Personality disorders (PDs) are a heterogeneous group of mental disorders that arise when an individual’s personality is considered impaired and maladaptive. As will be discussed in greater detail, PDs are highly prevalent in the general population (up to 18%) and much higher in patient populations (up to 75%). In addition to being prevalent, PDs are often underappreciated sources of social cost, family burden, and morbidity and mortality (Hueston, Mainous, & Schilling, 1996).

This chapter first defines personality and PDs, differentiating them from related constructs, such as temperament. It outlines current classification and diagnostic frameworks for PDs, grounded in a historical perspective. It then provides data as well as implications of the high prevalence and comorbidity of PDs with other conditions, followed by an overview of assessment techniques, with their respective advantages and disadvantages. Next, it summarizes recent meta-analytic data regarding the efficacy of treatments for PDs. Finally, the chapter concludes by providing a look back at major accomplishments in the field of PD research and treatment and a look forward toward the progress the field likely will make in the next decade.

DEFINITIONS AND VARIANTS

What Is Personality?
Personality is a commonly used term that is often ill-defined even in the context of mental health (Livesley, 2001). Most conceptions understand personality as an umbrella concept that encompasses the dynamic organization of psychological functioning of enduring and consistent patterns of thoughts, feelings, and behaviors that can be flexibly experienced and expressed in a variety of circumstances (e.g., Allport, 1961; Mischel & Shoda, 1995). Thus, personality is a coherent self-system that is relatively consistent but also flexible and responsive to circumstances; in essence, personality is who you are. As such, personality represents a complex interaction of temperament, internalized experiences, and evolved behavioral patterns that come to be shaped by our interpretation of these attributes and the consequences of our life choices.

The concept of personality can be distinguished from related terms, such as temperament and character. Traditionally, temperament has been conceptualized as those aspects of personality that are constitutional or biological in origin and related to the general reactivity of the individual. At a basic level, temperament can be thought of as an individual’s “characteristic nature.” These inborn differences show themselves from the beginning of life. Temperament has a number of different conceptions; however, most of these conceptions emphasize the general reactivity of the individual, such as susceptibility and reactivity to emotional stimulation, the strength and speed of response, and the quality and intensity of mood. Other aspects of temperament include activity level, tendency toward smiling and laughing, fearfulness, distress to limitations, soothability, and vocal activity.

A body of research has suggested that temperament may not be as heritable or stable as initially
thought. For example, genetic studies suggest that temperamental variables are only 50%–60% heritable (Heath, Cloninger, & Martin, 1994), with some estimates as low as 20% heritability for certain temperamental variables (Saudino, 2005). This suggests that environmental influence may play a large role in temperamental development. Furthermore, findings from longitudinal sibling research have shown that temperamental variables in early adolescence only explain 20%–60% of the variance in the same variables 2 to 3 years later, suggesting considerable fluctuation in temperament over time (Ganiban et al., 2008).

Character is more complicated to understand than temperament. Initial descriptions of character tended to be synonymous with personality, with the terms used somewhat interchangeably, particularly in the psychoanalytic literature. Freud, for example wrote about character types in a manner similar to how we now discuss personality disorders. Freud viewed personality formation as the process whereby an individual develops stable and enduring patterns of thinking, feeling, and behaving. These patterns were in large part the result of adaptations both to internal presses (e.g., drives in Freud’s terminology; temperament by 21st century terminology) as well as the external demands placed by others and society at large. Character formation resulted from the resolution of these conflicts or the compromise between these competing interests.

What Is a Personality Disorder?
Most definitions of personality disorders stress the chronic, long-standing nature of characteristics and patterns of responding to distress that often are limited in variability and rigidly applied regardless of appropriateness to context (Blatt et al., 1997). For example, in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5; American Psychiatric Association, 2013) PDs are described as a pattern of inner experience and behavior that deviates from cultural norms. These patterns of perceiving, relating to, and thinking about the environment and oneself are pervasive, inflexible, and stable over time and result in distress or impairment in functioning (American Psychiatric Association, 2000). People with PDs tend to find themselves in vicious cycles in which they enact the very experiences trying to be avoided, and these patterns come to define that individual’s experience. The ways the individual thinks, feels, acts, and relates to others directly restricts the capacity to work, pursue goals, and enjoy intimate relationships.

Most models of personality disorders conceptualize these pathologies as primarily disorders of self and relatedness. The criteria specified for each of the personality disorders in Section II of the DSM–5 (American Psychiatric Association, 2013) centrally describe problems with sense of identity or interpersonal problems. For example, impoverished interpersonal relationships are a cardinal feature of both schizoid and avoidant personality disorders; such individuals prefer to be alone and often seek solitude. Central to both dependent and borderline PD are difficulties with aloneness as well as preoccupation with fears of abandonment and the dissolution of close relationships (e.g., Gunderson, 1996; Zanarini et al., 2007). Histrionic and narcissistic individuals often need to be the center of attention and have difficulty not being admired by others.

An alternative model to diagnosing PDs included in DSM–5 (American Psychiatric Association, 2013) places self and relatedness as the core aspects of the definition of a PD, with symptoms organized along each of these two domains. The alternate criteria for borderline personality disorder (BPD) evaluate problems in self-functioning—particularly identity diffusion and feelings of emptiness—and interpersonal functioning. These problems of self and relatedness are not separate but rather are highly interdependent and have a cyclical relationship with one another. For example, chronic feelings of emptiness and uncertainty about oneself may lead individuals with BPD to look to their relationships to define who they are. Given the affective lability associated with this disorder, how such individuals see themselves in relation to others may then be highly dependent on the affective context—“I feel good because the person I love is good to me,” and conversely “I feel bad because this person is bad to me.” Furthermore, with a sense of self so centrally tethered to others, when there is a threat to a significant relationship ending, one comes to feel that the self is also threatened—“If I am not her boyfriend...
then who am I?” This may lead to intense fears of abandonment as well as desperate and impulsive attempts to pull the person back.

A Brief History of Personality Disorders

Because modern PDs such as borderline and narcissistic PD only first appeared in the DSM system with the advent of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM–III; American Psychiatric Association, 1980), they often are thought of as being of recent vintage. The concept of PD, however, is evident in the writings of classical times (Morey, 1997). The best-known classical account is of the legend of Narcissus, the subject of the Greek myth from which the term narcissism is derived, originally sung as Homeric hymns in the seventh or eighth century b.C. (Hamilton, 1942) and popularized in Ovid’s *Metamorphoses* (8/1958). Narcissus showed a lack of empathy and consideration toward those who cared about him and evidenced a grandiose sense of self in falling in love with his own reflection in a pool of water.

Modern conceptions of PDs begin with Pinel’s concept of *manie sans delire* (“madness without delirium,” or confusion of the mind; Pinel, 1801/1962). Before Pinel’s publication, psychopathology was usually tied to psychoses. By contrast, Pinel described patients who lacked impulse control, often raged when frustrated, and who were prone to outbursts of violence but who were not subject to delusions. About that time, Benjamin Rush made similar observations in the United States. These writers were among the first to note that psychological disorders could occur even when ability to reason was intact and without a loss of contact with reality.

By the late 19th century and early 20th century, Kraepelin (1904), Bleuler (1924), and Kretschmer (1926) described personality types, such as asthenic, autistic, schizoid, and cyclothymic (or cycloid); however, these writers conceptualized them as premorbid personalities to schizophrenic and manic-depressive disorders—thus, they were more similar to temperaments than PDs and were strongly tied to psychosis.

Freud (1906–1908/1959), for example, wrote about character types, describing the “anal-character” as frugal, orderly, parsimonious, and obstinate, as well as obsessive, not unlike 21st-century obsessive-compulsive personality disorder (OCPD). Abraham (1921, 1924/1994), using Freud’s psychosexual stages as referent points, described the “oral character,” the precursor to the modern conceptualization of dependent personality disorder (DPD), as desiring excessive levels of nurturance, acting childlike, and expecting to be rescued, protected, fed, and supported by others.

Personality Disorders in the DSM

Personality disorders have been included in every edition of the DSM, but their conceptualization has changed dramatically over time. The first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952) was a glossary describing 108 diagnostic categories based on Adolf Meyer’s developmental psychobiologic views, many of which were described as reactions to environmental conditions that could result in emotional problems. This first DSM distinguished among four personality pattern disturbances (inadequate, paranoid, cyclothmic, and schizoid), three personality trait disturbances (emotionally unstable, passive-aggressive, and compulsive), and two sociopathic personality disturbances” (antisocial and dissocial).

The *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (DSM–II; American Psychiatric Association, 1968) specified 182 different disorders and distinguished between neurotic and psychotic disorders. Except for the description of neuroses, which were strongly influenced by psychodynamic thought, DSM–II did not provide a theoretical framework for understanding nonorganic mental disorders but instead were based on the best clinical judgment of a committee of experts and its consultants (Widiger et al., 1991).

The *DSM–III* (American Psychiatric Association, 1980) provided a detailed lexicon or taxonomy that established common definitions of mental disorders that now enabled investigators and clinicians to have greater consistency (reliability) in their diagnoses. In attempts “to resolve various diagnostic issues, the developers relied, as much as possible, on research evidence relevant to various kinds of...
diagnostic validity” (American Psychiatric Association, 1980, p. 3).

The DSM–III used primarily descriptive symptom criteria to create a multiaxial diagnostic classification system, separating personality disorders (Axis II) from “clinical syndromes” (Axis I). The classificatory system was polythetic (Millon, 1991), meaning that not all symptoms or diagnostic criteria for a given disorder were necessary for making a diagnosis. Thus, the classificatory system created prototypic descriptions of particular disorders based on a cluster of symptoms, and these became the concrete signs of particular discrete categories.

Although PDs appeared in every DSM since its inception, it was only in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV; American Psychiatric Association, 1994) that a general definition of a personality disorder was introduced. This definition, which carried over into DSM–5 (American Psychiatric Association, 2013), stresses the core features of a PD as being pathological, persistent, and pervasive. Additionally, a PD should be noticeable by young adulthood and include behavior that is markedly inconsistent with what would be expected in one’s culture.

The current edition of the manual is the DSM–5 (American Psychiatric Association, 2013). DSM–5 sought to place many disorders along a spectrum (e.g., autism spectrum disorder) or among disorders that are similar, not only in phenomenology but also in genetic and neural substrates. For instance, posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD) were moved out of the superordinate anxiety disorder category and placed alongside more similar disorders like acute stress disorder and trichotillomania, respectively. Furthermore, DSM–5 eliminated the division between disorders of childhood and disorders of adulthood, attempting to incorporate a developmental perspective into the consideration of each individual criterion set. In so doing, however, DSM–5 may have blurred the conceptual boundaries between distinct longitudinally stable disorders and disorders that may be earlier or later manifestations of other similar disorders.

