

CHAPTER 19

Other Personality Disorders

KENNETH N. LEVY AND LORI N. SCOTT

One can live magnificently in this world if one knows how to work and love.

—Leo Tolstoy

DESCRIPTION OF THE DISORDER AND CLINICAL PICTURE

Personality disorders (PDs) are among the most common forms of psychological difficulties experienced. The overall lifetime prevalence for PDs ranges between 10 percent and 14 percent in untreated adult samples (Skodol et al., 2002). People with PDs exact a heavy cost from themselves and society as well as place considerable pressure on the mental health care system (Bender et al., 2001). Most definitions of PDs stress that they are pervasive, inflexible, maladaptive, and enduring expressions of personality (APA, 2000; Rutter, 1987) and acknowledge that they exist in several forms. Nevertheless there is considerable controversy over the definition, description, and degree to which meaningful distinctions are possible and which distinctions are valid (Westen & Shedler, 1999a, 1999b). The text revision of the fourth edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000)* is probably the most widely used diagnostic system to diagnose PD, particularly in the United States (Maser, Kaelber, & Weise, 1991); however, a number of other prominent approaches exist (*ICD-10; Millon, 1986; Westen & Shedler, 1999a, 1999b, 2000; World Health Organization, 1992*).

The *DSM-IV-TR* (APA, 2000) distinguishes between 10 PDs on Axis I that are conceptually organized into three clusters, designated Cluster A (odd-eccentric), Cluster B (dramatic-erratic), and Cluster C (anxious-fearful). Cluster A includes paranoid, schizoid, and schizotypal PDs. Cluster B includes antisocial, borderline, histrionic, and narcissistic PDs. Cluster C includes avoidant, dependent, and obsessive-compulsive PDs. In addition, *DSM* allows for the diagnosis

of personality disorder not otherwise specified (PD-NOS), which is given when a person meets general criteria for a personality disorder and traits of several PDs but does not meet the criteria for any one specific disorder; alternatively, a person meets general criteria for PD, but the type of disorder is not included in the classification system (e.g., passive-aggressive or depressive PDs, which are listed in the appendix as potential diagnoses requiring further study but can be used with the PD—not otherwise specified [NOS] option).

In this chapter we will review each of the PDs listed in the *DSM-IV-TR* (APA, 2000), with the exception of borderline personality disorder (BPD), which is described in detail in Chapter 18. Our review will focus on the prevalence, comorbidity, etiology, assessment, course, and treatment of the various PDs.

Cluster A Personality Disorders (Odd-Eccentric)

Paranoid Personality Disorder

Paranoid personality disorder (PPD) has a long and diverse clinical history (Freud, 1909/1925; Kraepelin, 1904, 1921). According to *DSM-IV-TR* (APA, 2000), PPD is characterized by a consistent pattern of distrust of the motives of other people. Further, people with this disorder assume that people will intentionally exploit, harm, or deceive them, and they often feel deeply injured by another person. They are frequently 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 very difficult for a person with PPD to forgive others for perceived insults or injuries. Prolonged hostility, aggression, reactions of anger to perceived insults, and jealousy without adequate justification are also common.

Although PPD is often thought of as a “schizophrenia spectrum” disorder (Kraepelin, 1921; Siever & Davis, 1991), it may have a stronger familial relationship with Axis I delusional disorder than with schizophrenia (Kendler, 1985). In clinical samples, about two-thirds of patients with PPD meet criteria for another PD, most frequently schizotypal, narcissistic, borderline, and avoidant PDs (Bernstein, Useda, & Siever, 1995).

Schizoid Personality Disorder

The term *schizoid* was coined by Bleuler (1929), following Hock's (1910) description of the “shut-in” personality type and Kraepelin's “autistic personality type” 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. Kretschmer (1925) differentiated between two distinct subtypes of the schizoid personality: the anesthetic or insensitive type characterized as indifferent, uninterested, unfeeling, unemotional, and dull, and the hyperaesthetic or overly sensitive type. The hyperaesthetic type is the forerunner of the *DSM* avoidant personality disorder. In the 1950s the early British object relations theorists (Fairbairn, 1952/1994; Guntrip, 1969; Winnicott, 1951) began to apply the concept to describe patients with difficulties with intimacy and a broad range of behavioral peculiarities. Fairbairn focused on depersonalization, derealization, disturbances in the perception of reality, detachment, and isolation. Guntrip similarly described the traits of derealization, depersonalization, disembodiment, autistic thinking, and a fragmented self-identity. In *DSM-III* (APA, 1980) these cognitive and perceptual symptoms were tied into the schizotypal category, whereas the interpersonal difficulties were made central to its narrower conception of schizoid personality disorder (SPD).

DSM-IV-TR (APA, 2000) notes that those with 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 are also usually unmoved by the disapproval of others. They might claim that they do not experience strong emotions, whether positive or negative. Further, 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.

SPD is consistently comorbid with schizotypal and avoidant PDs (Bernstein et al., 1995). Within the Five-Factor Model, SPD is thought to reflect extremely low scores on the extraversion facets of sociability and warmth (Trull, 1992).

Schizotypal Personality Disorder

Formerly classified in *DSM-III* (APA, 1980) as a borderline spectrum disorder, schizotypal personality disorder (STPD) was later identified as a disorder independent of BPD (APA, 1987) and placed within the realm of the schizophrenia spectrum disorders. The diagnosis of 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, Rado (1953), Hoch and Polatin (1949), Meehl (1962), and Spitzer, Endicott, and Gibbon (1979) described patients whose symptomatology resembled that of patients with schizophrenia, yet lacked the severity and frank psychosis of schizophrenia. On the other hand, in their work with nonclinical populations in the Danish adoption studies, Kety and colleagues (e.g., Kety, Rosenthal, Wender, & Schulsinger, 1968) noted borderline schizophrenic symptoms in nonpsychotic relatives of schizophrenia patients. Several authors (e.g., Bergman, Silverman, Harvey, Smith, & Siever, 2000) have suggested that 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, psychoticlike symptoms (e.g., eccentricity, ideas of reference, and socially inappropriate behavior).

According to *DSM-IV-TR* (APA, 2000), 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 persons with this disorder may experience transient psychotic episodes, they must be distinguished from those with Axis I 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.

STPD is frequently comorbid with eating disorders and psychotic disorders on Axis I (Oldham et al., 1995) and borderline, avoidant, paranoid, and schizoid PDs (Bernstein et al., 1995) on Axis II. Marinangeli et al. (2000) found that STPD was the most frequently co-occurring PD, as it was significantly comorbid with all PDs except for avoidant and dependent in their study. There is also evidence that the concurrent diagnosis of BPD amplifies schizotypal symptoms (Jacobsberg, Hymowitz, Barasch, & Frances, 1986).

Cluster B Personality Disorders (Dramatic-Erratic)

Antisocial Personality Disorder

Traits and behaviors corresponding to antisocial personality disorder (ASPD) have been described by Pinel (1809), Maudsley (1874), Meyer (1957), Kraepelin (1921), Schneider (1923), and Rush (1827), using such terms as *sociopath*, *psychopath*, *deviant*, *amoral*, *moral insanity*, and *dissocial*. The term *antisocial personality disorder* was introduced by the American Psychiatric Association in 1980 with the publication of *DSM-III*, and represented an attempt to operationalize the much-maligned term of psychopathy. The criteria were derived from empirical research based on Robins's (1966) seminal work. As defined by *DSM-IV-TR* (APA, 2000), antisocial PD is a pervasive pattern of irresponsible behavior and disregard for the rights of others that begins by childhood or early adolescence. People with this disorder repeatedly engage in unlawful and/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 victimizing 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 lead 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 display other evidence of consistent and extreme irresponsibility. Manipulativeness, deceitfulness, and dishonesty are also central features of this disorder, often making collateral sources of information necessary for accurate diagnosis.

In order to be diagnosed with ASPD, the *DSM* system requires that an individual must be at least 18 years old and must have met at least some criteria for conduct disorder prior to age 15. Such criteria may include the destruction of property, theft, lying, aggressive behavior toward people and/or animals, or other serious violations of rules or the rights of

others. The essential feature of ASPD is that this pattern of antisocial behavior begins during childhood and continues into adulthood. Although ASPD is the only PD in *DSM-III* (APA, 1980) to have been based on empirical research and the diagnosis has shown adequate levels of interrater reliability in routine clinical practice (Mellsop, Varghese, Joshua, & Hicks, 1982), it has been criticized for overemphasizing criminal acts and deemphasizing the general personality features of psychopathy described by Cleckley (1964/1976) in his classic book the *Mask of Sanity* (Hare, Hart, & Harpur, 1991).

In terms of comorbidity, ASPD is frequently comorbid with borderline (Becker, Grilo, Edell, & McGlashan, 2000), narcissistic (Oldham et al., 1992), histrionic (Lilienfeld, VanValkenburg, Larntz, & Akiskal, 1986), and schizotypal PDs (Marinangeli et al., 2000). On Axis I, research has demonstrated that ASPD has a particularly strong association with substance use disorders (Kessler et al., 1997).

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). Historically, the term hysteria has been applied primarily to describe women with a range of psychological difficulties, including conversion disorders, emotional instability, anxiety, and phobias (Chodoff & Lyons, 1958). Kretschmer (1926) wrote about hysteria in the context of personality, describing the hysterical individual as theatrical and egotistical. Reich (1933) added to this characterization that hysterical individuals displayed extreme fickleness, suggestibility, a tendency toward strong reactions of disappointment, and an attitude toward others that fluctuates between compliance and derogation. Further, Lazare, Klerman, and Armor (1966) described aggression, emotionality, oral aggression, exhibitionism, egocentricity, sexual provocativeness, and the rejection of others as central traits of the hysterical personality.

Hysteria was first officially linked to the term "histrionic personality" in *DSM-II* (APA, 1968), which listed hysterical personality disorder and mentioned histrionic personality disorder parenthetically thereafter. By *DSM-III* (APA, 1980), however, hysterical personality disorder had been completely replaced by histrionic personality disorder (HPD). The core components of HPD include excessive emotionality, attention-seeking behavior, egocentricity, flirtatiousness, seductiveness, and denial of anger or hostility (Horowitz, 1991; Pfohl, 1991). Other characteristics of HPD are extreme gregariousness, manipulativeness, low frustration tolerance, suggestibility, and somatization (Andrews & Moore, 1991; Millon,

1996). In addition, according to *DSM-IV-TR* (APA, 2000), histrionic individuals consistently use their physical appearance in order to draw attention to themselves, spending excessive time, attention, and money on clothes and grooming.

The *DSM-IV-TR* (APA, 2000) notes that the emotional expression of an individual with HPD is often excessive, theatrical, shallow, and rapidly shifting. Public displays of emotion or temper tantrums are common, yet they begin and end too quickly to be perceived as genuine in feeling. In addition, the speech of a person with HPD may be overly impressionistic in style, yet lacking in detail. For instance, strong opinions might be dramatically expressed without giving adequate reasons to support them.

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).

Narcissistic Personality Disorder

The term *narcissism* derives from the commonly known Greek myth of Narcissus, who, mistaking his own image for another, falls in love with that image and dies when it fails to love him back. Clinical theorists across various orientations describe individuals diagnosed with narcissistic personality disorder (NPD) as characterized by a pervasive pattern of grandiosity, a sense of privilege or entitlement, an expectation of preferential treatment, an exaggerated sense of self-importance, and arrogant or haughty behaviors or attitudes (Westen & Shedler, 1999b). A fragile self-esteem and unconscious feelings of unworthiness are often underlying this inflated exterior.

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 are frequently uttered by people with NPD, although they are typically 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.

NPD is frequently comorbid with antisocial, histrionic, and borderline PDs (Becker et al., 2000; Oldham et al., 1992; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989). In addition, a review by Ronningstam (1996) found trends of

comorbidity between NPD and substance use disorders, bipolar disorder, depression, and anorexia nervosa but found no evidence of a significant relationship between NPD and any single Axis I disorder.

Cluster C Personality Disorders (Anxious-Fearful)

Avoidant Personality Disorder

Avoidant personality disorder (AVPD) was a new category added to the *DSM-III* based on Millon's (1981) evolutionary social-learning theory of PDs. According to *DSM-IV-TR* (APA, 2000), persons 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. Persons 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. Although AVPD has been conceptualized as linked to schizoid PD and has been found to be comorbid with schizoid PD (Oldham et al., 1992), multi-dimensional scaling has found AVPD can be discriminated from schizoid PD but not from dependent PD (Widiger, Trull, Hurt, Clarkin, & Frances, 1987). Avoidant PD is also frequently comorbid with dependent PD on Axis II (Oldham et al., 1992) and mood, anxiety, and eating disorders on Axis I (Oldham et al., 1995).

