schizoid diagnosis in clinical populations (Siever & Klar, 1986). Paranoid personality disorder may frequently overlap with schizoid personality disorder in clinical populations (Kass, Skodol, Charles, Spitzer, & Williams, 1985).

Historical Background

The concept of a schizoid personality dates to early writings on psychopathology and psychoanalysis. Bleuler (1922, 1929) used the term first to describe a character trait present, to some extent, in all people; he described it as a withdrawal from people and a turning inward of interests.

Schizophrenia was viewed as its most severe form, whereas more moderate degree of detachment from people and focus on one's inner life was described as a schizoid personality. Kretschmer (1925) distinguished between those schizoids who withdrew from others as a result of timidity and anxiety and those who withdrew out of lack of interest. Livesley, West, and Tanney (1985) have criticized Millon (1981) for misunderstanding Kretschmer's concept, and argue that a more clinically rich and meaningful description implies that the schizoid may at times be anxiously withdrawn and, at other times, coldly detached. They eschew the notion of an avoidant personality disorder as distinct from schizoid personality disorder. Elaborations of the concept of schizoid personality can be found in the work of Fairbairn (1940/1952), Winnicott (1945/1958), and Guntrip (1969).

Nature of the Disorder

In a factor-analytic approach, Livesley and Schroeder (1990) found a first factor composed of generalized hypersensitivity and self-absorption, social apprehensiveness, and effective social skills. A second factor, social avoidance, overlaps with schizotypal patients. This two-factor model of schizoid is similar to Kretschmer's (1925) description of both the extreme sensitivity and apparent aloofness of schizoid individuals. The Danish adoption studies revealed no relationship between schizoid or inadequate personality (a definition broader than the one in DSM-III-R) and schizophrenia (Kety et al., 1975).

Schizotypal Personality Disorder

Definition of the Disorder

The DSM-III-R criteria emphasize odd and peculiar ideation, which is reflected in interpersonal difficulties. The cognitive difficulties and distortions can include magical thinking, superstitious beliefs beyond those that are generally accepted in the culture, illusions, and odd appearance. Although this criterion set has good internal consistency, a primary difficulty is the significant overlap and correlation with schizoid personality

disorder (Morey, 1988). It has been found that paranoid personality overlaps in clinical populations with schizotypal personality disorder (Kass et al., 1985). Schizotypal personality disorder and paranoid personality disorder both includes a criterion concerning suspiciousness, so some clinical overlap may be simply definitional. Schizotypal also overlaps with borderline personality disorder, with 57% of borderlines also schizotypal in one survey (Spitzer, Endicott, & Gibbon, 1979).

Historical Background

Both Rado (1962) and Meehl (1962) used a concept of the schizotype in reference to individuals with a genetic predisposition to schizophrenia. Spitzer et al. (1979) established the criteria for schizotypal personality disorder based on the characteristics of the relatives of schizophrenic patients. It is, therefore, quite plausible that these characteristics are related to the genetic background of schizophrenia. However, negative symptoms (i.e., social isolation, constricted affect, poor rapport) may be more characteristic of these individuals than positive symptoms (i.e., perceptual distortions, magical thinking) (Siever & Kendler, 1988). Furthermore, other criteria sets might also describe and adequately distinguish schizophrenic relatives from controls.

Nature of the Disorder

The Danish adoption studies (Kety et al., 1975) established the empirical and theoretical background for the diagnosis of schizotypal personality disorder. The biologic relatives of schizophrenics in the study were seen as having borderline or latent schizophrenia characterized by social isolation, eccentricity, and transient psychotic-like symptoms. Since this beginning, studies have found evidence for schizotypal personality disorder in relatives of schizophrenic patients (Gunderson, 1983; Kendler, Gruenberg, & Strauss, 1981). The criteria for schizotypal personality disorder (DSM-III) had a prevalence rate of 73% in a sample of relatives of schizophrenics from three different samples (Reider et al., 1975). Also, there was increased prevalence of schizotypal symptoms in the relatives of schizophrenics

from three different samples (Reider et al., 1975). There was increased prevalence of schizotypal symptoms in the relatives of schizophrenics as compared to controls in a large American study (Kendler, Gruenberg, & Tsuang, 1983).

The prevalence of the disorder in the general population is probably low but may be more prevalent in inpatient psychiatric settings (Mellsop et al., 1982). Only two of the 138 biological relatives of control adoptees from the Copenhagen Adoption Studies were found to have schizotypal personality disorder (Kendler et al., 1981).

In an attempt to identify factors of structural validity, Livesley and Schroeder (1990) found a factor of schizotypal cognition that included ideas of reference, odd speech, and recurrent delusions. This factor distinguishes between schizotypal and schizoid personality disorder. A second factor, social avoidance, is shared by both schizotypal and schizoid personality disorder.

Paranoid Personality Disorder

Definition of the Disorder

The individual with paranoid personality disorder is characterized by a pervasive sense of suspicion and mistrust. There is a tendency to see others as critical, demeaning, and/or threatening. In their interpersonal and social behavior, these individuals are often tense, argumentative, fearful, cold, and restricted in emotional expression. They often lead aloof and isolated lives. The coefficient alpha for this criterion set is one of the best, but the disorder has poor discrimination from schizotypal, avoidant, and narcissistic personality disorders (Morey, 1988). The DSM-III criterion set was reduced in number to the DSM-III-R set. Non-specific behaviors were deleted and a new item concerning bearing grudges was added.