Currently, a number of systems are used to classify PDs. These include the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD–10; World Health Organization [WHO], 1992), the DSM–5 (American Psychiatric Association, 2013), the Psychodynamic Diagnostic Manual (PDM; Psychodynamic Task Force, 2006), and classification systems developed by Millon (1977) and Westen and Shedler (1999b; see Table 6.1). Worldwide, the ICD–10 and the DSM–5 are the two main systems used and will serve as the focus for discussing classification, although we will focus mainly on the DSM system.

The ICD–10 contains nine PDs: paranoid, schizoid, dissocial, emotionally unstable (borderline type and impulsive type), histrionic, anankastic, anxious (avoidant), and dependent. There is also an “other specific personality disorders” category that includes eccentric, immature, narcissistic, passive-aggressive, and psychoneurotic PDs as well as categories for “personality disorder, not otherwise specified” and “mixed and other personality disorders.”

Section III of DSM–5 (American Psychiatric Association, 2013) utilizes two main criteria to diagnose PDs: (a) severity is determined by clinically significant impairment in identity and relationship functioning, and (b) type is determined by a profile of pathological personality traits. To assess severity of functioning difficulties, DSM–5 Section III provides the Level of Personality Functioning Scale (LPFS), which assessors may use as a rubric to rate impairment (on a 0–4 scale) across four domains: identity, self-direction, empathy, and intimacy. These four areas of personality functioning capture much of the distress and impairment experienced by individuals with PDs. For determining pathological personality traits (the second main criterion in this alternate model), DSM–5 lays out five personality disorder trait domains composed of 25 individual facets. The domains, negative affectivity (vs. emotional stability), detachment (vs. extraversion), antagonism (vs. agreeableness), disinhibition (vs. conscientiousness), and psychoticism (vs. lucidity), resemble the five domains of the Five-Factor Model (FFM; Costa & McCrae, 1992) but are framed in a way to capture pathological personality features more precisely. In making specific PD diagnoses, assessors must compare information obtained on both functioning and personality traits against criteria for the PD of interest.
TABLE 6.1

Comparison of the DSM–5 with the ICD–10, PDM, Millon, and Westen and Shedler Personality Disorder Classification Systems

<table>
<thead>
<tr>
<th>DSM–5</th>
<th>ICD–10</th>
<th>PDM</th>
<th>Millon</th>
<th>Westen and Shedler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>Paranoid</td>
<td>Paranoid</td>
<td>Paranoid</td>
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<tr>
<td>Schizoid</td>
<td>Schizoid</td>
<td>Schizoid</td>
<td>Schizoid</td>
<td>Schizoid</td>
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<tr>
<td>Schizotypal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histrionic</td>
<td>Histrionic</td>
<td>Hysterical</td>
<td>Histrionic</td>
<td>Histrionic</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Dissocial</td>
<td>Psychopathic</td>
<td>Antisocial</td>
<td>Antisocial-psychopathic</td>
</tr>
<tr>
<td>Borderline</td>
<td>Emotionally unstable—borderline type</td>
<td>Borderline</td>
<td>Borderline</td>
<td>Dysphoric: emotionally dysregulated</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Narcissistic</td>
<td></td>
<td>Narcissistic</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>Anankastic</td>
<td>Obsessive-compulsive</td>
<td>Compulsive</td>
<td>Obsessional</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Anxious</td>
<td>Phobic</td>
<td>Avoidant</td>
<td>Dysphoric: avoidant</td>
</tr>
<tr>
<td>Dependent</td>
<td></td>
<td>Sadistic and Sadomasochistic</td>
<td>Dependent</td>
<td>Dysphoric: dependent-masochistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Masochistic</td>
<td></td>
<td>Masochistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depressive</td>
<td></td>
<td>Dysphoric: dependent-masochistic</td>
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<tr>
<td></td>
<td></td>
<td>Somatizing</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Anxious</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Dissociative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other specified personality disorder</td>
<td>Other specified personality disorders; mixed personality disorder</td>
<td>Mixed/other</td>
<td></td>
<td>Dysphoric: high-functioning neurotic</td>
</tr>
<tr>
<td>Unspecified personality disorder</td>
<td>Personality disorder, unspecified</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


As mentioned above, the DSM–IV and DSM–5 highlight the core components of a PD as being pathological, persistent, and pervasive. Building on this general definition, DSM–5 describes 10 specific personality disorders: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive, which are grouped into three clusters, A, B, and C, based on description similarities. Cluster A is for odd and eccentric disorders and includes paranoid, schizoid, and schizotypal PDs. Cluster B is for dramatic, emotional, and erratic disorders and includes...
antisocial, borderline, histrionic, and narcissistic PDs. Cluster C is for anxious or fearful disorders and includes avoidant, dependent, and OCPDs. The DSM–5 also includes categories for “other specified personality disorder” and “unspecified personality disorder” as well as “personality change due to another medical condition.”

Cluster A: Odd-Eccentric Personality Disorders

Paranoid personality disorder. According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM–IV–TR; American Psychiatric Association, 2000), paranoid personality disorder (PPD) is characterized by a consistent pattern of distrust of the motives of other people. Furthermore, people with this disorder assume that people intentionally will exploit, harm, or deceive them, and they often feel deeply injured by another person. They frequently are reluctant to become close to others out of fear that any personal information they reveal about themselves will later be used to hurt them. An individual with this disorder is also severely sensitive to criticism and therefore is likely to often feel attacked, threatened, or criticized by others. He or she might read hidden meanings or malevolent intentions into innocent remarks, mistakes, or compliments. It is also difficult for a person with PPD to forgive others even for minor wrongs. Persistently suspects that friends or colleagues will be disloyal or untrustworthy. Persistently suspects that his or her romantic partner is being unfaithful. Hesitates to be candid with others for fear that they will use information against him or her in a malicious or sabotaging way.

Schizoid personality disorder. The term schizoid was coined by Bleuler (1929) to describe individuals who tended to turn inwardly and away from the external world, be indifferent to relationships or pleasure, show muted emotional expressiveness, be comfortably dull, and have vague undeveloped interests. Originally, two distinct subtypes of the schizoid personality were identified: the anaesthetic or insensitive type, characterized as indifferent, uninterested, unfeeling, unemotional, and dull, and the hyperaesthetic or overly sensitive type (Kretschmer, 1925). The hyperaesthetic type is the forerunner of the DSM avoidant personality disorder.

DSM–5 (American Psychiatric Association, 2013) notes that those with schizoid personality disorder (SPD) are characteristically detached from and uninterested in social relationships. People with SPD may choose careers or hobbies that allow them to avoid contact with other people, and they typically are uninterested in developing intimate or sexual relationships. In addition, those with SPD have a flatness of affect that leads others to experience them as cold and aloof. Not only do they derive little pleasure from sensory or interpersonal experiences, they usually are unmoved by the disapproval of others. They might claim that they do not experience strong emotions, whether positive or negative. Furthermore, people with SPD may fail to respond to social cues, such as a smile, leading others to perceive them as self-absorbed, socially inept, or conceited. Within the FFM, SPD is thought to reflect extremely low scores on the extraversion facets of sociability and warmth (Trull, 1992).

To receive a diagnosis, individuals must meet four or more of the following criteria:

- Is suspicious, without evidence, of being used, manipulated, or harmed by others
- Views, without evidence, what others say or do as intentionally threatening or harmful
- Readily views and reacts quickly to benign events or remarks as attacking his or her character
Personality Disorders

■ Has little or no interest in close relationships
■ Has little or no interest in sexual activity with others
■ Has little or no interest in activities or hobbies
■ Has very few, if any, close relationships
■ Prefers activities that do not involve interaction with others
■ Shows little, if any, reactivity to others’ praise or criticism
■ Shows little, if any, affect or emotion

Schizotypal personality disorder. The diagnosis of schizotypal personality disorder (STPD) has its roots in research with two distinct sets of populations (clinical and familial) and therefore may represent an especially heterogeneous category. From clinical populations, researchers variously described patients whose symptomatology resembled that of patients with schizophrenia, yet lacked the severity and frank psychosis of schizophrenia. On the other hand, research from nonclinical populations in Danish adoption studies has found subthreshold schizophrenic symptoms in nonpsychotic relatives of schizophrenia patients (e.g., Kety et al., 1968). Familial samples may differ from clinically selected samples by presenting with more negative symptoms (e.g., social isolation and impaired functioning), whereas clinical samples are better characterized by positive, psychotic-like symptoms (e.g., eccentricity, ideas of reference, and socially inappropriate behavior).

According to DSM–5, STPD is characterized by a pattern of marked interpersonal deficits, discomfort with close relationships, behavioral eccentricities, and distortions in perception and thinking. The DSM notes that individuals with STPD will often seek treatment for anxiety, depression, or other affective dysphoria. Although people with this disorder may experience transient psychotic episodes, they must be distinguished from those with non-PD psychotic disorders that feature more persistent delusions and hallucinations. Ideas of reference are a common feature of STPD, as are odd beliefs such as magical thinking, extreme superstition, or a preoccupation with paranormal phenomena. In addition, people with STPD might have perceptual distortions, such as bodily illusions or sensory alterations, and many have odd thought and speech patterns. For example, their speech might be excessively vague, abstract, or loose, yet still maintain basic coherence. They often appear uncomfortable and act peculiar in social situations, and their affective expression is frequently constricted or inappropriate.

To receive a diagnosis, individuals must meet five or more of the following criteria:
■ Exhibits ideas that seemingly insignificant events or occurrences have special meaning or value
■ Holds beliefs in the occult, magic, or the supernatural that are not shared by other members of his or her cultural background
■ Appears to think or speak in nondescript, superficial, abstract, or stereotyped ways
■ Experiences unusual perceptions or bodily sensations
■ Shows affect that is inconsistent or unusual given the context
■ Exhibits behavior that is inconsistent or unusual given the context
■ Exhibits paranoia or distrust of others
■ Avoids social situations for fear of being hurt, harmed, or manipulated by others
■ Has very few, if any, close relationships

Cluster B: Dramatic-Erratic
Personality Disorders

Borderline personality disorder. Affective lability, as seen in BPD, has been identified in individuals since the works of the ancient Greek physician Aretaeus. It was not until the early 20th century, however, that this syndrome was given the name borderline (A. Stern, 1938) to describe patients who were considered borderline psychotic, that is, at the border between psychosis and neurosis, or from a psychoanalytic perspective on the border of analyzability and nonanalyzability.

Other names frequently used to describe these patients that indicate the relationship between schizophrenia and borderline pathology included: ambulatory and latent schizophrenia, schizophrenic character, abortive schizophrenia, pseudo-psychopathic schizophrenia, psychotic character,
subclinical schizophrenia, occult schizophrenic, pseudo-neurotic schizophrenia, and borderland (Frosch, 1964). Additionally, for many, the hallmark of these patients became their difficulty to treat (Waldinger & Gunderson, 1984).