Dependent Personality Disorder

The history of dependent personality disorder (DPD) begins with descriptions of oral dependency by Abraham and Freud. The *DSM-I* (APA, 1952) mentioned what was called "passive-dependent personality," which was virtually synonymous with *DSM-IV* DPD. According to the *DSM-IV-TR* (APA, 2000), 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 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-IV-TR (APA, 2000) 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 also 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 will often be followed by urgent efforts to replace the person with another source of closeness and support.

DPD is substantially comorbid with mood, anxiety, and psychotic disorders on Axis I (Oldham et al., 1995) and borderline and avoidant PDs on Axis II (Marinangeli et al., 2000; Oldham et al., 1992). DPD is also frequently comorbid with paranoid PD (Marinangeli et al., 2000) and obsessive-compulsive PD (Oldham et al., 1992).

Obsessive-Compulsive Personality Disorder

The modern concept of obsessive-compulsive personality disorder (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 Europe, the *DSM-IV-TR* (APA, 2000) 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).

Although individuals with obsessive-compulsive PD usually have difficulty expressing emotion (Horney, 1950), Bailey (1998) notes that they 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 their spending, believing that money should be saved for a future catastrophe.

In terms of comorbidity, the results of studies on OCPD are inconsistent. Although Marinangeli et al. (2000) found that OCPD co-occurs significantly with several other PDs, including borderline, narcissistic, histrionic, paranoid, and schizotypal PDs, Oldham et al. (1992) only found significant comorbidity with dependent PD on Axis II. Investigations of the relationship between OCPD and Axis I obsessive-compulsive disorder (OCD) have also yielded mixed results, with some researchers finding significant co-occurrence (Aubuchon & Malatesta, 1994; Baer & Jenike, 1992; Skodol, et al., 1995) and others failing to find a strong relationship between these disorders (Black, Noyes, Pfohl, Goldstein, & Blum, 1993; Joffe, Swinson, & Regan, 1988). Pfohl and Blum (1991) reviewed the literature on OCD and OCPD and concluded that the majority of patients with OCD do not meet criteria for OCPD. Further, for those with OCD with concurrent PD diagnosis, OCPD occurs no more frequently than any other PD. The authors concluded that there was not enough information to support a meaningful relationship between OCD and OCPD. Clinically, the symptoms in OCPD tend to be ego syntonic, whereas the symptoms in OCD tend to be ego dystonic.

EPIDEMIOLOGY

Prevalence rates for PDs in the general population range from approximately 6 percent to 20 percent (APA, 1994; Black et al., 1993; Bodlund, Ekselius, & Lindstrom, 1993; de Girolamo & Dotto, 2000; Drake, Adler, Vaillant, 1988; Ekselius, Tillfors, Furmark, & Fredrikson, 2001; Klein et al., 1995;

Lenzenweger, Loranger, Korfine, & Neff, 1997; Maier, Lichtermann, Klingler, Heun, & Hallmayer, 1992; Moldin, Rice, Erlenmeyer-Kimling, & Squires-Wheeler, 1994; Reich, Yates, & Nduaguba, 1989; Samuels, Nestadt, Romanoski, Folstein, & McHugh, 1994; Torgersen, Kringlen, & Cramer, 2001; Zimmerman & Coryell, 1990). There are almost no community prevalence data on PDs from countries other than the United States, the United Kingdom, Germany, Norway, and Australia.

In primary care settings, Casey and Tyrer (1990) found that about a third of the people attending general practitioners had a personality disorder. The vast majority of patients were not presenting for personality difficulties but presented as problematic medical patients (Emerson, Pankratz, Joos, & Smith, 1994). Although the whole range of PDs were present in these samples, patients with Cluster C PDs are the most common PDs to be encountered in primary care settings (Moran, Jenkins, Tylee, Blizard, & Mann, 2000).

Rates of PDs are generally much higher in clinical populations. Studies using structured diagnostic assessments have found that 20 percent to 40 percent of psychiatric outpatients and about 50 percent of psychiatric inpatients meet criteria for a personality disorder (for overviews, see de Girolamo & Reich, 1993; Dowson & Grounds, 1995; Moran, 1999). However, again PDs are rarely the primary focus of treatment.

Studies on the prevalence of specific PDs have found rates for paranoid PD ranging from 0.4 percent to 3.3 percent; schizoid, 0.5 percent to 0.9 percent; schizotypal, 0.6 percent to 5.6 percent; histrionic, 1.3 percent to 3.0 percent; narcissistic, 0 percent to 5.3 percent; antisocial, 0.2 percent to 3.7 percent; avoidant, 0 percent to 1.3 percent; dependent, 1.6 percent to 6.7 percent; and obsessive compulsive, 1.7 percent to 6.4 percent (Baron, Gruen, Asnis, & Lord, 1985; Coryell & Zimmerman, 1989; Drake & Vaillant, 1985; Kendler & Gruenberg, 1982). Nestadt et al. (1990) examined the prevalence of histrionic PD as part of the NIMH Epidemiological Catchment Area Program. Using *DSM-III-R* criteria, they found a prevalence rate of 2.1 percent for HPD in the general population. Contrary to general belief, men and women were equally affected with the disorder. The most consistently studied personality disorder in community studies has been antisocial PD, which has a lifetime prevalence of between 2 percent and 3 percent, and is more common in men, younger people, those of low socioeconomic status, single individuals, the poorly educated and those living in urban areas (Moran, 1999).

Research has generally shown that individuals diagnosed with PDs are likely to be single (Moran et al., 2000; Samuels et al., 2002). These studies have found that PDs are generally more common in younger age groups (particularly the 25 to

44 year age group) and equally distributed between men and women (one exception is that of ASPD, which is more commonly diagnosed in men). At a community level, personality disordered individuals are more likely to suffer from alcohol and drug problems. In addition, they are also more likely to experience adverse life events, such as relationship difficulties, housing problems and long-term unemployment (Moran, 1999).

Several studies have found PDs to be inversely related to age, such that younger age groups are more likely to meet diagnostic criteria than older age groups (e.g., Ekselius et al., 2001). However, Abrams and Horowitz (1996) concluded that the prevalence of PDs in the elderly (older than age 50) was approximately 10 percent across studies from 1980 to 1994, with no overall decrease in the frequency of personality disorder diagnosis with age. If PDs are indeed less common in the elderly, there are several possible explanations for this trend. Fishbain (1991) suggested that early mortality in those with PD due to impulsive and sensation-seeking behavior might lead to fewer observed cases in elderly samples. Alternatively, improvement for treated PD patients may extend over a long period of time after release. Stone, Hurt, and Stone (1987) postulated that patients improved by the second decade after discharge from treatment. Furthermore, neurodevelopmental and neurochemical changes that decrease impulsivity and aggression over the life span may be responsible for a decline in PDs in the elderly (Elliott, 1992; Morgan, May, & Finch, 1987). Supporting this theory is evidence that neuroticism and extraversion decrease with age (e.g., McCrae et al., 1999), which might suggest greater stability and impulse control as people grow older. Other authors have suggested that the current PD classifications may not be as applicable to adults older than age 50 (Clarkin, 1998), as evidenced by the predominance of PD-NOS in this age group (Abrams & Horowitz, 1996).

ETIOLOGY

The empirical data on the etiology of PDs is extremely limited and complicated by the fact that PDs are a heterogeneous group of disorders. Therefore, there is no universal agreement on their etiology. Initial etiological theories of PDs, particularly disorders like narcissistic and histrionic PDs, were mainly derived from psychodynamic object relations theorists (Kernberg, 1975; Kohut, 1971, 1977; Masterson, 1990). Most of the work in this area was based on inferences drawn in clinical settings from patients' recollections of childhood family dynamics and/or the analysis of transference. Other prominent theories include Millon's evolutionary-based social-

learning theory. Recently, Fonagy (Fonagy, Gergely, Jurist, & Target, 2002) and Schore (1994), from a psychoanalytic frame, have discussed the development of PDs based on a combination of object relations theory with a more explicit integration of empirical findings from developmental psychology.

Most theories of PDs acknowledge that they are at least partially genetically determined (Siever & Davis, 1991; Torgersen et al., 2000) and that temperamental and behavioral abnormalities during childhood can precede their development (Depue & Lenzenweger, 2005; Paris, 2000; Posner et al., 2002; Rutter, 1987). These predispositions are believed to interact with environmental experience to shape personality during the early years of development (Rutter, 1987). Environmental factors are believed to range in severity and influence as a function of biological predispositions and protective factors. Traumas can include serious abuse such as physical and sexual abuse, abandonment and betrayal, emotional and physical neglect, and inconsistent emotional care. For example, Johnson et al. (1999) found that abused or neglected children were more than four times at risk of developing PD than those who were not abused or neglected. However, given the rates of abuse in PD samples and the fact that the majority of PD patients do not have histories of physical or sexual abuse, abuse is better conceptualized as a risk factor rather than as causal. These findings suggest that more subtle environmental factors may also be operating. For example, Nash et al. (1993) found that when the shared relationship between sexual abuse and pathological family environment was controlled for, only a pathological family environment accounted for increased pathology in sexually abused women. Weaver and Clum (1993) found that parental overinvolvement predicted personality pathology even after controlling for sexual abuse.

Although a number of researchers have suggested that PDs are partially genetically determined (Siever & Davis, 1991; Torgersen et al., 2000), the evidence is mixed (Nigg & Goldsmith, 1994). A number of studies have focused on the heritability of facets of personality that are relevant to PDs such as neuroticism or extroversion. Few studies have examined the heritability of specific PD diagnoses (Cadoret & Stewart, 1991; Cadoret et al., 1995; Kendler & Walsh, 1995; Torgersen et al., 1993). Findings from the few studies to date suggest that schizotypal PD has a strong genetic link to schizophrenia and that antisocial PD appears to have both genetic and environmental bases.

Using the Dimensional Assessment of Personality Problems (DAPP), Jang, Livesley, & Vernon, (1996) reported the heritability of specific traits related to personality pathology ranging from 45 percent for rejection through 56 percent for callousness. With regard to narcissism, the heritability of the

specific traits ranged from 37 percent for grandiosity to 50 percent for need for approval. Torgersen et al. (2000) examined heritability in 92 MZ and 129 DZ twin pairs using the SCID-II. They found 45 percent concordance in MZ and 9 percent in DZ twins using a broad definition of the narcissistic PD (three or more criteria met). Heritability estimates were 60 percent for overall personality disorder diagnosis, 37 percent for Cluster A, 60 percent for Cluster B, and 62 percent for Cluster C. Specific PD heritability was 79 percent for narcissistic and 78 percent for obsessive-compulsive PDs. However, these estimates were determined using broadly defined diagnoses, best fitting models never included shared environmental effects, and the interviewers interviewed both twins and were not blind to zygosity status. All three of these limitations are known to inflate estimates of heritability. Another important limitation includes the absence of a clear definitive phenotype, which is a prerequisite for the establishment of inheritance. Lack of diagnostic clarity (e.g., misdiagnosis, overlap) will inevitably lead to spurious estimates of heritability (Jang & Vernon, 2001).

PDs appear to fall along a continuum of heritability, with schizotypal most strongly linked to genetic influences, antisocial linked to both environmental and genetic factors, and borderline and narcissistic typically showing the smallest estimates of heritability. Given the contradictory findings and limitations of the study designs, it is safe to say that the heritability of certain PDs like borderline and narcissistic, although reasonable to posit, is uncertain at this time and there is clearer evidence for environmental contributions to the development of these disorders. Paris (1993) suggested that the etiology of PDs is unlikely to be underpinned by simple, linear, narrow-causal processes; complex interactive processes between variables are likely to be involved in the etiology of PDs. Much work remains in order to understand the etiological significance of genetic and environmental inputs in the development of PDs.

COURSE, COMPLICATIONS, AND PROGNOSIS

PDs are thought to have an onset in late adolescence or early adulthood (APA, 2000) and are assumed to persist throughout the life span, although there is a relative paucity of empirical evidence that supports these notions (Clarkin, 1998). Recent research suggests that personality can change significantly over time (Seivewright, Tyrer, & Johnson, 2002), and PDs might not be as temporally stable as once thought (Lenzenweger, Johnson, & Willett, 2004; Shea et al., 2002). Seivewright et al. (2002) assessed a group of personality disordered patients at baseline and later at 12-year follow-up

and found that whereas Cluster B traits decreased with time, Cluster A and Cluster C traits actually became more pronounced. Further, Shea and Yen (2003) concluded in their review of three longitudinal studies that PDs had higher remission rates than Axis I anxiety disorders.