Historical Background

The concept of paranoia goes back to earliest medical literature. It was Kraepelin who narrowed the concept of paranoia to highly systematized and contained delusions in those who otherwise showed no signs of personality deterioration (Millon, 1981). Kraepelin described three different

clinical courses of those who manifested paranoia: deterioration to dementia praecox, a mixture of paranoia and dementia praecox, and remaining paranoid without further deterioration. It was on the latter that Kraepelin described the premorbid characteristics of the paranoid patient, quite relevant to Axis II personality disorder. While Freud conceptualized paranoia as a defense, it was Ferenczi and Abraham who posited the formation of the paranoid character type in the anal period of development.

Nature of the Disorder

Factor analysis (Livesley & Schroeder, 1990) suggests that one factor represents the core feature of this diagnosis involving resentfulness toward authority, vindictiveness, externalization, suspiciousness, anger at conditional positive regard, blame/avoidance, a rigid cognitive style, and hypervigilance. A second factor, called fear of negative appraisal, does not seem specific to paranoid personality disorder. Some studies suggest a relationship between paranoid personality disorder and schizophrenia. Increased prevalence of paranoid personality disorder has been detected in the biological relatives of schizophrenic adoptees when compared to the biological relatives of control adoptees (Kendler & Gruenberg, 1982). However, the relationship of paranoid personality disorder may be stronger with delusional disorder. For example, Kendler, Masterson, and Davis (in press) found a greater prevalence of paranoid personality disorder in the first-degree relatives of patients with delusional disorder than in the first-degree relatives of schizophrenics and controls. In one study (Siever & Kendler, 1988), the risk for paranoid personality disorder/traits was significantly greater in the relatives of those with paranoid psychosis than in relatives of schizophrenics. Thus, the specific familial link may be between paranoid personality disorder and paranoid psychosis.

Future Directions for Cluster A Disorders

A central unresolved issue is the relationship of the "odd" cluster with Axis I schizophrenia. The

empirical and theoretical background to the description of schizotypal personality disorder was the finding of these behaviors in the relatives of schizophrenics. The evidence is stronger for a relationship between schizophrenia and schizotypal personality disorder and less clear for paranoid personality disorder. The distinction between schizotypal and schizoid personality disorder is not complete, as they share a common factor. Given this overlap and the relatively little use of the diagnosis, one approach would be to coalesce the two disorders.

The distinction between schizoid and avoidant personality disorder is conceptually sound—desired social isolation versus isolation out of fear—but may not be founded in clinical phenomena. The relatively infrequent use of the schizoid diagnosis and the more frequent avoidant diagnosis may be relevant to this issue. It should be noted that in an empirical clustering of the personality disorders, paranoid personality disorder is grouped with the acting-out disorders along with histrionic and borderline, whereas schizoid and schizotypal are closely grouped together in the ruminative, anxious group, along with obsessive-compulsive, dependent, and avoidant (Morey, 1988).

CLUSTER B PERSONALITY DISORDERS

This cluster includes the antisocial, borderline, histrionic, and narcissistic personality disorders. These disorders are grouped together because the criteria identify individuals who are dramatic, emotional, and/or erratic in their behavior.

Antisocial Personality Disorder

Definition of the Disorder

A long-standing pattern of irresponsible behavior that violates the rights of others is most characteristic of antisocial personality disorder. Before the age of 15, behaviors such as truancy, running away from home, initiating physical fights, forcing sexual activity on others, cruelty to animals and/or others, lying, and stealing are

present. In adulthood, antisocial behaviors continue, and unstable work behavior, illegal activity, irritable and aggressive behavior, failure to honor financial obligations, repeated lying, recklessness with own and others' personal safety, poor parenting, and lack of monogamous relationships are also involved. The internal consistency and discriminative ability of this criterion set is among the strongest (Morey, 1988). There is some difficulty in the discrimination of this disorder from narcissistic and passive-aggressive personality disorders. Because of the criticism of the DSM-III set for ignoring the Cleckley criteria, an item was added to DSM-III-R assessing lack of remorse.

Historical Background

One can find a clinical literature going back at least to Pinel, Rush, and Prichard, all of whom recognize that some patients without deficits in reasoning are capable of impulsive acts that are socially repugnant, reprehensible, and self-damaging. It was the German psychiatrist Koch who used the term *psychopathic inferiority* to indicate a hypothesized organic cause for antisocial behavior. Kraepelin distinguished a number of psychopaths deficient in affect and/or volition; the liars and swindlers, and the antisocial and the quarrelsome are similar to the current conception of the antisocial personality disorder (Millon, 1981).

The earlier definition of a psychopath (Cleckley, 1941) describes an individual with an absence of guilt, egocentricity, incapacity for love, superficial charm, lack of remorse or shame, lack of insight, and a failure to learn from past experience. The DSM criteria, based heavily on the research of Robins (1986), are narrower than this earlier historical definition and would miss many of those with the classic Cleckley behaviors who avoid contact with the legal system. The DSM system thus has been criticized for being too narrow and missing those who do not get involved with the legal system (Millon, 1981).

Nature of the Disorder

There are two factors in antisocial personality disorder: interpersonal disesteem and conduct

problems (Livesley & Schroeder, 1990). Interpersonal disesteem involves exploitative behaviors that show a lack of concern for others and an absence of guilt about the effects of these actions on others, a group of behaviors that seems quite similar to Cleckley's concept. The second factor of conduct problems relates to actual behaviors that get individuals into difficulty with the law, the factor that most emphasized in DSM-III-R.