To receive a DSM diagnosis of BPD, individuals must meet five or more of the following criteria:

- Vacillates between valuing and devaluing close others and consistently experiences relationships characterized by instability
- Exhibits instability or frequent shifts in self-image, sense of identity, and goals
- Experiences quick and sudden shifts in mood, especially that appear to exceed what is expected given the context
- Experiences or displays intense and inappropriate anger
- Experiences persistent feelings of emptiness
- Experiences paranoia or dissociation when acutely stressed
- Is impulsive in more than one domain
- Exhibits suicidal or self-harming behavior, thoughts, or threats on more than one occasion
- Expresses significant fears of abandonment and exhibits behaviors intended to reduce the possibility of being abandoned

**Antisocial personality disorder.** Traits and behaviors corresponding to antisocial personality disorder (ASPD) have been described using such terms as sociopath, psychopath, deviant, amoral, moral insanity, and dyssocial. The term *antisocial personality disorder* was introduced with the publication of *DSM–III* (American Psychiatric Association, 1980) and represented an attempt to operationalize the much-maligned term of psychopathy. The criteria were derived from empirical research based on Robin's (1966) seminal work.

As defined by *DSM–5*, ASPD is a pervasive pattern of irresponsible behavior and disregard for the rights of others that begins in childhood or early adolescence. People with this disorder repeatedly engage in unlawful or reckless behavior. Frequently victimizing others and blaming their victims for their own fate, they typically lack remorse for having hurt or mistreated another person. “They had it coming” is a common rationalization for victimized others. Alternatively, a person with this disorder might minimize the negative consequences of their actions, or blame others for being weak or foolish. Those with ASPD are prone to impulsiveness, irritability, and aggressiveness that often leads to physical fights or assault, and they have a reckless disregard for the safety of themselves or others. In addition, they might repeatedly fail to honor work or financial obligations, or they may display other evidence of consistent and extreme irresponsibility. Manipulativeness, deceitfulness, and dishonesty are central features of this disorder, often making collateral sources of information necessary for accurate diagnosis.

To receive a diagnosis, individuals must present with evidence of conduct disorder before age 15 years, as well as three or more of the following criteria as adults:

- Is impulsive in more than one domain
- Shows lack of respect for laws or social customs by repeatedly engaging in illegal activity
- Exhibits irresponsibility by repeated absenteeism or by failing to honor debts, loans, or other obligations
- Is aggressive or irritable to the point of repeatedly engaging in physical fights
- Manipulates others, lies, or is frequently deceitful
- Shows little, if any, consideration of the safety of him- or herself or others
- Shows little, if any, remorse or empathy for others he or she may have endangered, injured, slighted, or taken advantage of

**Histrionic personality disorder.** Histrionic personality disorder (HPD) has its early roots in Hippocrates’ writings more than 2,000 years ago on “hysteria” in women, thought to be caused by a “wandering womb” (Veith, 1977). According to ancient Greek medicine, the uterus would detach from its proper place and wander throughout the body, affecting the brain and causing excessive emotionality.

Hysteria was first officially linked to the term *histrionic personality* in *DSM–II* (American Psychiatric Association, 1968), which listed hysterical personality disorder and mentioned HPD parenthetically thereafter. By *DSM–III* (American Psychiatric
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Association, 1980), however, hysterical personality disorder had been replaced completely by HPD.

The core components of HPD include excessive emotionality, attention-seeking behavior, egocentricity, flirtatiousness, seductiveness, and denial of anger. Other characteristics of HPD are extreme gregariousness, manipulativeness, low frustration tolerance, suggestibility, and somatization. In addition, according to DSM–IV–TR (American Psychiatric Association, 2000), histrionic individuals consistently use their physical appearance to draw attention to themselves, spending excessive time, attention, and money on clothes and grooming.

To receive a diagnosis, individuals must meet five or more of the following criteria:

- Experiences distress if he or she is not the center of attention
- Engages with others in a sexually inappropriate or exaggerated way
- Uses his or her physical appearance in a showy or attention-seeking way
- Speaks in a vague, dramatic, or superficial manner
- Exhibits exaggerated emotions or carries him- or herself in a theatrical or dramatic way
- Shows quickly changing or shallow emotions
- Is easily swayed by others’ opinions or suggestions
- Feels that he or she is closer to others than they feel to him or her

Narcissistic personality disorder. According to DSM–5 (American Psychiatric Association, 2013), the central features of narcissistic personality disorder (NPD) are pervasive grandiosity, a constant need for admiration, and a lack of empathy for others. An individual with NPD has a sense of self-importance and an attitude of arrogance that might manifest in boastfulness, pretentiousness, or disdain. An overestimation of one’s own abilities and a devaluation of others are characteristic of this disorder. Also common is a preoccupation with fantasies about one’s own brilliance, beauty, or expected success.

People suffering from NPD usually require constant attention and admiration and may become furious with others who do not shower them with compliments or accolades. People with this disorder commonly are concerned with their own performance and how others evaluate them. They typically have fragile self-esteem, so their self-importance might alternate with feelings of unworthiness. They frequently either experience feelings of envy of other people or imagine that others are envious of them.

The sense of entitlement that is central to NPD often precludes the recognition of others’ abilities, needs, feelings, or concerns. Individuals with this disorder might discuss their own problems or concerns in lengthy detail, yet react with insensitivity or impatience to the problems of others. Inappropriate and hurtful remarks frequently are uttered by people with NPD, although they typically are oblivious to how these remarks affect others. They might also unconsciously exploit others and believe that the needs and feelings of other people are signs of weakness. To others these individuals appear cold, disinterested, disdainful, snobbish, or patronizing.

To receive a diagnosis, individuals must meet five or more of the following criteria:

- Considers his or her own importance to be much greater than others
- Considers only high-status or unique people to be able to understand him or her or to be worth affiliating with
- Frequently fantasizes about being highly successful, wealthy, powerful, or having the perfect romantic relationship
- Exhibits frequent envy of others or frequently considers others to be envious of him or her
- Seeks or demands excessive respect or deference
- Expects specialized treatment or unwavering compliance from others
- Takes advantage of others for personal gain
- Is unable or unwilling to show empathy or concern for others
- Exhibits arrogance in his or her behaviors or attitudes

Cluster C: Anxious-Fearful Personality Disorders

Avoidant personality disorder. Avoidant personality disorder (AVPD) was a new category added to the DSM–III (American Psychiatric Association, 1980) based on an evolutionary social-learning
theory of PDs (Millon, 1981). According to DSM–5, people with AVPD are characterized by pervasive social inhibition and discomfort in social situations, feelings of inadequacy and low self-esteem, and hypersensitivity to criticism or rejection. Although they long for close relationships, they avoid activities that involve interpersonal contact and have difficulty joining group activities. People with this disorder assume that other people will be critical and disapproving. They act with restraint in social situations and have difficulty sharing intimate feelings for fear of criticism, disapproval, shame, or ridicule. They have a strong need for certainty and security that severely restricts their ability to become close to others, and they typically are not able to establish new friendships or intimate relationships without the assurance of uncritical acceptance.

People with AVPD frequently feel socially incompetent, personally unappealing, or inferior to others. Therefore, they are reluctant to engage in new activities and they tend to be shy, inhibited, and quiet to avoid attracting attention to themselves. In addition, they are hypervigilant about detecting subtle cues that suggest the slightest criticism or rejection. Because they expect others to disapprove of them, they quickly detect any indication of such disapproval and typically feel extremely hurt.

To receive a diagnosis, individuals must meet four or more of the following criteria:

- Avoids new activities or ventures for fear of embarrassment
- Fears negative evaluation in occupational settings, which leads to frequent avoidance of occupational activities that involve others
- Fears negative evaluation in social arenas, which leads to frequent avoidance of social interactions with others
- Considers him- or herself to be incapable, unattractive, or of less value than others
- Hesitates to form relationships with others unless he or she is certain of being well-liked
- Is shy, restrained, or quiet in interactions with strangers due to feelings of inadequacy
- Is often unwilling to be open or candid in relationships for fear of being negatively evaluated

**Dependent personality disorder.** The history of DPD begins with descriptions of oral dependency by Abraham and Freud. The DSM (American Psychiatric Association, 1952) mentioned what was called “passive-dependent personality,” which was virtually synonymous with DSM–5 (American Psychiatric Association, 2013) DPD.

According to the DSM–5, the central characteristic of DPD is a pervasive need to be taken care of that begins by early adulthood. People with this disorder have an exaggerated fear that they are incapable of doing things or taking care of themselves on their own, and they therefore rely on other people (usually one person) to help them. They rely heavily on advice and reassurance from others in making decisions. Because of their lack of self-confidence, it is difficult for people with DPD to begin tasks on their own without being assured that someone is supervising them. They may appear to others to be incompetent because they believe that they are inept and they present themselves as such.

DSM–5 notes that because of their dependency on others, people with DPD often fail to learn basic independent living skills, and frequently find themselves in abusive or otherwise unbalanced relationships. It is not unusual for people with DPD to feel unrealistically fearful of being abandoned. They are typically passive and unwilling to disagree or become appropriately angry with the person on whom they depend. They will go to great lengths to secure or maintain the support of another person. People with DPD usually feel highly uncomfortable being alone because of an exaggerated fear of helplessness or the inability to care for themselves. The end of an intimate relationship often will be followed by urgent efforts to replace the person with another source of closeness and support.

To receive a diagnosis, individuals must meet four or more of the following criteria:

- Requires considerable input or advice from others before being able to make everyday decisions
- Is reliant on others for managing finances, living arrangements, and other major areas of responsibility
- Is often unable to begin projects or activities due to a fear of the consequences of his or her own incapacity or ignorance
Personality Disorders

■ Willingly engages in unpleasant tasks or duties to gain support and encouragement from others
■ Avoids arguments or disagreements with others for fear of losing their assistance or care
■ If a close relationship ends, he or she tries desperately to form a new source of care and assistance
■ Is distressed when alone due to feelings of helplessness or an inability to take care of him- or herself
■ Exhibits excessive fear of being able to manage his or her own affairs or care for him- or herself.

Obsessive-compulsive personality disorder. The modern concept of OCPD has its roots in Freud’s description of the anal personality as one who is excessively orderly, obstinate, and parsimonious (Freud, 1906–1908/1959). Synonymous with anankastic personality disorder in the *ICD–10*, the *DSM–5* (American Psychiatric Association, 2013) describes OCPD as a pervasive pattern of perfectionism, orderliness, and inflexibility that begins by early adulthood. People with OCPD have an excessive need for control that interferes with their ability to maintain interpersonal relationships or employment. They are typically preoccupied with rules, lists, schedules, or other minor details (Abraham, 1921). Their rigidity, inflexibility, and stubbornness often prevent them from accepting any new ideas or alternative ways of doing things, creating difficulty in both work and personal relationships.

In addition, the *DSM* notes that individuals with OCPD often sacrifice personal relationships in favor of work and become obsessively devoted to productivity. They hold both themselves and others to unrealistic standards of morality, ethics, or values. They are also reluctant to delegate tasks to others because they insist that everything be done their own way. Their excessive attention to trivial details, however, often interferes with their ability to complete a task (Horney, 1950).