Although PD diagnosis during childhood or adolescence has demonstrated short-term stability (Mattanah, Becker, Levy, Edell, & McGlashan, 1995), it is not as likely to be stable over longer periods of time (Bernstein et al., 1993; Grilo, Becker, Edell, & McGlashan, 2001; Korenblum, Marton, Golembeck, & Stein, 1990). However, Axis II pathology during childhood and adolescence increases the odds of adult PD within the same cluster (Kasen, Cohen, Skodol, Johnson, & Brook, 1999).

Generally, research has demonstrated that people with Cluster A disorders do not typically improve significantly over time (Paris, 2003). Reich et al. (1989) found that whereas those with Cluster B disorders tended to improve with age, no such age cohort effect was found for patients with Cluster A disorders. Similarly, Seivewright et al. (2002) concluded that patients with Cluster A disorders did not improve significantly at 12-year follow-up. However, some treatment gains have been documented for persons with schizotypal PD. For example, one study found that 13 patients with STPD showed marked improvement at 14-year follow-up (Plakun, Burkhardt, & Muller, 1985). In another long-term follow-up study, outcomes for patients with STPD were better than outcomes for patients with schizophrenia, yet STPD patients continued to experience interpersonal difficulties and half were unemployed at follow-up (McGlashan, 1986). There is evidence that the capacity for object relatedness, emotional warmth, and empathy in patients with STPD is related to better outcomes (McGlashan, 1986; Stone, 1983). McGlashan (1986) found that STPD patients who also had borderline PD had better outcomes than those with pure schizotypal personality disorder. McGlashan postulated that the object-seeking factor in BPD might contribute to a greater capacity for interpersonal relatedness for the schizotypal patient, and hence, contribute to better long-term outcomes.

There is evidence that many patients with antisocial and borderline PD recover as they grow older (Abrams & Horowitz, 1996), although they typically continue to experience severe interpersonal dysfunction and other forms of psychopathology (Paris, 2003). Black, Baumgard, and Bell (1995) followed antisocial patients from 16 to 45 years and found that upon long-term follow-up, most no longer met criteria for ASPD, yet the majority still experienced relationship and work-related problems.

Narcissistic PD may also remit with age, although some authors have suggested that these patients may eventually ex-

press somatic complaints (Demopoulos et al., 1996). Kernberg (1976) suggested that narcissism declines with age and older patients with NPD can become more treatable in later years of life. Supporting this hypothesis, Plakun (1991) reported close to normal functioning in narcissistic patients at 14-year follow-up. Similarly, Ronningstam, Gunderson, and Lyons (1995) found that at only a three-year follow-up with narcissistic patients, only a minority still met criteria for NPD. However, both of these studies concerned patients who were formerly hospitalized, and may not accurately represent the course of pure NPD that is normally seen in outpatient settings.

Research has generally shown that Cluster C disorders do not remit with age (Paris, 2003; Reich et al., 1989; Seivewright et al., 2002). At 12-year follow-up with Cluster C personality disordered patients, Seivewright et al. (2002) found that characteristic Cluster C traits had actually increased over time. Further, these patients showed increases in isolation and dysphoria, and developed significant Axis I mood and anxiety disorder symptomology.

ASSESSMENT AND DIAGNOSIS

Assessment

For obvious reasons, both researchers who study PDs and clinicians who treat individuals with PDs have been concerned about the assessment of PDs. However, the assessment of PDs has been highly controversial. Important conceptual issues remain unanswered. Broadly speaking there are five procedures available for PD assessment. Millon and Davis (2000) outlined these as self-report inventories, rating scales and checklists, clinical and structured interviews, projective techniques, and neurocognitive/physiological measurements (neurotransmitter or hormone levels). At this point, there is little evidence for the specificity or sensitivity of neurocognitive or psychophysiological measures for assessing or diagnosing PDs, although these types of measures are useful for studying the basic psychopathology of PDs and as concrete markers of relevant constructs (e.g., impulsivity).

With regard to self-report instruments for PDs, the most widely used in assessing PDs are the Millon Clinical Multiaxial Inventory (MCMI-III; Millon, Millon, & Davis, 1994), the fourth edition of the Personality Diagnostic Questionnaire (PDQ-4; Hyler, Kellman, Oldham, & Skodol, 1992), the Personality Assessment Inventory (PAI; Morey, 1991), and the Dimensional Assessment of Personality Pathology—Basic Questionnaire (Livesley, Jackson, & Schroeder, 1992; Livesley, Reiffer, Sheldon, & West, 1987). Other personality disorder

measures include the Schedule of Nonadaptive and Adaptive Personality (SNAP; Clark, 1993), the OMNI Personality Inventory (OMNI; Loranger, 2002), the Personality Inventory Questionnaire (PIQ-II; Widiger, 1987), the Wisconsin Personality Disorder Inventory (WIPSI-IV; Klein, Benjamin, Rosenfeld, & Treece, 1993), and the Minnesota Multiphasic Personality Inventory 2–Personality Disorder Scales (MMPI 2-PD; Butcher, Dahlstrom, Graham, Tellegen, & Kraemmer, 1989).

Some theorists have recently suggested that because PDs can be conceptualized as maladaptive and inflexible expressions of basic dimensions of personality (Wiggins & Pincus, 1989), the Five-Factor Model (FFM) of personality may be relevant to assessing PDs (Widiger & Trull, 1992). Although controversial (Davis & Millon, 1993; Westen, 1996), a review of a number of studies (Widiger, Trull, Clarkin, Sanderson, & Costa, 2002) suggests that it is possible to describe PDs in terms of the FFM. However, Shedler and Westen (2004) examined the comprehensiveness of the FFM as compared to an expanded criteria set. Using the items restricted to the FFM, the factor structure could be replicated on a clinical sample. Nevertheless, they found that the expanded criteria set provided a conceptually richer factor solution that did not resemble the FFM. They concluded that the FFM was useful for layperson descriptions of personality; however, it omits important clinical constructs and does not capture the complexity of personality pathology.

Overall, self-report measures appear best suited either for assessing PDs at the dimensional level, particularly to examine multidimensional aspects of PDs, or as a screening measure for identifying individuals who might be likely to have a PD, but these measures are much less useful for diagnosing a specific personality disorder (Trull & Larson, 1994).

There are a number of structured interviews for *DSM* PDs, including the Structured Interview for *DSM* Personality Disorders–Revised (SIDP-R; Pfohl, Blum, & Zimmerman, 1997), Structured Clinical Interview for *DSM-III-R* Personality Disorders (SCID-II; First, Spitzer, Robert, Gibbon, & Williams, 1995), International Personality Disorders Examination (IPDE; Loranger, 1999), Personality Disorder Interview-IV (PDI-IV; Widiger, Mangine, Corbitt, Ellis, & Thomas, 1995), Diagnostic Interview for Personality Disorders (DIPD-IV; Zanarini, Frankenburg, Sickel, & Yong, 1996), and the Personality Assessment Schedule (PAS; Tyrer & Alexander, 1988). Diagnostic interviews exist for some specific PDs, including the Revised Diagnostic Interview for Borderlines (DIB-R; Zanarini et al., 1989), the Diagnostic Interview for Narcissistic Patients (Gunderson, Ronningstam, & Bodkin, 1990), and the Hare Psychopathy Checklist-Revised (PCL-R; Hare,

1991). There are substantial differences between the interviews, with some organized thematically (e.g., work, relationships; IPDE, SIDP-R), and others organized with respect to *DSM* categories (e.g., DIPD, SCID-II). In terms of questioning, the SCID-II is the most straightforward, the IPDE requires the interviewer to tease out the veracity of patients' reports with follow-up questions, and the PIQ-II employs vignettes and probes to elicit traits. All of these interviews emphasize that patients' self-assessments should not be taken at face value and require considerable judgment and latitude on the part of the clinician. Numerous studies have found disappointing diagnostic concordance when comparing two or more interviews (for a review, see Perry, 1992). The general finding is that the SCID-II is more liberal, whereas the IPDE is more conservative in terms of number of diagnoses given.

There are a number of checklist and rating scales that can be completed by clinicians, including the Personality Assessment Form (PAF; Shea, Glass, Pilkonis, Watkins, & Docherty, 1987), the Shedler-Westen Assessment Procedure (SWAP; Westen & Shedler, 1999a, 1999b), Personality Adjective Checklist (PACL; Strack, 1987), and the Millon Personality Diagnostic Checklist (MPDC). The PAF (Shea et al., 1987) presents a brief paragraph that describes important features of each personality disorder, which is rated on a six-point scale by an evaluator. The PAF is not a structured interview in that it does not provide systematic assessment or questions for evaluation. The SWAP (Westen & Shedler, 1999b) is a 200-item q-set of personality descriptive statements designed to quantify clinical judgment. 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. One important finding using the SWAP is a reduction of comorbidity (Westen & Shedler, 1999b). Clinician ratings on the SWAP have also been shown to be related to those of independent raters.

Rorschach and other projective tests are under renewed criticism for their alleged empirical inadequacies (Wood, Nezowski, Lilienfeld, & Garb, 2003). Although many of the criticisms levied are reasonable, the Rorschach and other projective measures are not inherently invalid as there are many valid scoring systems developed (Levy, Meehan, Auerbach, & Blatt, 2005). Nevertheless, there is no comprehensive projective measure scoring system to directly assess the *DSM* PD construct. Projective measures like the Rorschach and the Thematic Apperception Test have been used to study PDs and to clinically assess constructs related to PDs. A number of researchers have used projectives to differentiate PD patients from schizophrenic patients or to distinguish between different PDs (e.g., narcissistic versus borderline). Exner

(1969) has discussed the pair response as an indicator of narcissism, and he later developed the Egocentricity Index (EGOI) as an index of excessive self-concern. Harder (1979) constructed a projective narcissism scale for use with the Early Memory Test, the Thematic Apperception Test, and the Rorschach. The validity of the EGOI scale as a measure of narcissism is equivocal at best (Hilsenroth, Fowler, Padawer, & Handler, 1997; Nezworski & Wood, 1995), and the Harder scale has not gained widespread acceptance. A number of studies have examined Rorschach variables as they relate to the diagnosis of narcissism (Berg, Packer, & Nunno, 1993; Farris, 1988; Gacono, Meloy, & Berg, 1992; Hilsenroth, Hibbard, Nash, & Handler, 1993; Hilsenroth et al., 1997). Findings from these studies are difficult to interpret; however, consistent with the writings of Kernberg (1975) and Kohut (1971), NPD patients generally look healthier psychologically than patients with BPD.

Diagnosis

The *DSM* system purports to be atheoretical in its approach to conceptualizing PDs; however, it has been argued that it is polythetic, resulting in significant heterogeneity (Clarkin, 1998; Fong, 1995; Livesley, 2001). In addition, the evidence for the clusters is mixed with some studies providing empirical support (Widiger et al., 1987; Zimmerman & Coryell, 1990) and others failing to support this grouping (Livesley et al., 1992; Moldin et al., 1994; Plutchick, Conte, & Karasu, 1994; Widiger et al., 1991).

Numerous studies have found extensive overlap between *DSM* PDs despite the fact that these diagnostic categories were conceptualized as distinct (for review, see Blatt & Levy, 1998). The majority of patients with a personality disorder meet criteria for more than one PD, and behavioral criteria relating to different *DSM* PDs are substantially intercorrelated. Different investigators report that the average number of diagnosable PDs for an individual patient range from 2.8 to 4.6 (Blatt & Levy, 1998). It is not uncommon for patients to meet criteria for as many as seven or even more *DSM* PDs. The extensive overlap between *DSM* Axis II diagnoses suggests that the specific types of PDs based solely on symptoms and signs may not be the most efficient or meaningful way to describe PDs (Blatt & Levy, 1998; Westen, 1997). However, findings regarding the comorbidity of PDs are difficult to interpret because there are few adequate studies examining comorbidity in epidemiological samples. Most studies used convenience samples from treatment centers rather than randomly selected community samples, which introduces bias.

Many authors argue that the existing diagnostic criteria for PDs are imprecise, and some suggest a prototype ap-

proach to the classification of personality pathology (Livesley, 1986; Westen, 1997). In such an approach, the most prototypical behavioral qualities of a disorder form the center of a diagnostic category, whereas less descriptive behaviors form the periphery. Ideally, this method of classification would reduce overlap between PD criteria and lead to more precise diagnoses.

