

Bloumsburg University ILL



ILLiad TN: 129772

Borrower: UPM

Lending String: *PBB,REC,EEM,MNU,GZM

Patron: Rojas Acosta, Shirley

Journal Title: Encyclopedia of counseling /

Volume: 2 **Issue:**

Month/Year: 2008 **Pages:** 729-735

Article Author:

Article Title: Levy, K. N., Ellison, W. D., & Scott, L. N; Personality disorders

Imprint: Los Angeles ; SAGE Publications, c2008.

ILL Number: 100843542



Call #: BF636.54 .E53 2008

Location: Reference Collection --1st floor

ODYSSEY

Charge

Maxcost: 80.00IFM

Shipping Address:

Pennsylvania State University
127 Paterno Library - ILL
Curtin Rd.
University Park, PA 16802
IDS 158

Fax: (814) 865-0071

Ariel: 128.118.152.2

Email: ul-illoan@lists.psu.edu

Odyssey: 206.107.44.87

Bloomsburg University of Pennsylvania

Interlibrary Loan

NOTICE OF COPYRIGHT RESTRICTIONS

The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted materials.

Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be "used for any purpose other than private study, scholarship, or research". If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement.

This institution reserves the right to refuse to accept a copying order if, in its judgment, fulfillment of the order would involve violation of copyright law.

No further reproduction or distribution of this copy is permitted by electronic transmission or other means.

Problem report

If you have a problem with the delivery of the requested items, please contact us with the following information:

Missing pages: _____

Edges cut off: ___ Left ___ Right ___ Top ___ Bottom

Unable to read: ___ Blurry ___ Too dark ___ Too Light

Other: _____

Contact us:

Phone: 570-389-4218

Ariel: 148.137.188.215

Fax: 570-389-3895

Odyssey: 148.137.188.233

Email: ill@bloomu.edu

OCLC: PBB

Ref
BF
636.54
E53
2008
.2

Encyclopedia of
Counseling
Personal and Emotional Counseling

VOLUME
2

Editor-in-Chief

Frederick T. L. Leong

Michigan State University

Senior Editor

Howard E. A. Tinsley

Southern Illinois University, Carbondale

Associate Editor

Suzanne H. Lease

University of Memphis

 SAGE

Los Angeles • London • New Delhi • Singapore

A SAGE Reference Publication

180989595

Copyright © 2008 by SAGE Publications, Inc.

All rights reserved. No part of this book may be reproduced or utilized in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without permission in writing from the publisher.

For information:



SAGE Publications, Inc.
2455 Teller Road
Thousand Oaks, California 91320
E-mail: order@sagepub.com

SAGE Publications India Pvt. Ltd.
B 1/I 1 Mohan Cooperative Industrial Area
Mathura Road, New Delhi 110 044
India

SAGE Publications Ltd.
1 Oliver's Yard
55 City Road
London EC1Y 1SP
United Kingdom

SAGE Publications Asia-Pacific Pte. Ltd.
33 Pekin Street #02-01
Far East Square
Singapore 048763

Printed in the United States of America.

Library of Congress Cataloging-in-Publication Data

Encyclopedia of counseling/Frederick T. L. Leong, general editor
v. cm.

"A SAGE reference publication."

Includes bibliographical references and index.

Contents: v. 1. Changes and challenges for counseling in the 21st century, A-Z/editor, Elizabeth M. Altmaier—v. 2. Personal and emotional counseling, A-Z/editor, Howard E. A. Tinsley—v. 3. Cross-cultural counseling, A-Z/editor, Madonna G. Constantine—v. 4. Career counseling, A-Z / editor, W. Bruce Walsh.

ISBN 978-1-4129-0928-0 (cloth : alk. paper)

1. Counseling—Encyclopedias. I. Leong, Frederick T. L. II. Altmaier, Elizabeth M.

BF636.54.E53 2008

158'.303—dc22

2007045854

This book is printed on acid-free paper.