Individuals with OCPD usually have difficulty expressing emotion (Horney, 1950) and are subject to dichotomous thinking, magnification, catastrophizing, and displays of anger, frustration, and irritability. The *DSM* further notes that individuals with OCPD might be reluctant to throw away worthless and unsentimental objects for fear that they might be needed at a later date. Furthermore, people with this disorder might hoard money and tightly control spending, believing that money should be saved for a future catastrophe.

To receive a diagnosis, individuals must meet four or more of the following criteria:

■ Values details, organization, and rules over the main point of activities
■ Is so devoted to ensuring tasks are done properly or correctly that they are often not completed
■ Avoids working with others or delegating tasks without being sure that his or her own way of doing things will be followed
■ Strongly prefers occupational activities over leisure activities or friendships
■ Maintains more rigid views of ethics and morality than other members of his or her cultural background
■ Exhibits excessive stubbornness and inflexibility
■ Avoids spending money on activities or goods that are not considered absolutely necessary
■ Hoards useless or broken items even if they have no sentimental value

The *Psychodynamic Diagnostic Manual*

In response to growing dissatisfaction with the *DSM* approach within the psychodynamic community, a task force was created by the major psychoanalytic organizations to develop a diagnostic manual, the *PDM* (Psychodynamic Task Force, 2006), that articulated disorders that were more consistent with psychodynamic theory and addressed concerns of psychodynamic clinicians (e.g., integrating descriptions of inferred internal psychological processes, such as defense and external manifestations of disorders; Psychodynamic Task Force, 2006). Included in the *PDM* is an axis describing personality patterns and disorders (Axis P). This conceptualization is based on an integration of the theoretical and clinical work of Kernberg and Westen and Shedler as well as the empirical research on PDs broadly. Similar to the *DSM*, the *PDM* differentiates PD as a different class from personality proper, symptom
disorders, psychosis, and the effects of brain trauma, chronic stress, and substances. The PDM points out that one can have an obsessive personality without necessarily having an obsessive personality disorder. Also based on Kernberg (1984), the PDM makes distinctions in the level of personality organization in terms of the severity of the PD with distinctions between healthy personalities (the absence of personality disorder), neurotic-level PDs, and borderline-level PD, and unlike manuals from the DSM system, the PDM discusses the implications for level of the severity dimension for psychotherapy.

Dimensional Models
Both the DSM–5 (American Psychiatric Association, 2013) Section II criteria and the ICD–10 (WHO, 1992) classification systems use categorical diagnostic taxonomies that present PDs as representing distinct clinical syndromes with specific cutoff points for reaching threshold for a specific PD. Although the use of categories implies discontinuity—that is, one either has or does not have the disorder—many researchers have argued that PDs can be better conceptualized along a continuum or dimension from normality to pathology. Two current systems exist by which dimensional assessment of PDs are possible: the FFM (Costa & McCrae, 1992) and ICD–11 (proposed to be released in 2017) dimensional frameworks.

The FFM is one of the most widely studied alternatives to the DSM categorical approach with regard to the assessment of personality disorders. In the FFM, PDs typically are assumed to represent extreme or maladaptive variants of normal personality traits. The five higher order traits and various lower order facets have been related to DSM PD categories in a number of studies. Given this research on the Five-Factor Model, some authors have suggested that a personality trait approach is sufficient to encapsulate personality disorder constructs. Indeed, a considerable corpus of studies has posited and supported the use of the FFM as an alternative to categorical diagnoses for PDs (Trull & Durrett, 2005). For example, the DSM–5 Section III alternative model to the assessment and diagnosis of PDs utilizes a trait-based approach, reflecting a shift toward dimensional PD assessment adopted by many in the field.

The ICD–11, in contrast to the dimensional models discussed previously that are based on dimensional ratings of traits and personality constructs, has adopted a dimensional model based on the notion of severity of dysfunction (Gunderson, Links, & Reich, 1991; Tyrer, 1999; Tyrer & Johnson, 1996). This model is consistent with the approach taken by the DSM–5 workgroup’s conceptualization of severity of functional impairment particularly around self and other functioning (American Psychiatric Association, 2013; Tyrer, 2013). This approach is consistent with other clinical writers such as Kernberg (Kernberg & Caligor, 2005) who have stressed severity as an important diagnostic indicator.

The ICD–11 dimensional scale ranges from 0 to 4, with 0 indicating no personality disorder; 1 some personality difficulty as indicated by being subthreshold for one or more PDs; 2 indicating the presence of a simple personality disorders, that is, meeting criteria for one or more disorders within the same cluster; 3 as a complex or diffuse PD, as indicated by meeting criteria for one or more PDs across more than one cluster; and 4, a severe PD as indicated by meeting criteria for severe disruption to both the individual and others.

Prototype Models
In contrast to classical categories used in the DSM systems, some have proposed the use of prototypes. Learning psychology has shown that humans tend to use prototype models when storing or retrieving information about categories (Rosch, 1983). In this vein, Westen and Shedler (2007; Shedler & Westen, 2007) have proposed a prototype-based model of PD assessment, the Shedler-Westen Assessment Procedure (SWAP), in which patients are rated against detailed descriptions of personality pathology on a scale assessing similarity and dissimilarity. These authors provide initial data from 496 psychiatrists and psychologists who report on their caseload using individual descriptive items, such as “tends to feel unhappy, depressed, or despondent” (Westen & Shedler, 1999b).

Factor analysis of these data resulted in only some factors resembling DSM diagnostic categories. Other factors, such as what Westen and Shedler
labeled “dysphoric personality disorder,” accounted for large portions of the variance in items, but they were distinct from DSM nosology. Several advantages of the SWAP prototype measure are that it is empirically derived, reduces diagnostic overlap and artifactual comorbidity resulting from orthogonal rotation of factors in the factor analysis, and assesses severity of personality pathology through dimensional ratings.

INCIDENCE AND COMORBIDITY

Epidemiology

Epidemiological data in the United States indicate that PDs have a high overall lifetime prevalence ranging between 5.9% and 21.5% in the community (Crawford et al., 2005; Lenzenweger et al., 2007; Trull et al., 2010) with most estimates between 9% and 11%. International epidemiological studies find similar rates ranging from 4.4% to 13.4%, depending on whether PD not otherwise specified (PDNOS) was included or not (Coid et al., 2006).

Using DSM–IV (American Psychiatric Association, 1994) PD criteria, 9.1% of an epidemiological sample from the National Comorbidity Survey Replication study met criteria for a personality disorder (Lenzenweger et al., 2007). In 2001 and 2002, prevalence data of 7 of the 10 PDs assessed through the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) suggested that 14.79% of adult Americans—or 30.8 million—had at least one PD (B. F. Grant et al., 2004).

Among countries other than the United States, PD prevalence rates tend to vary. In Norway, PDs are prevalent at 13.4% (Torgersen, Kringlen, & Cramer, 2001), and in Germany, around 10% (Maier et al., 1992). In Great Britain, the estimate is lower, at 4.4% (Coid et al., 2006). If assessed based on ICD–10 criteria, the general prevalence rate of PDs is estimated to be 6.5% in Australia (Jackson & Burgess, 2000; Maier et al., 1992). There are almost no community data on PDs from countries other than the United States, the United Kingdom, Germany, Norway, and Australia.

In primary care settings, about a third of people presenting to general practitioners had a personality disorder (Casey & Tyrer, 1990). The vast majority of patients were not presenting for PDs but presented as problematic medical patients (Emerson et al., 1994). Patients with Cluster C PDs are the most common PDs to be encountered in primary care settings (Moran et al., 2000).

Rates of PDs are generally much higher in clinical populations. Studies using structured diagnostic assessments have found that 20%–40% of psychiatric outpatients and about 50% of psychiatric inpatients meet criteria for a PD (de Girolamo & Reich, 1993; Dowson & Grounds, 1995; Moran, 1999).

Studies on the prevalence of specific PDs in the general community have found rates for paranoid PD ranging from 0.4% to 3.3%; schizoid, 0.5% to 0.9%; schizotypal, 0.6% to 5.6%; histrionic, 1.3% to 3.0%; narcissistic, 0% to 6.2%; antisocial 0.2% to 3.7%; avoidant, 0% to 1.3%; dependent, 1.6% to 6.7%; and obsessive-compulsive, 1.7% to 6.4% (Baron et al., 1985; Coryell & Zimmerman, 1989; Drake & Vaillant, 1985). Wave 2 data from the NESARC study has found rates of 5.9% for BPD (B. F. Grant et al., 2008), 6.2% for NPD (Stinson et al., 2008), and 3.9% for schizotypal PD (Pulay et al., 2009). The most consistently studied PD in community studies has been antisocial PD, which has a lifetime prevalence of between 2% and 3% and is especially common in those living in urban areas (Moran, 1999).

Research generally has shown that individuals diagnosed with PDs are likely to be single (e.g., Stinson et al., 2008). These studies also have found that PDs are generally more common in younger age-groups (particularly the 25–44 age-group). Many PDs are distributed equally between men and women in representative population samples, although most studies have found increased rates in men of NPD, STPD, and ASPD, and increased rates in women of AVPD and DPD.

Comorbidity

At a community level, individuals with PD are more likely to suffer from alcohol and drug problems. In addition, they are more likely to experience adverse life events, such as relationship difficulties, housing problems, and long-term unemployment (Moran, 1999).

Reasons for comorbidity include discrete disorders sharing risk factors, overlap between risk
factors, and that one disorder creates increased risk for the other disorder. For example, substance abuse and PDs may share temperamental aspects of impulsivity and negative affect as a shared risk factor (Szerman & Peris, 2015) and PTSD and PDs may share traumatic experiences as a shared risk factor. Additionally, substance abuse may impair identity formation and lead to PDs such as ASPD and BPD. Conversely, ASPD and BPD may impair a person’s capacity to regulate him- or herself and lead to the use of substances. Thus, rates and patterns of comorbidity could represent the natural order or nature of psychopathology—that is, these could represent true or valid levels of comorbidity. Different disorders may share a common etiology and be different phenotypic expressions of a common causal factor or factors.

Some estimates suggest that 75% of patients with a PD meet criteria for another mental disorder (Clarkin & Kendall, 1992; Dolan-Sewell, Krueger, & Shea, 2001; Fyer et al., 1988). For instance, most patients who meet criteria for a PD also meet criteria for at least one other PD. In fact, the average patient meeting criteria for a PD is diagnosed with 2.8 to 4.6 PDs (Widiger & Frances, 1994) and it is common for patients to meet criteria for as many as five or more DSM PDs. This level of comorbidity has been considered a serious problem within the following domains: (a) the validity of the concept of PDs, (b) the DSM system as a whole, and (c) the interviews developed to assess PD and disorders in general (see the Identification and Assessment section).