Comorbidity with Axis I disorders is also common in patients with PDs (Keown, Holloway, & Kuipers, 2002). In a study of the relationship between *DSM-III* Axis I and Axis II diagnoses, PDs were most associated with substance use disorders, anxiety disorders, and/or somatoform disorders, and were least associated with psychotic and major affective illnesses (Koenigsberg, Kaplan, Gilmore, & Cooper, 1985). At the cluster level, Oldham et al. (1995) found that those with Cluster A PDs had significantly increased odds of a concurrent Axis I psychotic disorder but did not show increased odds of having concurrent mood, anxiety, substance abuse, or eating disorders. Cluster B and C PDs were significantly associated with increased odds of anxiety, eating, and psychotic disorders. Cluster B disorders have also been shown to have a particularly strong relationship with alcohol abuse and dependence, and Cluster C disorders seem to be strongly related to anxiety and somatoform disorders (Tyrer, Gunderson, Lyons, & Tohen, 1997).

Symptomatically related Axis I and Axis II diagnoses tend to co-occur, and their comorbidity is likely to be highly relevant to clinical assessment and outcome. For instance, several researchers have found a strong relationship between social phobia and avoidant PD (Herbert, Hope, & Bellack, 1992; Skodol et al., 1995). In addition, many authors have noted that dependent, avoidant, and histrionic PDs are associated with phobic avoidance and agoraphobia (Chambless, Renneberg, Goldstein, & Gracely, 1992; Mavissakalian & Hamann, 1986; Reich, Noyes, & Troughton, 1987). Such relationships can provide clues to the etiological pathways of disorders, although it is difficult to determine the direction of causality (if there is a causal link at all). For example, dependent PDs may contribute to the development of phobias and avoidant behaviors. Alternatively, phobic avoidance may lead to dependent behavior patterns, thereby contributing to the development of dependent PDs (Reich et al., 1987).

IMPACT ON ENVIRONMENT

PDs are associated with high rates of substance abuse, impulsivity, suicidal actions, and the use of medical and psychiatric services (Brodsky, Malone, Ellis, Dulit, & Mann, 1997; Ekselius et al., 2001; Moran et al., 2000; O'Boyle &

Brandon, 1998), and thus, have a considerable impact on both individuals and society. Moran et al. (2000) found that those with PDs are more likely than those without PDs to attend their general medical practitioner on an emergency basis. Reich, Boerstler, Yates, and Nduaguba (1989) found that medical service utilization was positively correlated with the number of disordered personality traits. Saarento et al. (1998) found that PD diagnoses were the best predictor of repeated episodes of psychiatric hospitalization. In addition, Bongar, Peterson, Golann, and Hardiman (1990) found that chronically suicidal patients accounted for more than 12 percent of all emergency room visits. Even when *ICD-10* unstable PD (corresponding to BPD in the *DSM-IV*) was excluded, Ekselius et al. (2001) still found that those with PDs reported significantly more impulsive alcohol abuse and suicidal threats than those without PDs. Further, because the treatment of PD remains relatively underavailable (Keown et al., 2002), PDs put considerable strain on psychiatric resources when existing treatments fail to make lasting and significant changes. A survey of Australian psychiatrists found that although patients with PDs represented only 6 percent of the patients in treatment, they accounted for 13 percent of the psychiatrists' treatment time (Andrews & Hadzi-Pavlovic, 1988).

Research has also shown that those with PDs are significantly more psychologically impaired (Bodlund et al., 1998; Ekselius et al., 2001; Nakao, Gunderson, Phillips, & Tanaka, 1992; Reich, Boerstler, et al., 1989; Samuels et al., 1994) and more likely to lack social support (Ekselius et al., 2001) than individuals without PDs. Personality pathology has been found to predict future psychiatric hospitalization and drug abuse (Levy et al., 1999) and later psychological distress and functional impairment (Bernstein et al., 1993). Further, PDs are associated with occupational difficulties and unemployment (Bland, Stebelsky, Orn, & Newman, 1988), marital dissolution (McCranie & Kahan, 1986), violence, and criminal behaviors (Berman, Fallon, & Coccaro, 1998; Johnson et al., 2000).

TREATMENT IMPLICATIONS

Patients with PDs are notoriously difficult to treat. Improvement for patients with PDs typically consists of finding new and more adaptive ways of coping with maladaptive personality traits, rather than the complete remittance of symptoms and the achievement of normal functioning (Paris, 2003). Few controlled studies exist on treatment outcomes for specific PDs, and most have focused on BPD exclusively. A naturalistic outcome study evaluating intensive inpatient treatment for patients with various "severe" PDs (mostly borderline)

yielded positive results at discharge and one-year follow-up (Gabbard et al., 2000). Most of the patients in this study received some form of psychopharmacologic treatment in addition to intensive group therapy, individual psychotherapy, and psychoeducation.

A meta-analysis by Perry, Banon, and Ianni (1999) suggests that psychotherapy is an effective treatment for PDs and may be associated with up to a sevenfold faster rate of recovery in comparison with the natural history of disorders. A recent meta-analysis examined the effectiveness of psychodynamic therapy and cognitive behavioral therapy (CBT) in the treatment of PDs (Leichsenring & Leibing, 2003). The study found that psychodynamic therapy yielded a large overall effect size of 1.46, with effect sizes of 1.08 for self-report measures and 1.79 for observer-rated measures. This contrasted with CBT in which the corresponding values were 1.00, 1.20, and .87, respectively. However, these studies are difficult to interpret because the studies differ, even within the same therapy group, in terms of therapy content, patient diagnosis, length of treatments, outcome assessments and other variables. Another finding was that the longer the treatment the greater the effect size.

There are a number of controlled studies for avoidant PD (Alden, 1989; Alden & Capreol, 1993; Marzillier, Lambert, & Kellett, 1976; Stravynski, Belisle, Marcouiller, & Lavalley-Yvon, 1994; Stravynski, Marks, & Yule, 1982; Stravynski et al., 1989). Overall, these studies suggest that improvements can be found with treatments that employ social skills training alone or in combination with exposure and cognitive techniques; however, many patients did not show clinically significant improvement or generalization to other contexts. There is one study examining antisocial PD (Woody, McLellan, Luborsky, & O'Brien, 1985), in which depressed opiate addicts with ASPD were compared to nondepressed opiate addicts with ASPD. They found that the presence of depression and the capacity to form a therapeutic alliance were good prognostic indicators in terms of outcome.

There are also a number of uncontrolled studies that suggest promising treatment approaches. Barber, Morse, Krakauer, Chittams, and Crits-Christoph (1997) found that a supportive-expressive psychodynamic psychotherapy was effective for treating both obsessive-compulsive and avoidant PDs. At the end of one year of treatment, 85 percent of OCPD patients and more than 60 percent of AVPD patients no longer met criteria for the disorders.

To date, there have been no controlled or uncontrolled outcome studies for histrionic, dependent, schizotypal, schizoid, narcissistic, passive-aggressive, or paranoid PDs. However, a number of studies have used samples that included a mixture of PDs (Diguer et al., 1993; Hellerstein et al., 1998;

Karterud et al., 1992; Monson, Odland, Faugli, Daae, & Eilertsen, 1995; Rosenthal, Muran, Pinsker, Hellerstein, & Winston, 1999; Turkat, 1990; Winston, Laikin, Pollack, & Samstag, 1994; Winston et al., 1991). Usually these studies excluded patients with BPD. Although these studies generally show improvement in treated patients, particularly with the brief psychodynamic treatments, these studies are difficult to interpret in terms of specific PDs because they do not denote specific diagnostic cohorts. Recently Svartberg, Stiles, and Seltzer (2004) reported findings from an RCT examining the treatment of Cluster C PDs. They compared a short-term psychodynamic treatment with a cognitive behavioral treatment (CBT) and found significant reduction in symptomatology for the psychodynamic group but not the CBT group (although there were no between group differences between the two groups). Hardy et al. (1995) report the outcome for a subsample of patients with Cluster C PDs who had participated in a larger study comparing interpersonal-psychodynamic psychotherapy with cognitive therapy (CT) for major depression. Findings indicated that Cluster C patients continued to show more severe symptomatology than non-Cluster C patients if they received dynamic therapy, but not if they received CT.

There is strong evidence that the presence of PD negatively affects the outcome of treatment for Axis I disorders (Hirschfeld et al., 1998; Reich & Vasile, 1993; Seivewright et al., 1998; Shea, Widiger, & Klein, 1992; Skodol, Oldham, & Gallaher, 1999). For example, researchers have repeatedly found that patients treated for major depressive disorder who also have PD have worse outcomes than those without PD (e.g., Burns and Nolen-Hoeksema, 1992; Diguier et al., 1993; Fiorot, Boswell, & Murray, 1990; Greenberg, Craighead, Evans, & Craighead, 1995; Shea et al., 1990; Sullivan, Joyce, & Mulder, 1994; Thompson, Gallagher, & Czirr, 1988; Zimmerman, Coryell, Pfohl, Corenthal, & Stangl, 1986). PDs have had similar deleterious effects on treatment outcome for anxiety disorders (e.g., Chambless et al., 1992; Hermesh, Shahar, & Munitz, 1987; Mavissakalian & Hamann, 1986; Nurnberg et al., 1989; Turner, 1987), including obsessive-compulsive disorder (Jenike, Baer, Minichiello, Schwartz, & Carey, 1986), and may worsen the severity of Axis I symptomatology (Dreessen, Arntz, Luttels, & Sallaerts, 1994).¹ Recently, Westen and Morrison (2001) critiqued the external validity of controlled outcome studies, noting that the vast majority of RCTs for major depression and anxiety disorders exclude patients with comorbid PDs, even though comorbidity studies suggest that upward of 50 percent of these patients have one or more PDs. Examining the RCTs that did include PD patients indicates that the presence of PDs negatively affects the outcome of these Axis I disorders (Pilkonis & Frank, 1988; Shahar et al., 2003; Shea et al., 1990). Given

these findings, clinicians who consider Axis I mood disorder diagnoses or anxiety disorder diagnoses to be primary and PDs to be less relevant for treatment planning may be seriously mistaken.

In conclusion, the classification and assessment of PDs remain controversial; issues regarding the nature of categorization or dimensionality of PDs and the extensive comorbidity between PDs and with Axis I disorders continue to be central concerns for researchers and limit the conclusions that can be drawn from outcome studies. There are a number of manualized treatments for different PDs, for specific clusters, and for mixed PDs. Uncontrolled studies suggest that psychodynamic, behavioral, and interpersonal approaches may be helpful to these patients. At present, the most conclusive evidence exists for the behavioral treatment of avoidant PD, psychodynamic and cognitive therapy treatments for Cluster C disorders, psychodynamic treatment for mixed PDs, and supportive-expressive psychotherapy for opiate-addicted antisocial patients, particularly when comorbid with depression. Little, however, is known about the specific mechanisms of action in these treatments. Studying the mechanisms of change in the treatment of PDs is of utmost importance (see Levy, Clarkin, & Kernberg, in press). Bateman and Fonagy (2004) suggest that common mechanisms of action to most tested treatments for PDs may include the provision of a coherent model in the context of a well-structured treatment, focused efforts at compliance to the treatment and connection with the therapist, and the explicit targeting of problematic symptoms.

NOTE

1. It should be noted, however, that there are a few studies that have not found personality disorders to have a negative influence on the effects of therapy for anxiety disorders (e.g., Dreessen et al., 1994). Variations in outcomes between studies can be due to several methodological differences, including assessment methods, study design, type of treatment utilized, and other procedural divergences (for a review, see Dreessen et al., 1994).

REFERENCES

- Abraham, K. (1921). Contributions to the theory of the anal character (D. Byan & A. Strachey, Trans.). In E. Jones (Ed.), *Selected papers of Karl Abraham* (pp. 370–392). London: Hogarth.
- Abrams, R. C., & Horowitz, S. V. (1996). Personality disorders after age 50: A meta-analysis. *Journal of Personality Disorders*, 10 (3), 271–281.