Antisocial behavior/personality disorder is probably the only Axis II disorder for which there are data from a number of epidemiologic studies (Merikangas & Weissman, 1986). Rates per 100 vary from 0.2 to 9.4. In the recent ECA study (Robins et al., 1984), the lifetime prevalence rates for DSM-III antisocial personality disorder ranged from 2.1 to 3.3. Rutter and Giller (1983) have reviewed epidemiologic studies of juvenile delinquent behavior and abnormal personality functioning. Multiple causes are seen as active in antisocial behavior/character, including peer group pressure, social control, social learning, biological factors and situational factors. The disorder is more frequent in men (from 2:1 to 7:1).

Hare (1983, 1985) has shown that both the DSM criteria and the Cleckley criteria can be reliably assessed in male prison populations. Increased slow-wave activity in antisocial patients may reflect low levels of cortical arousal or a tendency to boredom. Lowered sedation threshold and reduced anticipatory responses to aversive stimuli are also found in psychopaths, suggesting lowered cortical arousal and a reduced sensitivity to environmental stimulation (Hare & Cox, 1978).

Since research on psychopathic and antisocial behavior long predates the creation of DSM-III and DSM-III-R, there are longitudinal data relevant to this condition. A recent summary and examination of this data (Loeber, 1990) suggests that there are multiple subgroups of antisocial individuals, with multiple developmental pathways to the behavioral clusters. Such a longitudinal approach is most useful in specifying the interaction of genetic dispositions and environmental pressures, and will be most important in tailoring intervention strategies. The longitudinal data in this area make the lack of information on all of the other Axis II disorders painfully clear.

Histrionic Personality Disorder

Definition of the Disorder

Excessive emotional reactivity and attention-seeking behavior are characteristic of the individual with histrionic personality disorder. These generalized orientations are manifested by behaviors such as constant seeking of attention, reassurance, and praise from others; sexual seductiveness; overconcern with physical attractiveness; exaggerated emotional responses; rapid changes in emotional expression; seeking of immediate satisfaction without delay; and use of verbal behavior that is impressionistic and lacking in detail. The DSM-III-R revision deleted items involving manipulative suicide attempts and angry outbursts, which overlap with borderline personality disorder. The DSM-III-R set added inappropriate, sexually seductive behavior. The internal consistency of this data set is fairly high, but the difficulty is in adequate discrimination from narcissistic and borderline personality disorder (Morey, 1988).

Historical Background

Histrionic personality disorder has its beginnings in the writings by early psychoanalysts on the concept of hysteria. As summarized by Millon (1981), descriptive psychiatrists such as Kraepelin, Bleuler, Kretschmer, and Schneider identified a type of patient who was prone to overexcitability, impulsivity, flightiness, exaggerated emotional reactions, and volatile emotional outbursts. Freud's early formulations for the etiology of hysterical reactions emphasized conflicts generated in later stages of psychosexual development. Reich (1933/1972) made notable contributions to a description of character types, including a rich description of both male and female hysterics.

Early clinical literature, especially that from a psychoanalytic perspective, describes patients with histrionic characteristics such as dependent, infantile, seductive, and emotionally labile. The difficulties encountered by early psychotherapists in the treatment of hysterical character led to a reformulation of hysteria as having its routes in a more infantile character structure that is based on oral issues (Kernberg, 1975). Probably one of the most

relevant clinical notions in this perspective is the distinction between more mature patients with seductive exhibitionistic behavior, and a more regressed group with impulsive, helpless, and infantile characteristics (Zetzel, 1968; Kernberg, 1975). Current psychoanalytic writers divide the disorder into its less severe form, hysterical personality disorder, and its more severe form, histrionic personality disorder, which is represented in DSM-III-R (Gabbard, 1990).

Nature of the Disorder

There seem to be four factors involved in histrionic personality disorder (Livesley, & Schroeder, 1990). Two of these factors, interpersonal exploitation and dependency, overlap with other Axis II personality disorders, namely borderline and dependent personality disorders. There are two other factors, however, that appear specific to hysterical personality disorder. This includes hysterical affective style (affective overreactivity and lability) and hysterical interpersonal style. In clinical samples, there is overlap between histrionic personality disorder with borderline and narcissistic personality disorder (Kass et al., 1985).

Narcissistic Personality Disorder

Definition of the Disorder

This clinical entity is characterized by a long-standing and pervasive sense of personal grandiosity in which there is an exaggerated sense of self-importance that has multiple behavioral manifestations (often expressed in the interpersonal sphere). Exaggerations of accomplishments, taking advantage of others for one's own ends, seeking constant attention and praise from others, and reacting to any implied or clear criticism with rage and/or shame are defining criteria. Preoccupation with fantasies of power and success and a lack of empathic linkage to others can be evident. The DSM-III-R set added items about envy and seeing one's problems as unique. Several items that overlap with the borderline criterion set were deleted. This criterion set has good internal consistency but has extensive overlap with histrionic and passive-aggressive personality disorders. There

are no DSM-III-R criteria that discriminate histrionic from narcissistic personality disorder (Morey, 1988).

Historical Background

Like histrionic personality disorder, narcissistic personality disorder does not originate from empirical work but from psychoanalytic writings such as those by Kohut (1984) and Kernberg (1975). Narcissism was considered by Freud to be an aspect of normal development, occurring when the infant experiences its own body as a source of fulfillment, early in the phases of psychosexual development. But Freud did not formulate a narcissistic character type; that distinction is claimed by Reich (1933/1972) in his writings on the "phallic-narcissistic" character. As noted by Millon (1981), both Freud's and Reich's conceptualizations stressed the arrogance, self-confidence, leadership, and overt self-interest demonstrated by the narcissistic individual. The more pathological aspects of narcissism were highlighted and developed in later psychoanalytic writings, receiving heightened attention in the last 20 years by Kernberg and Kohut.