Compounding the problem is that PDs are highly comorbid with the more episodic syndromal disorders, originally referred to as Axis I disorders in DSM–III (American Psychiatric Association, 1980) and DSM–IV (American Psychiatric Association, 1994). For instance, current mood disorders are comorbid with PDs between 15% and 50% (B. F. Grant et al., 2008; J. E. Grant, Mooney, & Kushner, 2012; Pulay et al., 2009) and anxiety disorders around 30%–60% (J. E. Grant et al., 2012; Lenzeweger et al., 2007; Newton-Howes et al., 2010), with these estimates being even higher for lifetime comorbidity of these disorders. Furthermore, substance abuse and impulse control disorders are commonly comorbid with PDs (Zanarini, Frankenburg, Dubo, et al., 1998). PDs are frequently comorbid with paraphilias (Raymond et al., 1999), dissociative disorders (Ono & Okonogi, 1988), and factious disorders (Zubenko et al., 1987). In fact, although sexual function disorders are relatively rare, around half of individuals with a PD also display some form of lifetime psychosexual dysfunction (Zimmerman & Coreyell, 1989). Zanarini refers to the pattern of comorbidity observed in PDs as “complex comorbidity” because of the high number of comorbid diagnoses and the co-occurrence of both internalizing (e.g., depression) and externalizing disorders (e.g., substance use disorders).

Among Cluster A PDs, about two thirds of patients with PPD meet criteria for another PD, most frequently schizotypal, narcissistic, borderline, and avoidant PDs (Bernstein, Useda, & Siever, 1993). SPD is consistently comorbid with schizotypal and avoidant PDs (Bernstein et al., 1993). STPD appears highly comorbid with other PDs, especially Cluster B PDs (Pulay et al., 2009), and it is often comorbid with dysthymia and anxiety disorders (Alnæs & Torgersen, 1988).

In Cluster B, ASPD is frequently comorbid with borderline (Becker et al., 2000), narcissistic (Oldham et al., 1992), histrionic (Lilienfeld et al., 1986), and schizotypal PDs (Marinangeli et al., 2000). Research has demonstrated that ASPD has a particularly strong association with substance use disorders (Kessler et al., 1997). HPD is consistently comorbid with borderline and narcissistic PDs (Becker et al., 2000; Marinangeli et al., 2000; Oldham et al., 1992). Some studies have also found HPD to co-occur substantially with antisocial (Lilienfeld et al., 1986; Marinangeli et al., 2000; Oldham et al., 1992) and dependent (Oldham et al., 1992) PDs and with psychoactive substance use (Oldham et al., 1995). NPD is often comorbid with borderline, schizotypal, and obsessive-compulsive PDs (Stinson et al., 2008; Zimmerman, Rothschild, & Chelminski, 2005). Some evidence suggests that antisocial and histrionic PDs also may be highly comorbid with NPD (Oldham et al., 1992; Zimmerman et al., 2005). Epidemiological data suggests that alcohol use disorders are significantly comorbid in NPD, although these and other substance use
Personality Disorders

problems are relatively less frequent compared to those diagnosed in other PDs (Stinson et al., 2008; Trull et al., 2010). The comorbidity of BPD is especially complex, as BPD has been conceptualized as both an internalizing and an externalizing disorder (Blatt & Levy, 2003; Levy & Blatt, 1999), contributing to rates of more than 80% comorbidity with at least one current non-PD disorder and an average of 3.2 comorbid non-PD disorders per patient (Lenzenweger et al., 2007).

The comorbidity of Cluster C PDs is often less clear. Although AVPD has been conceptualized as linked to SPD and has been found to be comorbid with SPD (Oldham et al., 1992), multidimensional scaling has found AVPD can be discriminated from SPD but not DPD (Widiger et al., 1987). AVPD is often comorbid with DPD (Oldham et al., 1992) as well as with mood, anxiety, and eating disorders (Oldham et al., 1995) and especially social phobia (Alnæs & Torgersen, 1988). DPD is substantially comorbid with mood, anxiety, and non-PD psychotic disorders (Oldham et al., 1995) and borderline and avoidant PDs (Marinangeli et al., 2000; Oldham et al., 1992). DPD is also frequently comorbid with PPD (Marinangeli et al., 2000) and OCPD (Oldham et al., 1992). The results of studies on OCPD comorbidity are inconsistent. Although some evidence suggests OCPD co-occurs significantly with several other PDs, including borderline, narcissistic, histrionic, paranoid, and schizotypal PDs (Marinangeli et al., 2000), other data find significant comorbidity with DPD among the PDs (Oldham et al., 1992). Investigations of the relationship between OCPD and OCD also have yielded mixed results, with some researchers finding significant co-occurrence (AuBuchon & Malatesta, 1994; Baer et al., 1992; Skodol et al., 1995), and others failing to find a strong relationship between these disorders (Black et al., 1993; Joffe, Swinson, & Regan, 1988). On the whole, the literature on OCD and OCPD suggests that the majority of patients with OCD do not meet criteria for OCPD (Pfohl & Blum, 1991). Furthermore, for those with OCD with concurrent PD diagnosis, OCPD occurs no more frequently than any other PD. Previous authors have concluded that information is insufficient to support a meaningful relationship between OCD and OCPD.

The bulk of the evidence indicates that PDs, while frequently comorbid with non-PDs, appear to be a distinct, independent problem that provide important information to the clinician in terms of the impact on course and treatment (Fournier et al., 2008; Grilo et al., 2010; Zanarini et al., 2004). With regard to PTSD, researchers have found high rates of childhood abuse in BPD populations (Ogata et al., 1990), and some have argued that trauma may be a potential trigger of posttraumatic BPD symptoms (Soloff, Lynch, & Kelly, 2002). Although it is accurate that many BPD patients have suffered traumatic physical or sexual abuse, not all have. In fact, data suggest that 30%-70% have not. Thus, the idea that BPD is really a complex PTSD can only explain between 30%-70% of BPD cases, whereas the diagnosis of BPD can explain all cases, including those with complex traumas.

In addition to mental disorders, PDs often present with comorbidity among medical and physical conditions as well. For example, data from the NESARC suggest that a diagnosis of BPD may be related to a number of physical health conditions, such as hypertension, cardiovascular disease, and gastrointestinal diseases (El-Gabalawy et al., 2010). This study further found that comorbid medical conditions may in fact increase the risk of suicide attempts in BPD, highlighting that paying attention to comorbidity is vital. In sum, PDs are both highly prevalent and highly comorbid with a range of psychiatric and medical disorders.

Effects of PD Comorbidity on Other Disorders

Although it has been common to view a comorbid PD as being a variant of the disorder it is comorbid with, the evidence suggests the opposite. For instance, when comorbid, PDs negatively affect the course of other disorders and the outcome of otherwise efficacious treatments. Bipolar patients with comorbid PDs are less employed, use more medications, have increased rates of alcohol and substance use disorders, show poorer treatment response, and have significantly worse interepisode functioning than bipolar patients not afflicted with PDs (Bieling, Green, & MacQueen, 2007). Interestingly, the reverse is not true: a comorbid bipolar disorder
does not affect the course or outcome of treatment for PD patients (Gunderson et al., 2006). Similarly, a number of studies have found that improvements in BPD often were followed by improvements in depression but that improvements in depression were not followed by improvements in BPD (Gunderson et al., 2004; D. N. Klein & Schwartz, 2002; Links et al., 1995). BPD also adversely affects treatment for substance abusers, but substance abuse (highly comorbid with BPD) does not appear to alter the course of treatment for BPD (Lee et al., 2010). Finally, a number of studies have shown that the efficacy of treatment of PTSD is significantly reduced when the patient has comorbid BPD (Cloitre & Koenen, 2001; Feeny, Zoellner, & Foa, 2002).

IDENTIFICATION AND DIAGNOSIS
Identification and Assessment
Most psychologists in clinical practice rely on unstructured clinical interviews for diagnosing patients presenting for treatment (Zimmerman, 2003). Unstructured clinical interviews, however, can be idiosyncratic and unreliable and are vulnerable to a number of biases, such as failure to consider all of the necessary diagnostic criteria (and failure to consider additional symptoms and diagnoses beyond the chief complaints once a disorder has been identified). A number of studies comparing clinical diagnoses made by unstructured interviews with diagnoses made using structured and semistructured interviews have shown poor correspondence between the two and have indicated that unstructured clinical interviews miss many diagnoses (e.g., Barbato & Hafner, 1998; Ramirez Basco et al., 2000).

This problem appears to be particularly pronounced for PDs. For example, in university-based outpatient clinics, when clinicians were left to their own judgments based on unstructured clinical interviews, they diagnosed BPD in 0.4% of almost 500 patients seen compared with 14.4% by structured interview (Zimmerman & Mattia, 1999). This means that 97% of those patients diagnosed by structured interviews with BPD were missed by unstructured clinical interviews. The research evidence is clear that without a formal assessment most cases of PDs will be missed (Levy, 2013; Magnavita et al., 2010). This may be especially true of NPD and ASPD in which manifestations of pathology can be relatively nuanced, distress is denied and externalized, self-monitoring is high, and the criteria for these disorders have both high face validity and a negative connotation.

Beyond the unstructured clinical interview, clinicians and researchers can draw from an array of sources when assessing PDs. These sources include self-report paper-and-pencil or computer-administered inventories, clinician rating scales and checklists, structured and semistructured clinical interviews, projective techniques, and data from informants. Many of these instruments assess PDs based on the prevailing taxonomy in DSM–IV–TR (American Psychiatric Association, 2000) and DSM–5 (American Psychiatric Association, 2013), which articulates the 10 PDs described earlier. A number of instruments exist, however, that are based on other conceptualizations of PDs and pathology.

Semistructured Interviews
Semistructured interviews provide specific, carefully selected questions for each diagnostic criterion to be assessed, with the purpose of increasing the consistency between interviewers through the use of systematic, replicable, and objective methods. Semistructured interviews are meant to be semistructured rather than fully structured because they include many open-ended and indirect questions, allow for interviewers to follow up, seek elaboration, and obtain clarification of the information provided as well as observation of the patient’s manner of responding and relating to the interviewer. Thus, to conduct a semistructured interview, the interviewer needs to have training and experience to utilize the clinical judgment required to know when to follow up and how to rate the criteria.

A number of semistructured and structured interviews are available for the full range of DSM PDs. These include the Structured Interview for DSM Personality Disorders—Revised (SIDP–R; Pfohl, Blum, & Zimmerman, 1997), Structured Clinical Interview for DSM–IV Personality Disorders (SCID–II; First et al., 1995), International Personality Disorders Examination (IPDE; Loranger, 1999), Personality Disorder...
Interview—IV (PDI–IV; Widiger & Corbett, 1995), and the Diagnostic Interview for Personality Disorders (DIPD–IV; Zanarini et al., 1987, 2000). They differ from each other in their wording of questions, inclusion of follow-up, suggestions for inquiry, and organization. For instance, the SCID–II is organized by disorder, whereas the IPDE is organized by domains of functioning (e.g., work, relationships, self, affect). Although these interviews have varying levels of psychometric data, evidence suggests that they are promising measures with good reliability and initial validity data. No data suggest that one structured interview is more valid than another.