- Alden, L. (1989). Short-term structured treatment for avoidant personality disorder. *Journal of Consulting and Clinical Psychology*, 57(6), 756–764.
- Alden, L., & Capreol, M. (1993). Avoidant personality disorder: Interpersonal problems as predictors of treatment response. *Behavior Therapy*, 24, 357–376.
- American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.
- American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Andrews, G., & Hadzi-Pavlovic, D. (1988). The work of Australian psychiatrists, circa 1986. *Australian and New Zealand Journal of Psychiatry*, 22(2), 153–165.
- Andrews, J., & Moore, S. (1991). Social cognition in the histrionic/overconventional personality. In P. A. Magaro (Ed.), *Cognitive bases of mental disorders* (pp. 11–76). Newbury Park, CA: Sage.
- Angus, L., & Marziali, E. (1988). A comparison of three measures for the diagnosis of borderline personality disorder. *American Journal of Psychiatry*, 145, 1453–1454.
- Aubuchon, P. G., & Malatesta, V. J. (1994). Obsessive compulsive patients with comorbid personality disorder: Associated problems and response to a comprehensive behavior therapy. *Journal of Clinical Psychiatry*, 5, 448–453.
- Baer, L., & Jenike, M. A. (1992). Personality disorders in obsessive compulsive disorder. *Psychiatric Clinics of North America*, 15, 803–812.
- Bailey, G. R. (1998). Cognitive-behavioral treatment of obsessive-compulsive personality disorder. *Journal of Psychological Practice*, 4(1), 51–59.
- Barber, J. P., Morse, J. Q., Krakauer, I. D., Chittams, J., & Crits-Christoph, K. (1997). Change in obsessive-compulsive and avoidant personality disorders following time-limited supportive-expressive therapy. *Psychotherapy*, 34(2), 133–143.
- Baron, M., Gruen, R., Asnis, L., & Lord, S. (1985). Familial transmission of schizotypal and borderline personality disorders. *American Journal of Psychiatry*, 142, 927–934.
- Bateman, A., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders*, 18(1), 36–51.
- Becker, D. F., Grilo, C. M., Edell, W. S., & McGlashan, T. H. (2000). Comorbidity of borderline personality disorder with other personality disorders in hospitalized adolescents and adults. *American Journal of Psychiatry*, 157(12), 2011–2016.
- Bender, D., Dolan, R., Skodol, A., Sanislow, C., Dyck, I., McGlashan, T., et al. (2001). Treatment utilization by patients with personality disorders. *American Journal of Psychiatry* 158(2), 295–302.
- Berg, J. L., Packer, A., & Nunno, V. J. (1993). A Rorschach analysis: Parallel disturbance in thought and in self/object representation. *Journal of Personality Assessment*, 61, 311–323.
- Bergman, A. J., Silverman, J. M., Harvey, P. D., Smith, C. J., & Siever, L. J. (2000). Schizotypal symptoms in the relatives of schizophrenia patients: An empirical analysis of the factor structure. *Schizophrenia Bulletin*, 26(3), 577–586.
- Berman, M., Fallon, A., & Coccaro, E. (1998). The relationship between personality psychopathology and aggressive behavior in research volunteers. *Journal of Abnormal Psychology*, 107(4), 651–658.
- Bernstein, D. P., Cohen, P., Velez, C. N., Schwab-Stone, M., Siever, L. J., & Shinsato, L. (1993). Prevalence and stability of DSM-III-R personality disorders in a community-based survey of adolescents. *American Journal of Psychiatry*, 150, 1237–1243.
- Bernstein, D. P., Useda, D., & Siever, L. J. (1995). Paranoid personality disorder: Review of the literature and recommendations for DSM-IV. *Journal of Personality Disorders*, 7(1), 53–62.
- Black, D. W., Baumgard, C. H., & Bell, S. E. (1995). A 16- to 45-year follow-up of 71 men with antisocial personality disorder. *Comprehensive Psychiatry*, 36(2), 130–140.
- Black, D. W., Noyes, R., Pfohl, B., Goldstein, R. B., & Blum, N. (1993). Personality disorder in obsessive-compulsive volunteers, well comparison subjects, and their first-degree relatives. *American Journal of Psychiatry*, 150(8), 1226–1232.
- Bland, R., Stebelsky, G., Orn, H., & Newman, S. (1988). Psychiatric disorders and unemployment in Edmonton. *Acta Psychiatrica Scandinavica*, 77(Suppl. 338), 72–80.
- Blatt, S. J., & Levy, K. N. (1998). A psychodynamic approach to the diagnosis of psychopathology. In J. W. Barron (Ed.), *Making diagnosis meaningful: Enhancing evaluation and treatment of psychological disorders* (pp. 73–109). Washington, DC: American Psychological Association.
- Bleuler, E. (1929). Zeitschrift-fuer-die-Gesamte-Neurologie-und-Psychiatrie. A contribution to biopsychology/Ein Stueck Biopsychologie, 121, 476–486.
- Bodlund, O., Ekselius, L., & Lindstrom, E. (1993). Personality traits and disorders among psychiatric outpatients and normal subjects on the basis of the SCID screen questionnaire. *Nordic Journal of Psychiatry*, 47(6), 425–433.
- Bodlund, O., Ottosson, H., Ekselius, L., Grann, M., Von-Knorrning, L., Kullgren, G., et al. (1998). DSM-IV and ICD-10 personality disorders: A comparison of a self-report questionnaire (DIP-Q) with a structured interview. *European Psychiatry*, 13(5), 246–253.
- Bongar, B., Peterson, L. G., Golann, S., & Hardiman, J. J. (1990). Self-mutilation and the chronically suicidal patient: An exami-

- nation of the frequent visitor to the psychiatric emergency room. *Annals of Clinical Psychiatry*, 2, 217-222.
- Brodsky, B., Malone, K., Ellis, S., Dulit, R., & Mann, J. (1997). Characteristics of borderline personality disorder associated with suicidal behavior. *American Journal of Psychiatry*, 154(12), 1715-1719.
- Burns, D., & Nolen-Hoeksema, S. (1992). Therapeutic empathy and recovery from depression in cognitive behavioral therapy: A structural equation model. *Journal of Consulting and Clinical Psychology*, 60(3), 441-449.
- Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A., & Kaemmer, B. (1989). *Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring*. Minneapolis: University of Minnesota Press.
- Cadoret, R., & Stewart, M. (1991). An adoption study of attention deficit/hyperactivity/aggression and their relationship to adult antisocial personality. *Comprehensive Psychiatry*, 32(1), 73-82.
- Cadoret, R. J., Yates, W. R., Troughton, E., Woodworth, G., & Stewart, M. A. (1995). Genetic-environmental interaction in the genesis of aggressivity and conduct disorders. *Archives of General Psychiatry*, 52(11), 916-924.
- Casey, P. R., & Tyrer, P. (1990). Personality disorder and psychiatric illness in general practice. *British Journal of Psychiatry*, 156, 261-265.
- Chambless, D., Renneberg, B., Goldstein, A., & Gracely, E. (1992). MCMI-diagnosed personality disorders among agoraphobic outpatients: Prevalence and relationship to severity and treatment outcome. *Journal of Anxiety Disorders*, 6, 193-211.
- Chodoff, P., & Lyons, H. (1958). Hysteria, the hysterical personality and "hysterical" conversion. *American Journal of Psychiatry*, 114, 734-740.
- Clark, L. A. (1993). *Schedule for Nonadaptive and Adaptive Personality: Manual for administration, scoring and interpretation*. Minneapolis: University of Minnesota Press.
- Clark, L., Livesley, W., & Morey, L. (1997). Personality disorder assessment: The challenge of construct validity. *Journal of Personality Disorders*, 11, 205-231.
- Clarkin, J. F. (1998). Research findings on the personality disorders. In *Session: Psychotherapy in Practice*, 4(4), 91-102.
- Cleckley, H. E. (1976). *The mask of sanity*. St. Louis, MO: Mosby. (Original work published 1964)
- Coryell, W. H., & Zimmerman, M. (1989). Personality disorder in the families of depressed, schizophrenic, and never-ill probands. *American Journal of Psychiatry*, 146(4), 496-502.
- Davis, R., & Millon, T. (1993). The Five-Factor Model for personality disorders: Apt or misguided? *Psychological-Inquiry*, 4, 104-109.
- de Girolamo, G., & Dotto, P. (2000). Epidemiology of personality disorders. In M. G. Gelder, J. J. Lopez-Ibor, & N. C. Andreasen (Eds.), *New Oxford textbook of psychiatry* (pp. 959-964). New York: Oxford University Press.
- de Girolamo, G., & Reich, J. H. (1993). *Personality disorders: Epidemiology of mental disorders and psychosocial problems*. Geneva, Switzerland: World Health Organization.
- Demopoulos, C., Fava, M., McLean, N. E., Alpert, J. E., Nierenberg, A. A., & Rosenbaum, J. F. (1996). Hypochondriacal concerns in depressed outpatients. *Psychosomatic Medicine*, 58, 314-320.
- Depue, R. A., & Lenzenweger, M. F. (2005). A neurobehavioral dimensional model of personality disturbances. In J. F. Clarkin & M. F. Lenzenweger (Eds.), *Major theories of personality disorder* (2nd ed., pp. 391-453). New York: Guilford Press.
- Diguer, L., Luborsky, L., Luborsky, E., McLellan, A., Woody, G., & Alexander, L. (1993). Psychological health-sickness (PHS) as a predictor of outcomes in dynamic and other psychotherapies. *Journal of Consulting and Clinical Psychology*, 61(4), 542-548.
- Dowson, J. H., & Grounds, A. T. (1995). *Personality disorders: Recognition and clinical management*. New York: Cambridge University Press.
- Drake, R. E., Adler, D. A., & Vaillant, G. E. (1988). Antecedents of personality disorders in a community sample of men. *Journal of Personality Disorders*, 2, 60-68.
- Drake, R. E., & Vaillant, G. E. (1985). A validity study of Axis II of DSM-III. *American Journal of Psychiatry*, 142(5), 553-558.
- Dreessen, L., Arntz, A., Luttels, C., & Sallaerts, S. (1994). Personality disorders do not influence the results of cognitive behavior therapies for anxiety disorders. *Comprehensive Psychiatry*, 35(4), 265-274.
- Ekselius, L., Tillfors, M., Furmark, T., & Fredrikson, M. (2001). Personality disorders in the general population: DSM-IV and ICD-10 defined prevalence as related to sociodemographic profile. *Personality and Individual Differences*, 30, 311-320.
- Elliott, F. (1992). Violence: The neurologic contribution: An overview. *Archives of Neurology*, 49, 595-603.
- Emerson, J., Pankratz, L., Joos, S., & Smith, S. (1994). Personality disorders in problematic medical patients. *Psychosomatics*, 35(5), 469-473.
- Exner, J. (1969). Rorschach responses as an index of narcissism. *Journal of Projective Techniques and Personality Assessment* 33, 324-333.
- Fairbairn, W. R. D. (1994). *Psychoanalytical studies of the personality*. London: Routledge. (Original work published 1952)
- Farris, M. (1988). *Differential diagnosis of borderline and narcissistic personality disorders: Primitive mental states and the Rorschach*. Madison, CT: International Universities Press.
- Fiorot, M., Boswell, P., & Murray, E. (1990). Personality and response to psychotherapy in depressed elderly women. *Behavior, Health, and Aging*, 1, 51-53.
- First, M., Spitzer, R., Robert, L., Gibbon, M., & Williams, J. (1995). The Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II): I. Description. *Journal of Personality Disorders*, 9, 83-91.
- Fishbain, D. A. (1991). Personality disorder diagnosis in old age. *Journal of Clinical Psychiatry*, 52, 477-8.

- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.
- Fong, M. L. (1995). Assessment and *DSM-IV* diagnosis of personality disorders: A primer for counselors. *Journal of Counseling and Development*, 73, 635–639.
- Freud, S. (1925). *Collected papers: Case histories*. Oxford, England: Hogarth. (Original work published 1909)
- Freud, S. (1959). Character and anal eroticism. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 9, pp. 169–175). London: Hogarth. (Original work published 1906–1908)
- Gabbard, G. O., Coyne, L., Allen, J. G., Spohn, H., Colson, D. B., & Vary, M. (2000). Evaluation of intensive inpatient treatment of patients with severe personality disorders. *Psychiatric Services*, 51(7), 893–898.
- Gacono, C. B., Meloy, R., & Berg, J. L. (1992). Object relations, defensive operations, and affective states in narcissistic, borderline, and antisocial personality disorder. *Journal of Personality Assessment*, 59, 32–49.
- Greenberg, M., Craighead, W., Evans, D., & Craighead, L. (1995). An investigation of the effects of comorbid Axis II pathology on outcome of inpatient treatment of unipolar depression. *Journal of Psychopathology and Behavioral Assessment*, 17, 305–321.
- Grilo, C., Becker, D., Edell, W., & McGlashan, T. (2001). Stability and change of *DSM-III-R* personality disorder dimensions in adolescents followed up 2 years after psychiatric hospitalization. *Comprehensive Psychiatry*, 42, 364–368.
- Grilo, C. M., McGlashan, T. H., & Oldham, J. M. (1998). Course and stability of personality disorders. *Journal of Practical Psychiatry and Behavioral Health*, 4, 61–75.
- Gunderson, J., Ronningstam, E., & Bodkin, A. (1990). The Diagnostic Interview for Narcissistic Patients. *Archives of General Psychiatry*, 47, 676–680.
- Gunderson, J., Zanarini, M., & Kiesel, C. (1991). Borderline personality disorder: A review of data on *DSM-III-R* descriptions. *Journal of Personality Disorders*, 5, 340–352.
- Guntrip, H. (1969). *Schizoid phenomena, object-relations, and the self*. New York: International Universities Press.
- Harder, D. (1979). The assessment of ambitious-narcissistic character style with three projective tests: The Early Memories, TAT, and Rorschach. *Journal of Personality Assessment*, 43, 23–32.
- Hardy, G., Barkham, M., Shapiro, D., Stiles, W., Rees, A., & Reynolds, S. (1995). Impact of Cluster C personality disorders on outcomes of contrasting brief psychotherapies for depression. *Journal of Consulting and Clinical Psychology*, 63(6), 997–1004.
- Hare, R. D. (1991). *The Hare Psychopathy Checklist-Revised*. Toronto, Ontario: Multi-Health Systems.
- Hare, R. D., Hart, S. D., & Harpur, T. J. (1991). Psychopathy and the *DSM-IV* criteria for antisocial personality disorder. *Journal of Abnormal Psychology*, 100(3), 391–398.
- Hellerstein, D. J., Rosenthal, R. N., Pinsker, H., Samstag, L. W., Muran, J. C., & Winston, A. (1998). A randomized prospective study comparing supportive and dynamic therapies. *Journal of Psychotherapy Practice and Research*, 7, 261–271.
- Herbert, J. D., Hope, D. A., & Bellack, A. S. (1992). Validity of the distinction between generalized social phobia and avoidant personality disorder. *Journal of Abnormal Psychology*, 101(2), 332–339.
- Hermesh, H., Shahar, A., & Munitz, H. (1987). Obsessive-compulsive disorder and borderline personality disorder. *American Journal of Psychiatry*, 144, 120–121.
- Hilsenroth, M. J., Fowler, C., Padawer, J. R., & Handler, L. (1997). Narcissism in the Rorschach revisited: Some reflections on empirical data. *Psychological Assessment*, 9, 113–121.
- Hilsenroth, M., Hibbard, S., Nash, M., & Handler, L. (1993). A Rorschach study of narcissism, defense, and aggression in borderline, narcissistic, and Cluster C personality disorders. *Journal of Personality Assessment*, 60, 346–361.
- Hirschfeld, R., Russell, J., Delgado, P., Fawcett, J., Friedman, R., Harrison, W., et al. (1998). Predictors of response to acute treatment of chronic and double depression with sertraline or imipramine. *Journal of Clinical Psychiatry*, 59, 669–675.
- Hoch, A. (1910). Constitutional factors in the Dementia Praecox Group. *Review of Neurology & Psychiatry*, 8, 463–474.
- Hoch, P., & Polatin, P. (1949). Pseudoneurotic forms of schizophrenia. *Psychiatric Quarterly*, 23, 248–276.
- Horney, K. (1950). *Neuroses and human growth: The struggle toward self-realization*. New York: Norton.
- Horowitz, M. J. (1991). *Hysterical personality style and the histrionic personality disorder*. Northvale, NJ: Aronson.
- Hyler, S. E., Kellman, H. D., Oldham, J. M., & Skodol, A. E. (1992). Validity of the Personality Diagnostic Questionnaire-Revised: A replication in an outpatient sample. *Comprehensive Psychiatry*, 33, 73–77.
- Jacobsberg, L. B., Hymowitz, P., Barasch, A., & Frances, A. J. (1986). Symptoms of schizotypal personality disorder. *American Journal of Psychiatry*, 143(10), 1222–1227.
- Jang, K., Livesley, W., & Vernon, P. (1996). The genetic basis of personality at different ages: A cross-sectional twin study. *Personality and Individual Differences*, 21(2), 299–301.
- Jang, K. L., & Vernon, P. A. (2001). Genetics. In W. J. Livesley (Ed.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 177–195). New York: Guilford Press.
- Jenike, M., Baer, L., Minichiello, W., Schwartz, C., & Carey, R. (1986). Concomitant obsessive-compulsive disorder and schizotypal personality disorder. *Journal of Clinical Psychiatry*, 143, 530–532.
- Joffe, R. T., Swinson, R. P., & Regan, J. J. (1988). Personality features of obsessive-compulsive disorder. *American Journal of Psychiatry*, 145, 1127–1129.
- Johnson, J. G., Cohen, P., Brown, J., Smailes, E., & Bernstein, D. P. (1999). Childhood maltreatment increases risk for personality

- disorders during early adulthood. *Archives of General Psychiatry*, 56(7), 600–606.
- Johnson, J. G., Cohen, P., Smailes, E., Kasen, S., Oldham, J. M., & Skodol, A. E. (2000). Adolescent personality disorders associated with violence and criminal behavior during adolescence and early adulthood. *American Journal of Psychiatry*, 157, 1406–1412.
- Karterud, S., Vaglum, S., Friis, S., Irion, T., Johns, S., & Vaglum, P. (1992). Day hospital therapeutic community treatment for patients with personality disorders: An empirical evaluation of the containment function. *Journal of Nervous and Mental Diseases*, 180, 238–243.
- Kasen, S., Cohen, P., Skodol, A. E., Johnson, J. G., & Brook, J. S. (1999). Influence of child and adolescent psychiatric disorders on young adult personality disorder. *American Journal of Psychiatry*, 156, 1529–1535.
- Kendler, K. S. (1985). Diagnostic approaches to schizotypal personality disorder: A historical perspective. *Schizophrenia Bulletin*, 11(4), 538–553.
- Kendler, K. S., & Gruenberg, A. M. (1982). Genetic relationship between paranoid personality disorder and the “schizophrenic spectrum” disorders. *American Journal of Psychiatry*, 139, 1185–1186.
- Kendler, K., & Walsh, D. (1995). Schizotypal personality disorder in parents and the risk for schizophrenia in siblings. *Schizophrenia Bulletin*, 21(1), 47–52.
- Keown, P., Holloway, F., & Kuipers, E. (2002). The prevalence of personality disorders, psychotic disorders and affective disorders amongst the patients seen by a community mental health team in London. *Social Psychiatry and Psychiatric Epidemiology*, 37, 225–229.
- Kernberg, O. (1975). Further contributions to the treatment of narcissistic personalities: A reply to the discussion by Paul H. Ornstein. *International Journal of Psychoanalysis*, 56(2), 245–247.
- Kernberg, O. F. (1976). *Borderline conditions and pathological narcissism*. New York: Jason Aronson.
- Kessler, R. C., Crum, R. M., Warner, L. A., Nelson, C. B., Schulenberg, J., & Anthony, J. C. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 54(4), 313–321.
- Kety, S. S., Rosenthal, D., Wender, P. H., & Schulsinger, F. (1968). The types and prevalence of mental illness in the biological and adoptive families of adopted schizophrenics. *Journal of Psychiatric Research*, 6, 345–362.
- Klein, D. N., Riso, L. P., Donaldson, S. K., Schwartz, J. E., Anderson, R. L., Ouimette, P. C., et al. (1995). Family study of early-onset dysthymia: Mood and personality disorders in relatives of outpatients with dysthymia and episodic major depression and normal controls. *Archives of General Psychiatry*, 52, 487–496.
- Klein, M., Benjamin, L., Rosenfeld, R., & Treece, C. (1993). The Wisconsin Personality Disorders Inventory: Development, reliability, and validity. *Journal of Personality Disorders*, 7, 285–303.
- Koenigsberg, H. W., Kaplan, R. D., Gilmore, M. M., & Cooper, A. M. (1985). The relationship between syndrome and personality disorder in DSM-III: Experience with 2,462 patients. *American Journal of Psychiatry*, 142, 207–212.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Korenblum, M., Marton, P., Golembeck, H., & Stein, B. (1990). Personality status: Changes through adolescence. *Adolescence*, 13, 389–399.
- Kraepelin, E. (1904). *Lectures on clinical psychiatry* (T. Johnstone, Trans.). New York: William Wood.
- Kraepelin, E. (1921). Zeitschrift-fuer-die-Gesamte-Neurologie-und-Psychiatrie. *Depression/Ueber Entwurtzelung*, 63, 1–8.
- Kretschmer, E. (1925). *Physique and character* (2nd ed., rev.). Oxford, England: Harcourt, Brace.
- Kretschmer, E. (1926). *Hysteria*. New York: Nervous and Mental Disease Publishers.
- Lazare, A., Klerman, G. L., & Armor, D. J. (1966). Oral, obsessive, and hysterical personality patterns: An investigation of psychoanalytic concepts by means of factor analysis. *Archives of General Psychiatry*, 14, 624–630.
- Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, 160, 1223–1232.
- Lenzenweger, M., Johnson, M., & Willett, J. (2004). Individual growth curve analysis illuminates stability and change in personality disorder features: The longitudinal study of personality disorders. *Archives of General Psychiatry*, 61, 1015–1024.
- Lenzenweger, M., Loranger, A., Korfine, L., & Neff, C. (1997). Detecting personality disorders in a nonclinical population: Application of a 2-stage for case identification. *Archives of General Psychiatry*, 54(4), 345–351.
- Levy, K. N., Becker, D. F., Grilo, C. M., Mattanah, J. F., Garnet, K. E., Quinlan, D. M., et al. (1999). Concurrent and predictive validity of the personality disorder diagnosis in adolescent inpatients. *American Journal of Psychiatry*, 156, 1522–1528.
- Levy, K. N., Clarkin, J. F., Scott, L. N., & Kernberg, O. F. (in review). Putative mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy: What changes in the patient and how does it happen?
- Levy, K. N., Meehan, K. B., Auerbach, J. S., & Blatt, S. J. (2005). Concept of the object on the Rorschach scale. The LEA series in personality and clinical psychology. In J. M. Masling & R. F.

- Bornstein (Eds.), *Scoring the Rorschach: Seven validated systems* (pp. 97–133). Mahwah, NJ: Erlbaum.
- Lilienfeld, S. O., VanValkenburg, C., Lartzt, K., & Akiskal, H. S. (1986). The relationship of histrionic personality disorder to antisocial personality and somatization disorders. *American Journal of Psychiatry*, 143, 718–722.
- Livesley, J. (1986). Trait and behavioural prototypes of personality disorder. *American Journal of Psychiatry*, 143, 728–732.
- Livesley, W. J. (2001). Commentary on reconceptualizing personality disorder categories using trait dimensions. *Journal of Personality*, 69(2), 277–286.
- Livesley, W., & Jackson, D. (1986). The internal consistency and factorial structure of behaviors judged to be associated with *DSM-III* personality disorders. *American Journal of Psychiatry*, 143, 1473–1474.
- Livesley, W. J., Jackson, D. N., & Schroeder, M. L. (1992). Factorial structure of traits delineating personality disorders in clinical and general population samples. *Journal of Abnormal Psychology*, 101(3), 432–440.
- Livesley, W. J., Reiffer, L. I., Sheldon, A. E., & West, M. (1987). Prototypicality ratings of *DSM-III* criteria for personality disorders. *Journal of Nervous and Mental Disease*, 175, 395–401.
- Livesley, W. J., Schroeder, M. L., Jackson, D. N., & Jang, K. L. (1994). Categorical distinctions in the study of personality disorder: Implications for classification. *Journal of Abnormal Psychology*, 103(1), 6–17.
- Loranger, A. W. (1999). *International Personality Disorder Examination (IPDE) manual*. Odessa, FL: Psychological Assessment Resources.
- Loranger, A. W. (2002). *OMNI personality inventory and OMNI-IV personality disorder inventory manual*. Odessa, FL: Psychological Assessment Resources.
- Maier, W., Lichtermann, D., Klingler, T., Heun, R., & Hallmayer, J. (1992). Prevalences of personality disorders (*DSM-III-R*) in the community. *Journal of Personality Disorders*, 6, 187–196.
- Marinangeli, M. G., Butti, G., Scinto, A., Di Cicco, L., Petruzzi, C., Daneluzzo, E., et al. (2000). Patterns of comorbidity among *DSM-III-R* personality disorders. *Psychopathology*, 33(2), 69–74.
- Marzillier, J. S., Lambert, C., & Kellett, J. (1976). A controlled evaluation of systematic desensitization and social skills training for socially inadequate psychiatric patients. *Behavioural Research and Therapy*, 14, 225–238.
- Maser, J. D., Kaelber, C., & Weise, R. E. (1991). International use and attitudes toward *DSM-III* and *DSM-III-R*: Growing consensus in psychiatric classification. *Journal of Abnormal Psychology*, 100, 217–279.
- Masterson, J. (1990). Psychotherapy of borderline and narcissistic disorders: Establishing a therapeutic alliance (a developmental, self, and object relations approach). *Journal of Personality Disorders*, 4(2), 182–191.
- Mattanah, J., Becker, D., Levy, K., Edell, W., & McGlashan, T. H. (1995). Diagnostic stability in adolescents followed up 2 years after hospitalization. *American Journal of Psychiatry*, 152, 889–894.
- Maudsley, H. (1874). *Responsibility and mental disease*. New York: Appleton.
- Mavissakalian, M., & Hamann, M. (1986). Assessment and significance of behavioral avoidance in agoraphobia. *Journal of Psychopathology and Behavioral Assessment*, 8(4), 317–327.
- McCrae, R., Costa, P., de Lima, M., Simoes, A., Ostendorf, F., Angleitner, A., et al. (1999). Age differences in personality across the adult life span: Parallels in five cultures. *Developmental Psychology*, 35(2), 466–477.
- McCranie, E., & Kahan, J. (1986). Personality and multiple divorce: A prospective study. *Journal of Nervous and Mental Disease*, 174(3), 161–164.
- McGlashan, T. H. (1986). Schizotypal personality disorder: The Chestnut Lodge follow-up study IV. Long-term follow-up perspectives. *Archives of General Psychiatry*, 43, 329–334.
- Meehl, P. E. (1962). Schizotaxia, schizotypy and schizophrenia. *American Psychologist*, 17, 827–838.
- Mellsop, G., Varghese, F., Joshua, S., & Hicks, A. (1982). The reliability of Axis II of *DSM-III*. *American Journal of Psychiatry*, 139(10), 1360–1361.
- Meyer, A. (1957). *Psychobiology: A science of man*. Springfield, IL: Charles C. Thomas.
- Millon, T. (1981). *Disorders of personality: DSM-III, Axis II*. New York: Wiley.
- Millon, T. (1985). The MCMI provides a good assessment of *DSM-III* disorders: The MCMI-II will prove even better. *Journal of Personality Assessment*, 49, 379–391.
- Millon, T. (1986). On the past and future of the *DSM-III*: Personal recollections and projections. In T. Millon and G. L. Klerman (Eds.), *Contemporary directions in psychopathology: Toward the DSM-IV* (pp. 29–70). New York: Guilford Press.
- Millon, T. (1996). *Disorders of personality: DSM-IV and beyond*. New York: Wiley.
- Millon, T., & Davis, R. (2000). *Personality disorders in modern life*. New York: Wiley.
- Millon, T., Davis, R., Millon, C., Escovar, L., & Meagher, S. (2000). *Personality disorders in modern life*. New York: Wiley.
- Millon, T., Millon, C., & Davis, R. (1994). *Millon Clinical Multiaxial Inventory-III*. Minneapolis, MN: National Computer Systems.
- Moldin, S. O., Rice, J. P., Erlenmeyer-Kimling, L., & Squires-Wheeler, E. (1994). Latent structure of *DSM-III-R* Axis II psychopathology in a normal sample. *Journal of Abnormal Psychology*, 103(2), 259–266.
- Monsen, J., Odland, T., Faugli, A., Daae, E., & Eilertsen, D. E. (1995). Personality disorders: Changes and stability after intensive psychotherapy focusing on affect consciousness. *Psychotherapy Research*, 5, 33–48.