Both Kernberg and Kohut have written extensively on narcissistic personality disorder, creating considerable debate in the literature on its nature and treatment. Kernberg (1974, 1984) hypothesized that narcissistic personality disorder includes a borderline level of personality organization (identity diffusion, primitive defensive operations, tenuous reality testing). Kernberg also views excessive constitutional aggression as a key contributing factor to the development of pathological narcissism, whereas Kernberg posits that the instigation to aggression may lie in the environment (for instance, in the form of rejecting or ambivalent parental figures). The narcissistic individual's primitive defenses and arrogant misuse of others belie both intense rage toward and envy of others. Kohut (1977, 1984) viewed narcissism as developing from parental shortcomings in the form of empathic failures; he asserted that all individuals need certain responses from others that gratify the self. Narcissistic needs become pathological when parents fail to respond appropriately to a child's needs for validation and

admiration or when they fail to give the child themselves as objects of idealization. The child responds by feeling empty and depressed, and seeks an idealized other toward whom the child is self-deprecating and subordinate. The child also seeks to gain the admiration of others by striving incessantly to achieve or succeed. The differences between Kernberg's and Kohut's formulations are striking, and the reader will note that it is Kernberg's formulation that bears the closest resemblance to DSM-III-R criteria. For instance, DSM-III-R was revised to include an item related to envy, and the criteria set continues to emphasize interpersonal exploitation, entitlement, and lack of empathy with others.

Nature of the Disorder

There is very little empirical work on this diagnosis. In the factor-analytic work of Livesley and Schroeder (1990), three factors were found that relate to narcissistic personality disorder. These are factors of narcissistic entitlement, exhibitionism, and low self-confidence. However, none of these factors seem specific to narcissistic personality disorder; rather, they overlap substantially with other Cluster B diagnoses. This would suggest that narcissism is not a distinct entity but, rather, a dimension that is common to the Cluster B disorders.

Gunderson and colleagues (Ronningstam & Gunderson, 1989) isolated 33 characteristics of narcissism from the clinical descriptive literature and constructed a semistructured interview. These statements covered five major areas of pathology: grandiosity, interpersonal relations, reactivity, mood state, and social and moral adaptation. Grandiosity seems to be the most stable criterion set that discriminates narcissistic patients from other psychiatric patients. Four of the nine DSM-III-R criteria for narcissistic personality disorder were useful in discriminating narcissistic patients from others.

Borderline Personality Disorder

Definition of the Disorder

The Axis II criteria emphasize identity diffusion, disturbed interpersonal relations, affective

instability, and repetitive self-destructive behavior. Minor revisions were made for the DSM-III-R set, such as making the criterion for frantic efforts to avoid abandonment more specific to intense separation conflicts.

This criterion set is among the most internally consistent of the Axis II disorders (Morey, 1988), but there is difficulty in discriminating borderline personality disorder from histrionic and narcissistic (Morey, 1988). In fact, BPD has substantial overlap with histrionic, antisocial, schizotypal, narcissistic, and dependent personality disorders (Widiger & Frances, 1988). This overlap is consistent with the borderline personality organization concept of Kernberg (1984) and suggests once again that the Axis II disorders are not discrete phenomena (Widiger, Frances, Harris, Jacobsberg, Fyer, & Manning, in press).

Historical Background

Historically, there has been recognition of subtypes of borderline personality disorder (Grinker, Werble, & Drye, 1968). Prior to DSM-III there was a conception of a cluster of symptoms not captured clearly in either the schizophrenia category or the severe neurotic categories. Two major conditions, borderline schizophrenia and borderline personality, were culled from the literature, and a subsequent survey led to the criteria for Axis II schizotypal personality disorder and borderline personality disorder (Spitzer et al., 1979).

Nature of the Disorder

There are three factors in the borderline pathology (Livesley & Schroeder, 1990) including borderline pathology, interpersonal exploitation, and self-harm. The factor of borderline pathology includes diffuse self-concept, unstable moods and interpersonal relations, interpersonal attachment problems, and a tendency to decompensate under stress. In contrast to this factor, which seems quite distinctive to borderlines, the other two factors are shared by the other diagnoses.

Some combination of symptoms as defined in DSM-III not only diagnose the disorder with certainty but also have relatively high sensitivity rates.

This would be the combination of physically self-damaging acts and unstable, intense interpersonal relations or chronic boredom, and unstable intense relations and identity disturbance (Widiger, Hurt, Frances, Clarkin, & Gilmore, 1984). Using the overall hit rate and positive predictive power across 14 studies (Widiger & Frances, 1989), unstable-intense relations, physically self-destructive acts, and impulsivity were the most characteristic of BPD patients. Using non-Axis II criteria in combination with these criteria, factors that most distinguish BPD patients from patients with other personality disorders are self-destructive behavior and interpersonal difficulties (i.e., abandonment/engulfment/annihilation concerns, demandingness/entitlement, treatment regressions, and arousal of intense reactions from treatment personnel) not specified in the criterion set (Zanarini, Gunderson, Frankenburg, & Chauncey, 1990).

Prevalence of BPD in clinical samples varies from inpatient to outpatient settings. A summary across studies suggests that its average prevalence is 11% among outpatients and 19% among inpatients (Widiger & Frances, 1989). About 75% of diagnosed BPD patients are female.