A number of semistructured and structured interviews also assess for specific DSM PDs. These include the Revised Diagnostic Interview for Borderlines (DIB–R; Zanarini et al., 1989) and Borderline Personality Disorder Severity Index (BPDSI; Arntz et al., 2003), the Diagnostic Interview for Narcissism (Gunderson, Ronningstam, & Bodkin, 1990), and the Hare Psychopathy Checklist—Revised (Hare, 1991). In addition, ASPD can be assessed using the National Institute of Mental Health Diagnostic Interview Schedule, Antisocial Section (Robins et al., 1981).

A number of semistructured interviews utilize other conceptions of PDs. These include (a) the Structured Interview for the Five-Factor Model of Personality (Trull & Widiger, 1997), which assesses the five domains of the FFM and is the only semistructured interview that assesses general personality; (b) the Personality Assessment Schedule (PAS; Tyrer, 1988), which assess 24 traits (e.g., aggression, impulsivity, conscientiousness) and generates dimensional ratings of five personality styles (normal, passive-dependent, sociopathic, anankastic, and schizoid; and (c) the Structured Interview of Personality Organization (STIPO; Clarkin et al., 2004), which allows for dimensional assessment of identity, defenses, and reality testing based on Kernberg’s (1981) structural interview. This interview is conceptually concordant with DSM–5 (American Psychiatric Association, 2013) Section III conceptualization of PDs.

Clinician Rating Scales
A number of clinician rating scales are available, such as the Personality Assessment Form (PAF; Shea, Glass, Pilkonis, Watkins, & Docherty, 1987), the SWAP (Westen & Shedler, 1999a), and scales for the PDM. The PAF presents a brief paragraph that describes important features of each PD, and the individual’s similarity to the description is rated by an evaluator using a six-point scale. The SWAP is a 200-item Q-set of personality-descriptive statements designed to quantify clinical judgment based on the rater’s knowledge of clinical data about the patient. Clinicians are directed to arrange the 200 items (presented on separate index cards) into eight categories with a fixed distribution ranging from those that are not descriptive of the patient to those that are highly descriptive of the patient. SWAP ratings have been shown to be reliable and have concordance with independently carried out semistructured interviews. The SWAP has demonstrated a reduction in comorbidity with other PDs, especially Cluster B PDs. This reduction is important because a lack of discreteness of PDs has been a frequent critique of their construct validity.

Self-Report Instruments
Of the number of self-report instruments used to assess for PDs, the most widely used are the Millon Clinical Multiaxial Inventory (MCMI–III; Millon, Millon, & Davis, 1994), the Personality Diagnostic Questionnaire—Fourth Edition (PDQ–4; Hyler et al., 1992), the Personality Assessment Inventory (PAI; Morey, 1991), and the Dimensional Assessment of Personality Pathology—Basic Questionnaire (Schroeder, Wormworth, & Livesley, 1992). Other PD measures include the Schedule of Nonadaptive and Adaptive Personality (SNAP; Clark, 1993), the OMNI Personality Inventory (OMNI; Loranger, 2001), the Personality Inventory Questionnaire (PIQ–II; Widiger, 1987), the Wisconsin Personality Disorder Inventory (WIPSI–IV; M. H. Klein et al., 1993), and the Minnesota Multiphasic Personality Inventory 2—Personality Disorder Scales (MMPI 2–PD; Morey, Waugh, & Blashfield, 1985).

A number of self-report scales assess specific PDs. The most commonly used include the Psychopathic Personality Inventory (PPI; Lilienfeld & Windows, 2005), Pathological Narcissism Inventory (PNI; Pincus et al., 2009) and Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979) for
narcissism, and the Borderline Symptom Index (BSI; Bohus et al., 2007), Borderline Personality Inventory (BPI; Leichsenring, 1999), and the Inventory of Personality Organization (IPO; Clarkin, Foelsch, & Kernberg, 1995).

Because self-report measures tend to result in higher diagnostic base rates than interviews and there is poor concordance between them and interview measures, they are not recommended for diagnosis (McDermut & Zimmerman, 2005). A number of researchers, however, have used and recommend a two-stage or stepped procedure for identifying people with PDs. Self-report measures are administered as an alert to the probability of a PD, and then a semistructured interview is administered to those who scored positive for a PD to verify its presence and type.

A number of screening instruments have been developed to assess for PDs broadly and specifically. The most commonly used measures include the Standardized Assessment of Personality Disorders–Abbreviated Scale (SAPAS; Moran et al., 2003), Iowa Personality Disorder Screen (IPDS; Langbehn et al., 1999), Inventory of Interpersonal Problems–Personality Disorders-25 (IIP-PD-25; B. L. Stern et al., 2000), and International Personality Disorders Examination–Screening Questionnaire; IPDE-SQ; Loranger, 1999).

The IPDE-SQ screens for the 10 DSM–IV (American Psychiatric Association, 1994) personality disorders: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive. The IPDE-SQ PD scales are scored based on the sum of endorsed items. According to the scoring system, the endorsement of three or more items is suggestive of the presence of that disorder. As noted previously, previous research (Lenzenweger et al., 1997) has shown that the screener is highly sensitive to identify those with PD diagnoses.

Use of informant information is important when assessing PDs. Sole reliance on an individual’s personal report, which is the most common practice both clinically and in research (Klonsky & Oltmanns, 2002), can prove problematic. Although research shows that agreement between self- and peer-reported personality traits in normal samples can be good to excellent (McCrae & John, 1998), within clinical samples, findings between patient-reported data from interviews and measures with informants’ report tend to range from poor to adequate (Klonsky & Oltmanns, 2002). Informants can be aware of and have a better sense of behaviors, traits, and symptoms that the patient may be defensive about or consciously motivated to withhold from assessors. Informants are more willing to report on negative aspects of the patient, such as arrogance, dishonesty, suspiciousness, hostility, and dependence (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997).

Depending on the age, life situation, suspected diagnoses, and reason for referral of an individual, informants can include friends, spouses, parents, children, colleagues, law enforcement or parole officers and court records or judges, and previous and current treaters. For example, when a patient comes into treatment because of an ultimatum from their spouse or significant other, it is important to gather information from that person. Likewise, if a patient comes in for treatment because their boss has made it a condition of employment, it would be important to gather information from the boss. It is particularly important to meet with and gather data from informants when ASPD might be present. Additionally, it is important to gather informant information for any patient presenting to treatment with legal difficulties or through a court mandate.

The recommendation to utilize data from self-report, interviews, and observation as well as from informants simultaneously in making a diagnosis is in accordance with the “longitudinal, expert, all-data (LEAD) standard” (Pilkonis et al., 1991), which recommends that optimal diagnostic practice requires the consideration of all available data to derive a “best estimate” diagnosis or set of diagnoses. This method has been shown to be more valid and reliable than diagnostic interviews alone (Pilkonis et al., 1991) and to result in fewer comorbid diagnoses (Levy et al., 1998).

**Differential Diagnosis**

Another consideration in PD assessment is differential diagnosis, which consists of choosing from among two or more similar diagnostic criteria the diagnosis that best fits the presenting features.
The differential diagnosis for PDs commonly includes mood disorders, such as bipolar, major depression, and dysthymia; anxiety disorders; PTSD; and substance abuse disorders (SUDs). PDs frequently are comorbid with all these disorders, which complicates the diagnostic and clinical decision-making process. For example, it is often unclear whether symptoms of depression or anxiety reflect a comorbid diagnosis or are primarily an expression of personality pathology.

Even when not comorbid with other disorders, PDs can present in ways that resemble other disorders, particularly Cluster A disorders with psychotic spectrum disorders, Cluster B disorders with mood disorders, and Cluster C disorders with anxiety disorders. These similarities in presentation make it important for practicing clinicians to be able to determine differential diagnoses or to determine whether a disorder is comorbid. Studies have shown that it takes between 6 and 10 years after first psychiatric contact for those with BPD to be diagnosed properly (Meyerson, 2009; Zanarini, Frankenburg, Dubo, et al., 1998). During this gap, patients usually receive inadequate treatment.

Differential diagnosis of PDs may be categorized into three types: (a) differential from the effects of substances; (b) differential from similar disorders, including more episodic syndromal disorders (e.g., major depression, bipolar II, generalized anxiety disorder, panic disorder, formerly called Axis I) and other personality disorders (formerly Axis II); and (c) differentiating clinical levels of personality pathology from subclinical or healthy personality functioning.

Unipolar depression. One of the most common differential diagnoses of PDs is with various mood disorders, such as major depressive disorder (MDD), depressive disorder NOS, and persistent depressive disorder (formerly called dysthymia). Those with PDs, particularly BPD and NPD, often experience depression, and the patient’s phenomenological experience is often that they are depressed. In fact, research shows that BPD patients typically score as high or higher on measures of depression as those with MDD (Levy et al., 2007).

Making this differential requires an extensive evaluation of the symptoms and quality of the depression experienced. In BPD, the depression is often experienced as chronic dysphoria and emptiness (Zanarini, Frankenburg, DeLuca, et al., 1998). In NPD, the depression tends to occur more sporadically and after failures of one sort or another or when individuals are in a vulnerable state (Caligor, Levy, & Yeomans, 2015). In addition, those with BPD and NPD often report chronic suicidality and periodic self-injury and suicidal attempts, typically after interpersonal discord. Without careful assessment, the suicidality, suicide attempts, and self-injury can easily but mistakenly be interpreted as part of a depression rather than a response to interpersonal discord.

In contrast to MDD in which the depressed mood is episodic, in BPD the depressed mood is often chronic and tends to vacillate with anger and irritability (as opposed to normal mood or expansive mood in bipolar disorder). Also, in contrast to those with MDD, borderline patients often show more mood reactivity than is typical of those in a depressive episode. It is not unusual for a suicidal and otherwise seemingly depressed patient with BPD to quickly become quite relieved, cavalier, and even social with the other patients upon admission to an inpatient hospital unit. BPD patients often do not present with the neurovegetative signs that are frequently typical of those with major depression and are more likely to report atypical symptoms (e.g., increased appetitive and excessive sleeping). Symptoms related to poor appetite are not accompanied by weight loss, belaying the report of decreased appetite.

Probably the most important issue for differentiating BPD from MDD concerns identity disturbance. People with MDD alone do not suffer from identity disturbance, whereas identity disturbance is typically present in BPD. Given the chronic nature of the BPD patient’s depressed mood, it often can be difficult to differentiate BPD from dysthymia (now called persistent depressive disorder in DSM–5 [American Psychiatric Association, 2013]). Once again, mood reactivity, lack of neurovegetative signs, chronic irritability, suicidality, and parasuicidality are characteristic of BPD.