- Moran, P. (1999). The epidemiology of antisocial personality disorder. *Social Psychiatry & Psychiatric Epidemiology*, 34(5), 231–242.
- Moran, P., Jenkins, R., Tylee, A., Blizard, R., & Mann, A. (2000). The prevalence of personality disorder among UK primary care attenders. *Acta Psychiatrica Scandinavica*, 102, 52–57.
- Morey, L. C. (1991). *The Personality Assessment Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.
- Morgan, D., May, P., & Finch, C. (1987). Dopamine and serotonin systems in human and rodent brain: Effects of age and neurodegenerative disease. *Journal of the American Geriatrics Society*, 35(4), 334–345.
- Nakao, K., Gunderson, J., Phillips, K., & Tanaka, N. (1992). Functional impairment in personality disorders. *Journal of Personality Disorders*, 6(1), 24–33.
- Nash, M. R., Hulse, T. L., Sexton, M. C., Harralson, T. L., & Lambert, W. (1993). Long-term sequelae of childhood sexual abuse: Perceived family environment, psychopathology, and dissociation. *Journal of Consulting and Clinical Psychology*, 61(2), 276–283.
- Nestadt, G., Romanoski, A. J., Chahal, R., Merchant, A., Folstein, M. F., Gruenberg, E. M., et al. (1990). An epidemiological study of histrionic personality disorder. *Psychological Medicine*, 20(2), 413–422.
- Nestadt, G., Romanoski, A. J., Samuels, J. F., Folstein, M. F., & McHugh, P. R. (1992). The relationship between personality and DSM-III Axis I disorders in the population: Results from an epidemiological survey. *American Journal of Psychiatry*, 149(9), 1228–1233.
- Nezworski, T., & Wood, J. (1995). Narcissism in the Comprehensive System for the Rorschach. *Clinical Psychology: Science and Practice*, 2, 179–199.
- Nigg, J., & Goldsmith, H. (1994). Genetics of personality disorders: Perspectives from personality and psychopathology research. *Psychological Bulletin*, 115(3), 346–380.
- Nurnberg, H. G., Raskin, M., Levine, P. E., & Pollack, S. (1989). Borderline personality disorder as a negative prognostic factor in anxiety disorders. *Journal of Personality Disorders*, 3(3), 205–216.
- O'Boyle, M., & Brandon, E. (1998). Suicide attempts, substance abuse, and personality. *Journal of Substance Abuse Treatment*, 15(4), 353–356.
- O'Boyle, M., & Self, D. (1990). A comparison of two interviews for DSM-III-R personality disorders. *Psychiatry Research*, 32, 85–92.
- Oldham, J. M., Skodol, A. E., Kellman, H. D., Hyler, S. E., Doidge, N., Rosnick, L., et al. (1995). Comorbidity of Axis I and Axis II disorders. *American Journal of Psychiatry*, 152(4), 571–578.
- Oldham, J. M., Skodol, A. E., Kellman, H. D., Hyler, S. E., Rosnick, L., & Davies, M. (1992). Diagnosis of DSM-III-R personality disorders by two structured interviews: Patterns of comorbidity. *American Journal of Psychiatry*, 149(2), 213–220.
- Paris, J. (1993). Personality disorders: A biopsychosocial model. *Journal of Personality Disorders*, 7(3), 255–264.
- Paris, J. (2000). Childhood precursors of borderline personality disorder. *Psychiatric Clinics of North America*, 23, 77–88.
- Paris, J. (2003). Personality disorders over time: Precursors, course, and outcome. *Journal of Personality Disorders*, 17(6), 479–488.
- Perry, J. C. (1992). Problems and considerations in the valid assessment of personality disorders. *American Journal of Psychiatry*, 149, 1645–1653.
- Perry, J. C., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy for personality disorders. *American Journal of Psychiatry*, 156, 1312–1321.
- Pfohl, B. (1991). Histrionic personality disorder: A review of available data and recommendations for DSM-IV. *Journal of Personality Disorders*, 5, 150–166.
- Pfohl, B., & Blum, N. (1991). Obsessive-compulsive personality disorder: A review of available data and recommendations for DSM-IV. *Journal of Personality Disorders*, 5(4), 363–375.
- Pfohl, B., Blum, N., & Zimmerman, M. (1997). *Structured Interview for DSM-IV Personality*. Washington, DC: American Psychiatric Press.
- Pfohl, B., Coryell, W., Zimmerman, M., & Stangl, D. (1986). DSM-III personality disorders: Diagnostic overlap and internal consistency of individual DSM-III criteria. *Comprehensive Psychiatry*, 27, 21–34.
- Pilkonis, P., & Frank, E. (1988). Personality pathology in recurrent depression: Nature, prevalence, and relationship to treatment response. *American Journal of Psychiatry*, 145, 435–441.
- Pilkonis, P. A., Heape, C. L., Ruddy, J., & Serrao, P. (1991). Validity in the diagnosis of personality disorders: The use of the LEAD standard. *Psychological Assessment*, 3(1), 46–54.
- Pinel, P. (1809). *Traite medico-philosophique sur l'alienation mentale*. Paris: Brosson.
- Plakun, E. M. (1991). Empirical studies on narcissism. In S. M. Mirin, J. T. Gossett, & M. C. Grob (Eds.), *Psychiatric treatment: Advances in outcome research* (pp. 195–212). Washington, DC: American Psychiatric Press.
- Plakun, E. M., Burkhardt, P. E., & Muller, J. P. (1985). 14-year follow-up of borderline and schizotypal personality disorders. *Comprehensive Psychiatry*, 26(5), 448–455.
- Plutchik, R., Conte, H. R., & Karasu, T. B. (1994, June). *The circumplex structure of personality disorders*. Paper presented at the Society of Psychotherapy Research, Pittsburgh, PA.
- Posner, M. I., Rothbart, M., Vizueta, N., Thomas, K., Levy, K., Fossella, J., et al. (2003). An approach to the psychobiology of personality disorders. *Development and Psychopathology*, 15, 1093–1106.
- Rado, S. (1953). Dynamics and classification of disordered behavior. *American Journal of Psychiatry*, 110, 406–416.
- Reich, J., Boerstler, H., Yates, W., & Nduaguba, M. (1989). Utilization of medical resources in persons with DSM-III personality

- disorders in a community sample. *International Journal of Psychiatry in Medicine*, 19, 1–9.
- Reich, J., Noyes, R., & Troughton, E. (1987). Dependent personality disorder associated with phobic avoidance in patients with panic disorder. *American Journal of Psychiatry*, 144(3), 323–326.
- Reich, J. H., & Vasile, R. G. (1993). Effect of personality disorders on the treatment outcome of Axis I conditions: An update. *Journal of Nervous and Mental Diseases*, 181, 475–484.
- Reich, J., Yates, W., & Nduaguba, M. (1989). Prevalence of DSM-III personality disorders in the community. *Social Psychiatry and Psychiatric Epidemiology*, 24(1), 12–16.
- Reich, W. (1933). *Charackteranalyse*. Leipzig, Germany: Sexpol Verlag.
- Renneberg, B., Goldstein, A. J., Phillips, D., & Chambless, D. L. (1990). Intensive behavioral group treatment of avoidant personality disorder. *Behavior Therapy*, 21, 363–377.
- Robins, L. N. (1966). *Deviant children grown up: A sociological and psychiatric study of sociopathic personality*. Baltimore: Williams and Wilkins.
- Ronningstam, E., (1996). Pathological narcissism and narcissistic personality disorder in Axis I disorders. *Harvard Review of Psychiatry*, 3, 326–340.
- Ronningstam, E., Gunderson, J., & Lyons, M. (1995). Changes in pathological narcissism. *American Journal of Psychiatry*, 152(2), 253–257.
- Rosenthal, R. N., Muran, J. C., Pinsker, H., Hellerstein, D., & Winston, A. (1999). Interpersonal change in brief supportive psychotherapy. *Journal of Psychotherapy Practice and Research*, 8, 55–63.
- Rush, B. (1827). *Medical inquiries and observations upon the diseases of the mind* (3rd ed.). Philadelphia: Kimber and Richardson.
- Rutter, M. (1987). Temperament, personality and personality disorder. *British Journal of Psychiatry*, 150, 443–458.
- Saarento, O., Oeiesvold, T., Sytema, S., Goestas, G., Kastrup, M., Loennerberg, O., et al. (1998). The Nordic Comparative Study on Sectorized Psychiatry: Continuity of care related to characteristics of the psychiatric services and the patients. *Social Psychiatry and Psychiatric Epidemiology*, 33(11), 521–527.
- Samuels, J., Eaton, W. W., Bienvenu, O. J., III, Brown, C. H., Costa, P. T., Jr., & Nestadt, G. (2002). Prevalence and correlates of personality disorders in a community sample. *British Journal of Psychiatry*, 180, 536–542.
- Samuels, J. F., Nestadt, G., Romanoski, A. J., Folstein, M. F., & McHugh, P. R. (1994). DSM-III personality disorders in the community. *American Journal of Psychiatry*, 151(7), 1055–1062.
- Schneider, K. (1923). *Die psychopathischen Persönlichkeiten* [The Psychopathic Personalities]. Leipzig, Germany: Thieme.
- Schore, A. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Erlbaum.
- Seivewright, H., Tyrer, P., & Johnson, T. (2002). Change in personality status in neurotic disorders. *Lancet*, 359, 2253–2254.
- Shea, M. T., Pilkonis, P. A., Beckham, E., Collins, J. F., Elkin, I., Sotsky, S. M., et al. (1990). Personality disorders and treatment outcome in the NIMH Treatment of Depression Collaborative Research Program. *American Journal of Psychiatry*, 147, 711–718.
- Shea, M. T., Stout, R. L., Gunderson, J. G., Morey, L. C., Grilo, C. M., McGlashan, T. H., et al. (2002). Short-term diagnostic stability of schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *American Journal of Psychiatry*, 159, 2036–2041.
- Shea, M., Widiger, T., Klein, M. (1992). Comorbidity of personality disorders and depression: Implications for treatment. *Journal of Consulting and Clinical Psychology*, 60(6), 857–868.
- Shea, M. T., & Yen, S. (2003). Stability as a distinction between Axis I and Axis II disorders. *Journal of Personality Disorders*, 17(5), 373–386.
- Shea, T., Glass, D. R., Pilkonis, P. A., Watkins, J., & Docherty, J. P. (1987). Frequency and implications of personality disorders in a sample of depressed outpatients. *Journal of Personality Disorders*, 1, 27–42.
- Shedler, J., & Westen, D. (2004). Dimensions of personality pathology: An alternative to the Five-Factor Model. *American Journal of Psychiatry*, 161, 1743–1754.
- Siever, L. J., & Davis, K. L. (1991). A psychobiological perspective on the personality disorders. *American Journal of Psychiatry*, 148, 1647–1658.
- Skodol, A. E., Gunderson, J. G., Pfohl, B., Widiger, T. A., Livesley, W. J., & Siever, L. J. (2002). The borderline diagnosis I: Psychopathology, comorbidity, and personality structure. *Biological Psychiatry*, 51, 936–950.
- Skodol, A. E., Oldham, J. M., & Gallaher P. E. (1999). Axis II comorbidity of substance use disorders among patients referred for treatment of personality disorders. *American Journal of Psychiatry*, 156(5), 733–738.
- Skodol, A. E., Oldham, J. M., Hyler, S. E., Stein, D. J., Hollander, E., Gallaher, P. E., et al. (1995). Patterns of anxiety and personality disorder comorbidity. *Journal of Psychiatric Research*, 29(5), 361–374.
- Skodol, A. E., Rosnick, L., Kellman, D., Oldham, J. M., & Hyler, S. (1991). Development of a procedure for validating structured assessments of Axis II. In J. M. Oldham (Ed.), *Personality disorders: New perspectives on diagnostic validity* (pp. 43–70). Washington, DC: American Psychiatric Association.
- Spitzer, R. L., Endicott, J., & Gibbon, M. (1979). Crossing the border into borderline personality and borderline schizophrenia: The development of criteria. *Archives of General Psychiatry*, 36(1), 17–24.
- Stone, M. (1983). Psychotherapy with schizotypal borderline patients. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 11(1), 87–111.
- Stone, M. H., Hurt, S. W., & Stone, D. K. (1987). The PI 500: Long-term follow-up of borderline inpatients meeting DSM-III criteria:

- I. Global outcome. *Journal of Personality Disorders*, 1, 291–298.
- Strack, S. (1987). Development and validation of an adjective checklist to assess the Millon personality types in a normal population. *Journal of Personality Assessment*, 51, 572–587.
- Stravynski, A., Belisle, M., Marcouiller, M., & Lavalley-Yvon, J. (1994). The treatment of avoidant personality disorder by social skills training in the clinic or in real-life setting. *Canadian Journal of Psychiatry*, 39, 377–383.
- Stravynski, A., Lesage, A., Marcouiller, M., & Elie, R. (1989). A test of the therapeutic mechanism in social skills training with avoidant personality disorder. *Journal of Nervous and Mental Disease*, 177, 739–744.
- Stravynski, A., Marks, I., & Yule, W. (1982). Social skills problems in neurotic outpatients: Social skills training with and without cognitive modification. *Archives of General Psychiatry*, 39, 1378–1385.
- Sullivan, P., Joyce, P., & Mulder, R. (1994). Borderline personality disorder in major depression. *Journal of Nervous and Mental Disease*, 182(9), 508–516.
- Svartberg, M., Stiles, T., & Seltzer, M. (2004). Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for Cluster C personality disorders. *American Journal of Psychiatry*, 161(5), 810–817.
- Thompson, L., Gallagher, D., & Czirr, R. (1988). Personality disorder and outcome in the treatment of late-life depression. *Journal of Geriatric Psychiatry*, 21, 133–146.
- Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of General Psychiatry*, 58(6), 590–596.
- Torgersen, S., Lygren, S., Oien, P. A., Skre, I., Onstad, S., Edvardsen, J., et al. (2000). A twin study of personality disorders. *Comprehensive Psychiatry*, 41(6), 416–425.
- Torgersen, S., Onstad, S., Skre, I., Edvardsen, J., & Kringlen, E. (1993). "True" schizotypal personality disorder: A study of co-twins and relatives of schizophrenic probands. *American Journal of Psychiatry*, 150(11), 1661–1667.
- Trull, T. J. (1992). *DSM-III-R* personality disorders and the Five-Factor Model of personality: An empirical comparison. *Journal of Abnormal Psychology*, 101(3), 553–560.
- Trull, T., & Larson, S. (1994). External validity of two personality disorder inventories. *Journal of Personality Disorders*, 8, 96–103.
- Turkat, I. (1990). *The personality disorders: A psychological approach to clinical management*. Elmsford, NY: Pergamon Press.
- Turner, R. (1987). The effects of personality disorder diagnosis on the outcome of social anxiety symptom reduction. *Journal of Personality Disorders*, 1(2), 136–143.
- Tyrer, P., & Alexander, J. (1988). Personality assessment schedule. In P. Tyrer (Ed.), *Personality disorders: Diagnosis, management and course* (pp. 43–62). London: Wright.
- Tyrer, P., Casey, P., & Gall, J. (1983). Relationship between neurosis and personality disorder. *British Journal of Psychiatry*, 142, 404–408.
- Tyrer, P., Gunderson, J., Lyons, M., & Tohen, M. (1997). Extent of comorbidity between mental state and personality disorders. *Journal of Personality Disorders*, 11, 242–259.
- Veith, I. (1977). Four thousand years of hysteria. In M. Horowitz (Ed.), *Hysterical personality* (pp. 58–79). New York: Aronson.
- Weaver, T., & Clum, G. (1993). Early family environments and traumatic experiences associated with borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 61(6), 1068–1075.
- Westen, D. (1996). A model and a method for uncovering the nomothetic from the idiographic: An alternative to the Five-Factor Model? *Journal of Research in Personality*, 30, 400–413.
- Westen, D. (1997). Divergences between clinical and research methods for assessing personality disorders: Implications for research and the evolution of Axis II. *American Journal of Psychiatry*, 154(7), 895–903.
- Westen, D., & Arkowitz-Westen, L. (1998). Limitations of Axis II in diagnosing personality pathology in clinical practice. *American Journal of Psychiatry*, 155(12), 1767–1771.
- Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 69(6), 875–899.
- Westen, D., & Shedler, J. (1999a). Revising and assessing Axis II, part I: Developing a clinically and empirically valid assessment method. *American Journal of Psychiatry*, 156, 258–272.
- Westen, D., & Shedler, J. (1999b). Revising and assessing Axis II, part II: Toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry*, 156, 273–285.
- Westen, D., & Shedler, J. (2000). A prototype matching approach to diagnosing personality disorders: Toward *DSM-V*. *Journal of Personality Disorders*, 14(2), 109–126.
- Widiger, T. A. (1987). *Personality Interview Questionnaire II (PIQ II)*. White Plains, NY: Department of Psychiatry, Cornell Medical Center, Westchester Division.
- Widiger, T. A. (2001). Official classification systems. In W. J. Livesley (Ed.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 60–83). New York: Guilford Press.
- Widiger, T. A., & Corbitt, E. M. (1995). Antisocial personality disorder. In W. J. Livesley (Ed.), *DSM-IV personality disorders* (pp. 103–126). New York: Guilford Press.
- Widiger, T. A., Frances, A. J., Harris, M., Jacobsberg, L. B., Fyer, M., & Manning, D. (1991). Comorbidity among Axis II disorders. Progress in psychiatry, No. 20. In J. Oldham (Ed.), *Personality disorders: New perspectives on diagnostic validity* (pp. 165–194). Washington, DC: American Psychiatric Association.

- Widiger, T. A., Frances, A., Spitzer, R. L., & Williams, J. B. W. (1988). The *DSM-III-R* personality disorders: An overview. *American Journal of Psychiatry*, 145, 786–795.
- Widiger, T. A., Mangine, S., Corbitt, E. M., Ellis, C. G., & Thomas, G. V. (1995). *Personality Disorder Interview-IV: A semistructured interview for the assessment of personality disorders—Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Widiger, T., & Rogers, J. (1989). Prevalence and comorbidity of personality disorders. *Psychiatric Annals*, 19, 132–136.
- Widiger, T. A., & Trull, T. J. (1992). Personality and psychopathology: An application of the Five-Factor Model. *Journal of Personality*, 60(2), 363–393.
- Widiger, T. A., Trull, T. J., Clarkin, J. F., Sanderson, C., & Costa, P. T. (2002). A description of the *DSM-IV* personality disorders with the Five-Factor Model of personality. In T. A. Widiger & P. T. Costa, Jr. (Eds.), *Personality disorders and the Five-Factor Model of personality* (2nd ed., pp. 89–99). Washington, DC: American Psychological Association.
- Widiger, T. A., Trull, T. J., Hurt, S. W., Clarkin, J., & Frances, A. (1987). A multidimensional scaling of the *DSM-III* personality disorders. *Archives of General Psychiatry*, 44(6), 557–563.
- Wiggins, J., & Pincus, A. (1989). Conceptions of personality disorders and dimensions of personality. *Psychological Assessment*, 1, 305–316.
- Winnicott, D. W. (1951). Transitional objects and transitional phenomena. In *Through pediatrics to psycho-analysis* (pp. 229–242). London: Hogarth.
- Winston, A., Laikin, M., Pollack, J., & Samstag, L. (1994). Short-term psychotherapy of personality disorders. *American Journal of Psychiatry*, 151(2), 190–194.
- Winston, A., Pollack, J., McCullough, L., Flegenheimer, W., Kestenbaum, R., & Trujillo, M. (1991). Brief psychotherapy of personality disorders. *Journal of Nervous and Mental Diseases*, 179, 188–198.
- Wolff, S., Townshend, R., McGuire, R. J., & Weeks, D. J. (1991). "Schizoid" personality in childhood and adult life: II. Adult adjustment and the continuity with schizotypal personality disorder. *British Journal of Psychiatry*, 159, 620–629.
- Wood, J. M., & Lilienfeld, S. O. (1999). The Rorschach Inkblot Test: A case of overstatement? *Assessment*, 6, 341–351.
- Wood, J. M., Nezworski, M. T., Lilienfeld, S. O., & Garb, H. N. (2003). *What's wrong with the Rorschach? Science confronts the controversial inkblot test*. San Francisco: Jossey-Bass.
- Woody, G., McLellan, A., Luborsky, L., & O'Brien, C. (1985). Sociopathy and psychotherapy outcome. *Archives of General Psychiatry*, 42, 1081–1086.
- World Health Organization. (1992). The *ICD-10* classification of mental and behavioural disorders. Clinical descriptions and diagnostic guidelines. Geneva, Switzerland: Author.
- Zanarini, M., Frankenburg, F., Chauncey, D., & Gunderson, J. (1987). The Diagnostic Interview for Personality Disorders: Interrater and test-retest reliability. *Comprehensive Psychiatry*, 28, 467–480.
- Zanarini, M., Frankenburg, F., Sickel, A. E., & Yong, L. (1996). *The Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV)*. Belmont, MA: McLean Hospital.
- Zanarini, M. C., Gunderson, J. G., Frankenburg, F. R., & Chauncey, D. L. (1989). The Revised Diagnostic Interview for Borderlines: Discriminating BPD from other Axis II disorders. *Journal of Personality Disorders*, 3, 110–118.
- Zimmerman, M., & Coryell, W. H. (1989). *DSM-III* personality disorder diagnoses in a nonpatient sample: Demographic correlates and comorbidity. *Archives of General Psychiatry*, 46(8), 682–689.
- Zimmerman, M., & Coryell, W. H. (1990). Diagnosing personality disorders in the community. A comparison of self-report and interview measures. *Archives of General Psychiatry*, 47(6), 527–531.
- Zimmerman, M., & Coryell, W., Pfohl, B., Corenthal, C., & Stangl, D. (1986). The relationship between age and post-dexamethasone cortisol: A test of three hypotheses. *Journal of Affective Disorders*, 11, 185–197.
- Zimmerman, M., Pfohl, B., Stangl, D., & Corenthal, C. (1986). Assessment of *DSM-III* personality disorders: The importance of interviewing an informant. *Journal of Clinical Psychiatry*, 47(5), 261–263.