The comorbidity of BPD with major affective disorder is extensive. However, lest one comes to a reductionist conclusion that BPD and affective disorder are the same, it seems clear that some but not all BPD patients have a comorbid affective disorder, and the rate of comorbidity is often no greater than for other personality disorders (Barasch, Frances, Hart, Clarkin, & Cohen, 1985; Fyer, Frances, Sullivan, Hart, & Clarkin, 1988).

As with all personality disorders, there is a question as to whether the disorder is best conceptualized in a categorical or dimensional manner. There is little direct research on the question with little direction on how to explore the issue methodologically. Using Meehl's maximum covariance analysis, Trull, Widiger, and Guthrie (1990) found that a dimensional model was more consistent with the data than a categorical model. The authors recommend a dimensional classification of BPD in both clinical practice and research.

One can look for the origins of the disorder in the family incidence of pathology (suggesting

genetic factors), early family environment, and the nature of the disorder in reference to sex distribution. There have been a number of studies examining the incidence of pathology in the first-degree relatives of borderline patients. When probands of borderline patients are compared to probands of schizophrenic patients (Schulz, Soloff, Kelly, Morgenstern, & Skinner, 1986), borderline patients had significantly higher rates of depression, alcoholism, and antisocial personality disorder. The aforementioned data and other family studies suggest that BPD is related to the affective spectrum and not to the schizophrenic spectrum. The relationship of BPD with concurrent schizotypal personality disorder with the schizophrenic spectrum may exist in a subgroup of patients.

There have been four longitudinal studies of outcome in DSM borderlines (Paris, 1988). In all four studies the patients have clearly improved up to the range of neurotic adjustment. Rehospitalization was uncommon, and on follow-up most had jobs. Rate of suicide varied from 3% to 9.5%, with the mean age of suicide at 27 years. There have been a number of studies of the course of the disorder. Stone, Hurt, and Stone (1987) followed 188 BPD patients over a 20-year period. There is a large (9%) suicide rate, but those patients who survive do improve.

Future Directions for Cluster B Disorders

Two disorders in this cluster, borderline and antisocial, are not only prevalent but serious conditions that have attracted the most research of any of the personality disorders. Both the overlap noted among these disorders and the clinical presentation of actual patients suggests that these are not distinct disorders. Kernberg (1989) has argued that the unique combinations of narcissistic and antisocial personality disorders are more salient from both a psychodynamic and a treatment point of view. He distinguishes between narcissistic personality disorder, antisocial behavior, ego syntonic aggression or sadism, and a strong paranoid orientation. Clinically, the important combinations

involve antisocial personality disorder, malignant narcissism (narcissistic personality disorder, antisocial behavior, ego-syntonic sadism, and paranoia), narcissistic personality disorder with antisocial behavior, other severe personality disorders with antisocial features, and neurotic personality disorders with antisocial features. Both the prognosis and the treatment approaches are different for these various combinations. Stone (1989a) has buttressed this point of view with the long-term follow-up of various combinations: patients who are simultaneously borderline and narcissistic; borderline, narcissistic and antisocial; and narcissistic alone. Those patients with both BPD and narcissism (malignant narcissism), had a course well below those of most other borderlines. Stone (1989b) has provided fascinating reading on the famous malignant narcissists whose violent behavior has gotten into the press and the movies.

Although the criterion set for antisocial personality disorder includes some specific behaviors that can be reliably captured, this behavioral description misses the multiple attitudes, motivations, and situations that could give rise to these behaviors. For disorders that are similar on a phenotypic level but diverse on a genotypic level, research must be carried out to discover quite diverse predisposing factors (Rutter & Giller, 1983; Kernberg, 1989).

CLUSTER C PERSONALITY DISORDERS

This cluster includes the avoidant, dependent, obsessive-compulsive, passive-aggressive personality disorders, grouped together with the hypothesis that fear underlies the behaviors that characterize each of them. Except for obsessive-compulsive personality disorder, Cluster C is regarded by many as the weakest of the three clusters in terms of theoretical and empirical support.

Avoidant Personality Disorder

Definition of the Disorder

Patients with avoidant personality disorder are characterized by a desire and need for contact with

others but they are inhibited by tremendous fear. This involves extreme sensitivity to the criticism and disapproval of others, unwillingness to become involved with others unless certain of acceptance, reticence in social situations for fear of being foolish, and fears of showing signs of embarrassment (e.g., blushing or crying) in the presence of others. The individual has no close friends, avoids social and occupational contacts, and exaggerates dangers and risks in making plans with others. The DSM-III-R added concepts of the inhibited phobia character, including exaggeration of risks in everyday life and fears of embarrassment. This criterion set is among the least internally consistent in Axis II. In addition, there is a major problem with discriminability, as almost the entire criterion set is positively correlated with schizotypal, paranoid, dependent, and passive-aggressive personality disorders (Morey, 1988).

Historical Background

Avoidant personality disorder was conceptualized by Millon and based on his biosocial theory. The avoidant individual is characterized by a heightened sensitivity to pain, ambivalence about receiving reinforcement from others, and active detachment caused by increased sensitivity to various forms of perceived rejection and humiliation. The schizoid person, in Millon's scheme, would be characterized as detached with a decreased sensitivity to both pain and pleasure, he or she would look within for reinforcement and would be passive in seeking it.

Millon (1981) based his concept of avoidance on previous writings by Hoch (1910), Kraepelin (1921), and Kretschmer (1925). Both Kraepelin and Hoch described a retiring or "shut-in" type who shunned relationships, pursued private interests, and seemed to live in a kind of fantasy world.