Bipolar disorders. Another common and challenging differential diagnosis for those with PDs,
particularly those with BPD, NPD, and ASPD, is with bipolar disorder, particularly bipolar II. The comorbidity between PDs and bipolar I and II tends to be around 28%–48% (e.g., George et al., 2003; Kay et al., 1999). A large amount of data now suggests that those with BPD are often misdiagnosed with bipolar disorder. Even when bipolar disorder is present, it is important to determine whether a PD is present because evidence suggests that a comorbid PD diagnosis negatively affects the course and outcome for bipolar disorder, whereas comorbid bipolar disorder does not affect the course and outcome for PDs (e.g., Bieling et al., 2007; Gunderson et al., 2006; Kay et al., 2002).

At a practical level, probably the most important point of confusion in differentiating PDs from bipolar disorder concerns affective instability or emotional lability. Because affective instability is a core symptom of bipolar disorder, when it occurs in PDs, it is often mistaken as an indicator of bipolar disorder. Research shows, however, that affective instability in BPD is qualitatively different than what is proposed in the criteria for bipolar disorder. Affective instability in bipolar disorder occurs spontaneously and evolves over a period of days and weeks and tends to be longstanding (American Psychiatric Association, 2013). Additionally, the mood swings seen in bipolar disorder are typically between depression and elation, expansiveness, and grandiosity. On the other hand, in BPD and other PDs, the affective instability is reactive (i.e., environmentally driven), usually occurs in response to interpersonal events or internal thought processes, and tends to be of short duration and display frequent vacillations. These vacillations are not between depression and elation or grandiosity, but rather are between depression and anger, hostility, and irritability (Reisch et al., 2008). BPD patients report significantly more frequent and intense affective shifts than those with bipolar disorder (Reisch et al., 2001). Interestingly, the affective instability in BPD patients, compared with bipolar patients, tends to be more intense and frequent and to shift between depression and anxiety on the one hand and euthymia and anger on the other (Henry et al., 2001; Reisch et al., 2001).

Similar confusions arise when differentiating impulsivity and irritability in BPD and bipolar disorder. Impulsivity and irritability in BPD is chronic, whereas in bipolar disorders, these characteristics must represent a distinct occurrence and occur as part of a manic or hypomanic episode to be counted toward those disorders.

**Trauma disorders.** Distinguishing between PDs and PTSD can be clear-cut when the PTSD is an acute symptomatic reaction to a discrete traumatic event accompanied by psychophysiological correlates. With regard to acute traumas, chronic impulsivity, irritability, and identity disturbance will distinguish BPD and PTSD. This is especially easy to determine when the symptoms of BPD predate the traumatic event. The premorbid functioning in those with PTSD is usually good.

It is much more difficult, however, to disentangle these disorders in the context of the enduring effects that early and chronic trauma can have on personality development. A number of clinical researchers and theorists have suggested that BPD can be reconceptualized as a form of complex PTSD (e.g., Herman, 1993; Hodges, 2003; Kroll, 1993). Studies show that 30%–70% of BPD patients have broadly experienced traumatic events (e.g., Zanarini & Frankenburg, 1997); conversely, 30%–70% of those with BPD do not. Additionally, studies of consecutive admissions find that between 30% and 45% of BPD have a history of abuse, which often is not significantly different than other mental disorders (e.g., Chapman et al., 2004).

In a study of women with PTSD who experienced early childhood abuse, a comorbid BPD diagnosis did not affect traditional symptoms of PTSD, such as the frequency and severity of intrusions, avoidance, and arousal (Heffernan & Cloitre, 2000). A comorbid BPD diagnosis, however, did result in elevations in the newly proposed DSM–5 (American Psychiatric Association, 2013) symptoms of PTSD that historically were thought to be part of the BPD symptom picture: anger, anxiety, dissociation, and interpersonal problems (Heffernan & Cloitre, 2000). These findings suggest that BPD and traditional PTSD can be distinguished by their symptom picture and can cast doubts on the concept of
complex PTSD as a substitute for BPD. Thus, anger and interpersonal problems as well as anxiety and dissociation would suggest the possible comorbidity of BPD and the need for assessment in the context of trauma and PTSD.

Anxiety disorders. Other important differential diagnoses include anxiety disorders, particularly generalized anxiety disorder (GAD) and panic disorder. Those with PDs, particularly BPD, often report diffuse anxiety that may at times resemble GAD. The PD patient, however, tends to vacillate between feeling anxious over a range of situations and being remarkably unconcerned and cavalier about situations in which anxiety would be appropriate.

Additionally, whereas in GAD the anxieties often are discordant to the situation (e.g., the student with high grades who worries excessively about his or her grades), the worry in PDs tends to be about current crises that have arisen and dissipates once the crises are resolved. For example, a supervisee reports that she believes a patient may have GAD because of the patient's excessive worry about whether or not her disability benefits will be renewed. The patient is concerned because she has been talking in therapy about her off-the-books job, and she is afraid that the review agency will discover she is working. The anxiety interferes with her sleep and eating and also is making her irritable. Once her benefits are renewed, however, her anxiety quickly resolves, which is indicative more of a PD (or even healthy functioning) than GAD.

Substance use disorders. It is often the case that PD patients who abuse substances do so as a function of their PD. Sometimes, however, problems associated with substance abuse can create many of the symptoms of a PD. That is, patients who abuse substances can behave in ways consistent with PDs as a function of substance use. For example, it is not unusual for those with SUDs to act in antisocial ways, such as lying or stealing to obtain drugs or alcohol. Such a person while on drugs or in the pursuit of drugs may show a callous, remorseless attitude. The patient may not have engaged in these behaviors or shown such an attitude either before the development of the SUD or after becoming sober, suggesting the absence of antisocial PD.

In a retrospective chart review study of 137 inpatient borderline patients, more than two thirds met DSM–III (American Psychiatric Association, 1980) criteria for substance use disorders (Dulit et al., 1990). Interestingly, when substance use was not used as a criterion for BPD, 35% of patients no longer met DSM–III criteria for BPD. This subgroup was marked by lower severity of symptoms and less chronicity of course. Thus, a subgroup of PD patients may appear to have PDs because of behaviors associated with comorbid substance use, and these patients likely would lose the PD diagnosis after achieving abstinence.

It is relatively easy to rule out a PD for patients whose PD behavior begins after substance use, particularly when in adulthood or whose PD behavior quickly remits after refraining from substance use. It is much more difficult to make this determination when substance use begins early or when the patient is in the throes of substance use. In these cases, it is useful to rely on the hallmark indicators of PDs that are independent of the consequences of substance abuse, such as identity disturbance in BPD.

TREATMENT

PDs are considered a major treatment challenge. Historically, PDs have been thought to be difficult to treat, with patients frequently not adhering to treatment recommendations, using services chaotically, and repeatedly dropping out of treatment. Many clinicians are intimidated by the prospect of treating BPD patients and are pessimistic about the outcome of treatment (Lewis & Appleby, 1988; Lequesne & Hersh, 2004; McDonald-Scott et al., 1992). Therapists treating patients with BPD have displayed high levels of burnout and have been known to be prone to enactments and even engagement in iatrogenic behaviors (Linehan et al., 2000).

In recent years, however, a number of randomized controlled trials (RCTs) have found PDs can be treated successfully. Beginning with Linehan et al.’s (1991) seminal RCT of dialectical behavior therapy (DBT), a range of treatments—deriving from both the cognitive–behavioral (CBT) and psychodynamic (PDT) traditions—have shown efficacy in RCTs and now are available for clinician use. In addition to
DBT, efficacious treatments include schema-focused therapy (SFT) and systems training for emotional predictability and problem solving (STEPPS) from a CBT perspective and mentalization-based treatment (MBT), dynamic deconstructive psychotherapy (DDP), and transference-focused psychotherapy (TFP) from a psychodynamic perspective. Several other treatments appear promising, such as Meares’s Interpersonal Treatment (Stevenson et al., 1992), Ryle’s Cognitive Analytic Therapy (CAT; Ryle, Poynton, & Brockman, 1990), and Beck’s CBT (Beck, Freeman, & Davis, 2004), and have received support through RCT designs. All treatments with demonstrated efficacy or effectiveness share some commonalities: they tend to be long-term, integrative, structured, and modified from standard treatments.

Meta-Analyses of Treatment for PDs
Several meta-analyses of psychotherapy for PDs provide encouraging findings (Budge et al., 2013; Leichsenring & Leibing, 2003; Perry et al., 1999). One meta-analysis (Perry et al., 1999) identified 15 studies, including six RCTs, and found pre–post effect sizes ranging from 1.1 to 1.3. A second meta-analysis (Leichsenring & Leibing, 2003) examined the efficacy of both PDT (14 studies) and CBT (11 studies) in the treatment of patients with PDs; 11 of the studies were RCTs. The authors reported pre-to posttreatment effect sizes using the longest term follow-up data reported in the studies. For psychodynamic psychotherapy (mean length of treatment was 37 weeks), the mean follow-up period was 1.5 years after treatment end and the pre-to posttreatment effect size was 1.46, indicating that psychodynamic treatment benefits endure over time. For CBT (mean length of treatment was 16 weeks), the mean follow-up period was 13 weeks, and the pretreatment to posttreatment effect size was 1.0. The authors concluded that both PDT and CBT demonstrated effectiveness for patients with PDs, but that current evidence for long-term effectiveness is stronger for psychodynamic psychotherapy. The most recent and comprehensive meta-analysis on PDs (Budge et al., 2013) analyzed 30 studies that compared an active psychotherapeutic treatment with treatment as usual, finding that active psychotherapeutic treatments were more efficient than treatment-as-usual comparisons, with medium effect size ($d = .40$). In addition, the effectiveness of PDT for individuals with PDs is supported by two more recent meta-analytic studies for short-term PDT (Town, Abbass, & Hardy, 2011) and for the treatment of depression with comorbid PDs (Abbass et al., 2011).

Findings from these meta-analyses suggest that psychodynamic and CBT-based treatments for PDs are far more effective than no treatment, are modestly more effective than treatments as usual, and appear to be equally effective for PDs. Additionally, longer term treatments might yield better outcomes.

At the same time, findings from these meta-analyses of PDs are difficult to interpret because of the mixing of different disorders both within studies included in meta-analyses and within and between meta-analyses. These different PDs vary quite a bit in terms of severity. Further complicating the interpretation are the different controls used across studies and within meta-analyses. Research on specific PDs would be more informative particularly when the control group is better accounted for.

Pharmacotherapy
A systematic review of 40 RCTs for the PDs (most of which focused on BPD) found some limited effect of psychotropic medication for specific PD symptoms, such as the mood stabilizer lithium for aggression in ASPD and monoamine oxidase inhibitors for social anxiety in AVPD (Triebwasser & Siever, 2007). A 2010 review of 21 pharmacological treatment studies of BPD and STPD suggested that antipsychotics were moderately effective for cognitive or perceptual symptoms as well as for reducing anger (Ingenhoven et al., 2010). Antidepressants had a small effect on anxiety symptoms, but they were not effective for depression among these patients or for treating core PD symptomatology. Further systematic review evidence suggests antipsychotic medication may be especially helpful in reducing psychotic features of both BPD and STPD, and lithium may be effective for aggressive features among PDs such as ASPD (Hori, 1998). Another recent review posited that antipsychotics may help reduce psychotic features and behavioral symptoms
among the PDs (Öyekçin & Yıldız, 2012). This review suggested that (a) psychotherapy for BPD might be enhanced with concurrent pharmacological treatment when mood, cognitive, or behavioral symptoms are severe; (b) AVPD may be treated with the serotonin–norepinephrine reuptake inhibitor venlafaxine or with selective serotonin reuptake inhibitors (SSRIs); and (c) STPD may respond to antipsychotics; but (d) ASPD is not responsive to medication, contradicting earlier findings of the efficacy of lithium in this disorder (Hori, 1998).

For BPD specifically, a systematic review and meta-analysis of 27 RCTs conducted by the Cochrane Collaboration determined that mood stabilizers, such as lamotrigine, showed some efficacy in treating both core and accessory features of the disorder (Lieb et al., 2010). The second-generation antipsychotic aripiprazole also showed some effect in reducing BPD symptoms. Antidepressant medications (e.g., SSRIs) were not found to be effective as a BPD treatment option. These findings partially confirmed an earlier review (Nosé et al., 2006) that found that mood stabilizers reduced affective instability and anger in BPD, and antipsychotics were effective in reducing impulsivity and aggression as well as improving interpersonal functioning. As the authors of these studies point out, however, pharmacotherapy for the PDs tends to have only limited effect and to focus on specific core or secondary symptoms of specific disorders, rather than on global change, and, if used, should be considered adjunctive treatment to psychotherapy, which is the gold standard of care for PDs.

Self-Help Resources

A number of self-help resources are available for people with PDs, particularly BPD. These resources include (a) books written by professionals and/or patients or family members geared toward patients, families, and professionals; (b) Internet resource centers that provide information through text, videos, and additional links; and (c) self-help and family organizations that in addition to website and written information provide lectures, education, and trainings and support to people with PDs and their families. Many of these resources provide mechanisms for referrals, provide advocacy, and bring current research findings to individuals and families suffering from PDs.

In the United States the main self-help and family organizations include the BPD Resource Center (http://www.bpdresourcecenter.org), Treatment and Research Advancements for Borderline Personality Disorder (http://www.tara4bpd.org), National Education Alliance for BPD (NEA-BPD; http://www.borderlinepersonalitydisorder.com), and RethinkBPD. Other online resources include http://www.BPDCentral.com, http://www.borderlinepersonalitydisorder.com, http://www.bpdworld.org, http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml, and http://www.bpdfamily.com. The BPD Resource Center contains a number of videos with prominent BPD researchers and clinicians as well as patients discussing aspects of the disorder, the experience of BPD, and the kind of changes that can occur with treatment. In addition to producing a documentary called Back from the Edge that weaves together patient accounts, family commentary, and expert advice, they also have provided local lectures and outreach and, importantly, a referral service. RethinkBPD has provided lectures and developed a documentary called The Fight Within Us.

The two largest and most far-reaching organizations are TARA and NEA-BPD. These organizations not only provide current research information to patients and families but also provide educational trainings and support groups to families. NEA-BPD has sponsored family education workshops throughout the United States as well as a periodic call-in series to speak with experts in the field. Additionally, these two organizations have carried out research relevant to families as well as the outcome of their family education programs. Using retrospective self-reports, TARA examined the outcome for 74 graduates of its family education program. They found significant decreases in a number of problem areas, such as violent arguments, financial bailouts, suicide threats, and hospitalizations, as well as significant improvements in family relationships (Porr, 2010). In two published studies (Hoffman, Fruzzetti, & Buteau, 2007; Hoffman et al., 2005), NEA-BPD examined the outcome of its
Family–Connections program, a 12-week program, for 55 and 45 family members, respectively. Across the two studies, they found significant decreases in grief, burden, and depression and significant increases in mastery. These studies examined only treatment completers, however, and none of these studies employed control groups, making the results difficult to interpret. One RCT examined 12 weeks of psychoeducation for patients with BPD (Zanarini & Frankenburg, 2008). Although psychoeducation resulted in significant decreases in impulsivity and storminess in relationships, there was no effect on psychosocial functioning.


Books geared toward families with a member who has been diagnosed with a personality disorder include Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families, Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change, Remnants of a Life on Paper, Loving Someone With Borderline Personality Disorder, and The Essential Family Guide to Borderline Personality Disorder. As evident from this review, although BPD has received much attention in the domain of self-help and psychoeducation, such resources for other PDs are lacking.

MAJOR ACCOMPLISHMENTS

A key achievement in the field of PD research has been the establishment of diagnostic cutoffs and consensual diagnostic criteria for PDs. The reliability of various PD diagnoses have been shown to be as reliable as other accepted disorders (e.g., GAD and bipolar disorder; Brown et al., 2001). Another achievement consists of increased validity and clinical utility of the PD concept, such that many of the individual PDs are now well established (Pilkonis et al., 1991). Various PD diagnoses have been shown to be stable over time, particularly when compared with episodic disorders like major depression. Moreover, PDs have been differentiated from near-neighbor disorders and been determined to have clinical utility in predicting course and outcome when comorbid with the acute syndromal disorders.

Another key achievement has been the established efficacy of a number of treatments for PDs in RCTs. Several useful manualized treatments for treating PD from both CBT and PDT traditions have been tested in more than 40 RCTs combined. Much of this work has focused on BPD and to a lesser extent ASPD and mixed PDs, particularly Cluster C disorders. In contrast to dismal prognosis in the past, individuals with PDs now have access to a range of structured and empirically supported treatments that are likely to provide at least a moderate decrease in symptoms and improvement in functioning.

Finally, the field has also generated improvements in both research and training surrounding the PDs and their treatment. Published treatment manuals for evidence-based therapies allow for training in efficient and standardized ways across training programs that may help avoid conceptual drift or miscommunication. Research has now documented prevalence of PDs, their comorbidity, etiology, differential diagnosis, and efficacy of treatments, providing a solid foundation for future research in this area. Research has begun to explore and elaborate on theoretical conceptualizations of PD development in the hopes of one day delineating the progression of PD features and providing early intervention and prevention for these serious mental disorders.

FUTURE DIRECTIONS

Radical shifts in practice have evolved since the early 20th century. From the 1930s through the 1990s, practice with individuals with PDs was primarily carried out from a psychodynamic orientation and often involved intermittent short- and long-term hospitalizations. Diagnosis became increasingly based on signs and symptoms that were articulated by a few clinical theorists and integrated into the various versions of the DSM. The 1990s and early part of the 21st century saw the dominance
of DBT rapidly emerge based on a combination of empirical assessment and aggressive dissemination and outreach. In the beginning of the 21st century, other treatments slowly began to be examined. At present, a number of empirically supported treatments for PDs, particularly BPD, have derived from both CBT and PDT traditions. These treatments tend to be quite integrative. Although few direct comparisons exist, the ones that do exist, as well as a host of meta-analytic reviews, strongly suggest that no one current treatment is better than any other. Moreover the effects of these treatments tend to be smaller than hoped.

As the equivalence among treatments has emerged, the similarities between treatments, rather than the differences, have been stressed. As we move forward, an emphasis on empirical support continues. These different approaches need further study, however, and clinicians may need to be trained in multiple approaches to best serve their patients. It is unclear at this point whether or not one treatment might be better than another for a particular patient or type of patient or whether a better approach might be to combine aspects of treatments to develop more powerful interventions. Clinical practice is thus moving toward becoming more integrative.

Training in PDs is becoming more concrete and explicit. Before the rise of DBT, training in PDs tended to occur through supervision by experts, typically through clinical training experiences at a handful of internship and residency training programs that had specialized programs in PDs, such as Cornell Medical College or McLean Hospital. Training in PDs was even less common in clinical psychology training programs (Magnavita et al., 2010). Among the many innovations ushered in by Linehan with DBT was the explication and standardization of training procedures that allowed them to be transported widely into the community independent of one-on-one supervision. This model has been taken up by developers of various other empirically supported treatments, such as MBT, SFT, and TFP. Given the success of these methods of training clinicians, the future of training most likely will include the broad dissemination of training in psychotherapy techniques for those with PDs. As we learn more about the similarities and differences in the various treatments and make gains in their integration, we also should see more principle-based training, instead of training in treatment packages.

With regard to research, there are a number of important directions for the field. Research is moving toward better understanding the relationship between genotype, endophenotype, and phenotype, especially as they relate to diagnostic and etiological issues. A number of diagnostic issues need be resolved over the coming decade with regard to PDs. This includes better defining, or even redefining, the phenotypes underlying PDs. Debates about reliance on categories, prototypes, or dimensions—or some combination of these—remain unresolved. There has been some attempt to incorporate developments from a breadth of theoretical domains; for example, the Research Domain Criteria (RDoC; Insel et al., 2010) initiative begun by the National Institute of Mental Health (NIMH) is designed to address this issue. The RDoCs, with their exclusive focus on neurobiologically based markers of psychopathology, may not effectively capture all the necessary areas of PD research (Lilienfeld, 2014). Thus, there is a call to better integrate other conceptual models, such as dimensional trait models, into the diagnostic system.

Another important direction for PDs is a fuller understanding of their etiology and development. Over the past few decades, conceptions of PD development have evolved from being primarily focused on psychosocial contributions (e.g., parenting, trauma) to broader conceptions that include a wide array of biological, psychosocial, and cultural factors often in interaction with each other. The data suggest that each of these contribute a relatively small effect, and none appear to be necessary or sufficient to cause a PD. Future research will focus on explicating the relative parameters and contributing factors as well as the interaction between genetic and environmental contributions to the development of PDs.

In terms of treatment, we foresee developing and examining treatments for PDs beyond BPD, specifically NPD, given its prevalence, distress caused, and toll on society. Only a small portion of the treatments developed and tested thus far have
been widely disseminated. Given that even effective treatments tend to show only about 60% of patients improve, broader dissemination and establishment of the various empirically supported treatments is needed to better serve our patients. Consistent with the goals of research funding agencies and the NIMH’s focus on mechanisms, in the future, the field will move beyond a race-to-the-end mentality toward studying underlying change mechanisms. Those who study PDs have been interested in mechanisms that include not only processes elucidated by neuroscience but also those involving social cognition and therapy techniques.

The field has come a long way with regards to training, research, and practice in the area of PDs; nonetheless, the familiar claim that more research is needed is clearly true in the case of PDs. The field has defined important domains for further investigation. The answers to these questions and those that arise in the course of research hold promise in helping psychologists understand and treat the relatively large segment of the population suffering from PDs.

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Personality Disorders

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