Kretschmer utilized three distinct groups of behaviors to describe the schizoid and considered the first group — unsociable, quiet, shy, reserved, eccentric — as characteristic of all schizoids. The second group of descriptors included timid, sensitive, shy with feelings, nervous, and fond of books and nature; the third group, by contrast, was described as pliable, dull-witted, indifferent,

honest, and kindly. Kretschmer hypothesized that unstable schizoids vacillated between behaviors characterized by the behaviors in groups 2 and 3. Millon (1981) divided Kretschmer's unified concept into two distinct personality disorders: group 2 became the avoidant and group 3 the schizoid. Avoidant personality disorder characterizes the person who is overly sensitive and easily prone to embarrassment and interpersonal humiliation, but who desires closeness with others; schizoid personality disorder typifies the individual who is content with his or her solitude and indifferent about closeness with others.

Livesley et al. (1985) have noted that Millon relies on Kretschmer's formulations as a precursor to his own theory, but they argue that Millon has lost Kretschmer's original meaning in his reformulation. They indicate that Kretschmer's description of the schizoid personality did not imply different types on the ends of one continuum. Rather, he viewed the schizoid's sensitivity and coldness as belonging together.

Gunderson (1983) and Livesley et al. (1985) criticized Millon's formulation with two major objections. First, Millon's conceptualization of schizoid was viewed as impoverished and weakened, robbing the term of its rich development in psychoanalytic theory. Second, Millon's hypothetical avoidant personality disorder had no empirical or theoretical basis on which to stand. Livesley et al. further argued that Millon's measure of personality disorders, the MCMI, demonstrated a high intercorrelation between items on the avoidant scale and the schizoid-asocial scales, indicating that the two scales actually were measuring the more unified concept developed by Kretschmer.

Nature of the Disorder

Interestingly, more empirical support appears to have been garnered for avoidant personality disorder than for the schizoid personality disorder. Schizoid personality disorder appears to be rarely diagnosed, whereas avoidant personality disorder has more practical utility, being diagnosed more frequently by clinicians and by researchers. In a study of inpatients, Trull, Widiger, and Frances (1987) found significant and positive correlations

between items for avoidant personality disorder and dependent personality disorder, but no significant correlations between avoidant personality disorder and schizoid personality disorder. Further, they noted that schizoid personality disorder is so rarely diagnosed as to be almost clinically useless. Results from other studies have supported their conclusions (Kass et al., 1985; Pfohl, Coryell, Zimmermann, & Stangl, 1986).

A recent review (Turner & Beidel, 1989) documents the comorbidity of anxiety disorders on Axis I and avoidant personality disorder. Given the item overlap, it is unlikely that one can be avoidant without being social phobic. One can, however, be social phobic without being avoidant, but there seem to be important differences between avoidant personality disorder and social phobics. Persons with avoidant personality disorder appear to be more severely and pervasively disturbed in comparison to social phobics (Marks, 1985; Turner, Beidel, Dancu, & Keys, 1986). Most important for treatment planning, avoidant personality disorder patients have poorer social skills, and social phobics are more skilled interpersonally.

Dependent Personality Disorder

Definition of the Disorder

Patients with this disorder are characterized by a pervasive pattern of interpersonal behavior that involves dependency on and submission to others. This pattern of interpersonal behavior involves being unable to make decisions without excessive advice, allowing others to make important decisions, and agreeing with others at all costs. Such individuals crave the closeness and protection of others so that they have difficulty in taking their own initiative, volunteer to do unpleasant things in order to get others to like them, feel devastated when relationships end, and are preoccupied with fears of being abandoned. They are so uncomfortable when alone that they go to great lengths to avoid it. A number of items were added to the DSM-II-R set to include submissiveness and fears of separation.

The seven criteria in DSM-III-R are a shift

from the four criteria listed in DSM-III and are, in part, a response to criticisms of the earlier criteria set as gender-biased and vague (Widiger et al., 1988). This criterion set shows good internal consistency, but there is a problem with discrimination from avoidant personality disorder (Morey, 1988).

Historical Background

Kraepelin's (1913) "shiftless" individual and Schneider's (1923) "weak-willed" type are early forerunners of the dependent personality diagnosis inasmuch as they describe a person of pliable character who is easily led by the will of others (Millon, 1981). Later psychoanalytic theorists such as Abraham (1921) and Horney (1945), described "oral-sucking" and "compliant" character types, respectively. Their descriptions stressed the interpersonal behaviors that these individuals employed in their attempts to derive care and sustenance while engaging in a helpless, infantile stance with others.

Millon (1981) describes the dependent personality style as the "submissive pattern" and appears to base his formulation on earlier concepts of the oral character. He hypothesizes that dependent persons may be constitutionally gentle but anxious; he speculates that their neural organization causes them to be overly sensitive to painful emotional arousal without endowing them with the capacity to react adequately to protect themselves.

Gabbard (1990), by contrast, eschews the oral character as an adequate explanation for dependent personality disorder. Rather, he offers that current psychoanalytic theorists view such persons as having been reinforced throughout their childhood and adolescence for dependent behaviors. Such reinforcement is by no means limited to the oral stage of development. Further, he speculates that individuals exhibiting traits of dependent personality disorder may be using defensive operations to mask or suppress anger; they also may be avoiding the reenactment of a painful and traumatic loss suffered earlier in life.

Nature of the Disorder

There is little empirical support for the dependent personality disorder diagnosis. Trull,

Widiger, and Frances (1987) noted the overlap between the avoidant and dependent personality disorders in a study of 84 inpatients. The two diagnoses are very similar save for the criterion of social withdrawal in avoidant personality disorder and, most importantly, it is possible to receive a diagnosis of avoidant personality disorder without meeting that criterion (Gabbard, 1990). It is a diagnosis that is closely related to sexual stereotypes in the culture, given that dependent behavior in women is more tolerated than is similar behavior in men (Gunderson, 1988).

Obsessive-Compulsive Personality Disorder

Definition of the Disorder

The criteria for obsessive-compulsive personality disorder include perfectionism that interferes with the completion of tasks; a preoccupation with details, rules, lists, and the like to the extent that the point of an activity is lost; unreasonable insistence that others do things one's own way or unreasonable reluctance to let others do something because of concerns that it will be done incorrectly; excessive devotion to work to the exclusion of leisure and social relationships; indecisiveness; moral or religious inflexibility, scrupulousness, or overconscientiousness; restricted expression of affection; lack of generosity with material goods; and inability to discard worn-out or worthless objects even when they have no sentimental value. The DSM-III-R set was expanded to include parsimony, orderliness, and obstinacy, all psychoanalytic constructs concerning this condition. This data set shows the lowest internal consistency across Axis II but relatively good discrimination. A major problem is discriminating it from avoidant personality disorder (Morey, 1988).

Historical Background

Of the disorders in the C cluster, obsessive-compulsive personality disorder is the one with the greatest empirical support and strongest theoretical background. Psychoanalytic forerunners of obsessive-compulsive disorder can be found in the

writings of Freud, Abraham, Jones, and Menninger on anal character (Gabbard, 1990). Psychoanalytic theorists posited that individuals exhibiting perfectionism, emotional constriction, rigid adherence to rules, and a reliance on logic to the exclusion of affect were likely suffering from a punitive superego that leads to defense against aggressive drives. Later psychoanalytic writers emphasized that the interpersonal style of these individuals, devotion to work, cognitive set, and struggle to contain their emotions likely reflects self-doubt and a reaction to a childhood where they were unsure of the love of their parents. Although they long to possess that love, they defend against these wants — and their accompanying disappointment — by being overly self-reliant and counterdependent. Their striving for perfection is seen as an attempt to finally earn the love they did not receive, and their overcommitment to work belies conflict about intimacy. Intimate relationships carry a particular danger in that they pull for the spontaneous expression of feeling, which the obsessive-compulsive personality type has worked so long to contain.

Millon (1981) describes the obsessive-compulsive as the “conforming” pattern. He hypothesizes no predisposing constitutional factors; he does speculate that these individuals may have a neurologically based, heightened capacity for the experiences of fear and anger.

Nature of the Disorder

There is empirical support for obsessive-compulsive personality disorder as distinct from obsessive-compulsive disorder. Rasmussen and Tsuang (1986) demonstrated that fewer than half of the patients with obsessive-compulsive disorder met criteria for the diagnosis of obsessive-compulsive personality disorder. Interestingly, individuals who obtain the former diagnosis are most likely to receive a diagnosis of personality disorder NOS (not otherwise specified) with characteristics from the other Cluster C disorders. Unlike obsessive-compulsive disorder, which describes discrete symptoms, obsessive-compulsive personality disorder refers to enduring character traits that pervade the individual's social and professional lives. Although the symptoms of obses-

sive-compulsive disorder are ego-dystonic, the traits of obsessive-compulsive personality disorder are ego-syntonic and often help an individual toward professional success (Gabbard, 1990).

Passive-Aggressive Personality Disorder

Definition of the Disorder

These individuals have a characteristic and pervasive pattern of resisting environmental and interpersonal demands for adequate social and vocational performance. This resistance to standards can be manifested in a number of ways including procrastination; sulky, irritable, or argumentative behavior; working with deliberate slowness; “forgetfulness”; resenting useful suggestions from others; and criticism of those in authority. These criteria are a shift from DSM-III, which emphasized a general resistance to interpersonal demands, and they highlight “hostile negativism, resentment, unreasonable criticisms, and unjustifiable protestations” (Widiger et al., 1988). This criterion set shows reasonably good internal consistency, but there is poor discrimination from antisocial and narcissistic personality disorders (Morey, 1988).

Historical Background

Among the Axis II disorders, passive-aggressive personality disorder is judged by many to have the least clinical utility and the poorest theoretical justification. The concept of passive-aggressive personality disorder can be traced to 1945, when the term was first used by the U.S. military to describe individuals who, by their passive resistance to authority, undermined the efforts of their superior officers to complete tasks (Millon, 1981). Several years later it became part of the nosology employed by the Veterans Administration, and it has been included in every version of the *Diagnostic and Statistical Manual*, despite consistent poor reliability.

Gabbard (1990) has argued that the only reasonable way to discuss the concept is as behavior, not as a personality disorder. Psychoanalytic theory

explains passive-aggressive behavior as a result of the struggles that occur between the child and his parents during the anal stage of development. Millon (1981) has described the behavior as arising from several possible sources. He argues that, on the one hand, people with passive-aggressive personality disorder (in his terminology, active-ambivalent) may be born with a predisposition to be emotionally overreactive to stimuli, especially those that result in negative affect. He seems to describe such individuals as temperamentally difficult and hypothesizes that their parents may find them difficult to schedule or soothe. Millon (1981) also surmises that such children may have been reared by parents who were highly conflicted in their approach and inconsistent in their responses to them. He suggests that the passive-aggressive adult, having been exposed to too many approach-avoidance situations as a child, learns to cope with the inconsistencies of others by adopting a highly inconsistent and ambivalent pattern. By contrast, Gabbard (1990) draws on object relations theory to offer an *explanation* of passive-aggressive behavior. He explains that individuals who demonstrate such behavior are uncomfortable with anger as part of their self-representation. By means of the defense mechanism of projection, they dissociate anger from themselves, but induce it in others through passive resistance to others' requests or demands. This process of projective identification enables the individual to be free of anger and any anxiety that attends it. Gabbard (1990) argues that the relative freedom from anxiety or fear that characterizes someone engaging in passive-aggressive behavior makes it an especially illogical choice for inclusion in Cluster C.

Nature of the Disorder

It has been argued that the concept of passive-aggressive personality disorder lacks clinical utility or theoretical justification (Gunderson, 1988). The disorder is rarely diagnosed (Gabbard, 1990; Gunderson, 1988; Widiger et al., 1988); in practical application, passive-aggressive disorder is more often seen as a part of other personality disorders than a separate disorder in its own right. One of the problems in diagnosing it lies in ascer-

taining that the behavior occurs across interpersonal situations; it must be demonstrated that it is a trait and not a state induced in response to helplessness in the face of a disagreeable authority figure. Reliability for passive-aggressive personality disorder was poor in field trials for DSM-III; its kappa of .21, utilizing the DSM-III criteria, is among the lowest for the personality disorders. It is interesting to note that when interviewing a collateral versus interviewing the patient, the diagnosis can be made more frequently and reliably when an interview of an informant is involved (Zimmerman, Pfohl, Stangl, & Corenthal, 1986).

Gunderson (1988) notes that factor-analytic studies have failed to provide validation for the disorder as it is defined in DSM-III-R. Passive-aggressive loads highly on a factor with the avoidant and dependent personality disorders (Kass et al., 1985). In addition, passive-aggressive personality loads very highly on a factor of interpersonal and cognitive dysfunction (Livesley & Jackson, 1986).

Directions for Future Cluster C Disorders

Although obsessive-compulsive personality disorder has a long tradition in psychoanalytic theory, the other three disorders are relative newcomers (Gabbard, 1990). Furthermore, considerable skepticism has greeted both the validity of the other members of this cluster and the logic in grouping them. For example, Millon (1981) argued for the inclusion of avoidant personality disorder in DSM-III as a separate entity from schizoid personality disorder. But Livesley, West, and Tanney (1985) counter that separating schizoid and avoidant traits robs each of the theoretical richness that informed the disorder first defined in detail by Kretschmer (1925). Or, as understood by Gabbard (1990), passive-aggressive disorder hardly belongs in this grouping because most passive-aggressive individuals report little in the way of fear or anxiety. A review of the literature demonstrates the relative paucity of research on these disorders.

SUMMARY

The creation of the personality disorders by a committee of the American Psychiatric Association (APA) has resulted in criteria at different levels of operationalization generated from psychodynamic and research data, and "disorders" that have resulted in some reliability in assessment but often overlapping and lacking in construct and predictive validity. DSM-III-R was a quick successor and made some progress in refining the criteria. The benefit of this initiative by the APA was that it provided some explicit criteria, which in turn stimulated the construction of semistructured interviews for the reliable assessment of these behaviors. This development has resulted in the accrual of data concerning the incidence and comorbidity of these conditions/criteria.

Whereas the criteria on Axis II are of clinical interest, the "diagnostic" categories created by the grouping of the criteria are of limited value. They have been generated with little or no reference to decades of research concerning the dimensions of personality functioning. What is desperately needed is some bridge between the extensive research into personality traits and their development, and the so-called personality disorders. Some substantial work is beginning in this area, illustrated by the attempt to map the personality disorders onto personality traits that have substantial research backing (Costa & Widiger, in press).

It is difficult to take seriously the notion that the personality disorders are discrete conditions on the level, for instance, of schizophrenia or bipolar disorder. First of all, while there were 11 personality disorders in DSM-III, there were additional ones formulated for the appendix in DSM-III-R, and others are being considered for DSM-IV. Second, as noted in this chapter, the overlap between the so-called disorders is so extensive as to mock the use of the word *overlap*. The point at which personality traits become disorders has been insufficiently defined and operationalized. It has been suggested that personality disorders and extent of disability be measured concomitantly. Finally, without exception, there is no information on etiology, course, family history, and treatment outcome that sup-

ports the external validity of the disorders.

Every indication is that DSM-IV will have minimal changes from DSM-III-R in reference to the personality disorders. This is good news for researchers who need some stability in the criteria in order to have time to mount research projects. On the other hand, the conservatism in this approach will do nothing to address the many difficulties with Axis II.

To be useful for research and treatment (both psychological and pharmacological), the Axis II categories must lead to or relate to a set of constructs with demonstrated validity. Until it is proved otherwise in specific constructs, it is reasonable to put emphasis on those constructs of proven worth in personality research and look at the extremes of these, assuming that the disorders are extremes or the development of the latter. The most useful constructs at the present time are those that demonstrate internal construct validity, have some demonstrated external validity, and show clinical prevalence as represented in phenomenological research.

Most of the current data on the personality disorders have been gathered from patient self-report (on either self-report instruments or semistructured interviews that depend on clinicians' judgment around what the patient reports) at one point (cross-sectional) in time. Both of these limitations must be addressed if progress is to take place. It is hoped that future research will examine personality traits that manifest construct validity, and examine these constructs in longitudinal designs that have the capacity to examine external validity.

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