08 09 10 11 12 10 9 8 7 6 5 4 3 2 1

<i>Publisher/Acquiring Editor:</i>	Rolf A. Janke
<i>Developmental Editors:</i>	Sara Tauber, Carole Maurer
<i>Reference Systems Manager:</i>	Leticia Gutierrez
<i>Production Editor:</i>	Tracy Buyan
<i>Copy Editor:</i>	Jamie Robinson
<i>Typesetter:</i>	C&M Digital (P) Ltd.
<i>Proofreader:</i>	Penelope Sippel
<i>Indexer:</i>	Julie Sherman Grayson
<i>Cover Designer:</i>	Michelle Kenny
<i>Marketing Manager:</i>	Amberlyn Erzinger

Wood, J. M., Garb, H. N., Lilienfeld, S. O., & Nezworski, M. T. (2002). Clinical assessment. *Annual Review of Psychology*, 53, 519–543.

PERSONALITY DISORDERS

Personality disorders (PDs) pose a major challenge to the modern profession of mental health care. Unlike depression, anxiety, and other disorders that are more commonly the focus of treatment, personality disorders are generally understood to be pervasive, inflexible, maladaptive, and enduring expressions of personality. People with PDs exact a heavy cost from themselves and society, as well as place considerable pressure on the mental health care system. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* is currently the most widely used diagnostic system to diagnose personality disorders, particularly in the United States. The International Classification of Diseases (ICD-10), maintained by the World Health Organization, is another important diagnostic system.

The *DSM-IV-TR* distinguishes among 10 PDs 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, the *DSM* allows for the diagnosis of personality disorder not otherwise specified (PD-NOS), which can be 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. This entry reviews what is known about the personality disorders in the *DSM-IV-TR*. The review will focus on the features, etiology, prevalence, comorbidity, course, and treatment of the various PDs.

Features of *DSM-IV-TR* Personality Disorders

Cluster A (Odd-Eccentric)

Paranoid Personality Disorder

According to *DSM-IV-TR*, Paranoid PD (PPD) is characterized by a consistent pattern of distrust of the motives of other people. 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. Individuals with this disorder can be severely sensitive to criticism and therefore are likely to feel attacked, threatened, or criticized by others. They 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.

Schizoid Personality Disorder

DSM-IV-TR notes that those with schizoid PD (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.

Schizotypal Personality Disorder

According to *DSM-IV-TR*, schizotypal PD (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 emotional problems. 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.

Cluster B (Dramatic-Erratic)

Antisocial Personality Disorder

As defined by *DSM-IV-TR*, antisocial PD (ASPD) 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. Those with ASPD are prone to impulsiveness, irritability, and aggressiveness, which often leads to physical fights or assault, and they have a reckless disregard for the safety of themselves or others. In addition, they might repeatedly fail to honor work or financial obligations, or 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 be at least 18 years old and must have met at least some criteria for Conduct Disorder prior to age 15.

Borderline Personality Disorder

According to the *DSM-IV-TR*, individuals with borderline personality disorder (BPD) show a pattern of instability in various psychological and interpersonal domains. Their concept of self and feelings about self are markedly unstable, although thoughts about the self generally have a negative quality. Consonant with this characteristic, their beliefs, goals for the future, and social and sexual preferences may change often. These individuals' views of others also show extreme volatility; they frequently begin relationships by idealizing the other and assuming a closer relationship than normal. When the other pulls away or otherwise disappoints, the borderline individual can suddenly switch to demonizing him or her.

Individuals with BPD frequently show labile emotions, changing from relative calm to intense anger or dysphoria in response to very subtle cues from others, which tends to further exacerbate interpersonal problems. In addition, they frequently report chronic feelings of emptiness, diffuse anxiety, and irritability.

Behaviorally, those with BPD are frequently suicidal and prone to self-injury. While the rate of completed suicide is high in this population—around 10%—these behaviors frequently serve to regulate their chaotic emotions, communicate their feelings to others, and keep others from leaving them. Other behavioral symptoms of BPD include angry, hostile outbursts and impulsivity (e.g., reckless behavior, binge eating, or substance use), and transient psychotic symptoms.

Histrionic Personality Disorder

The *DSM-IV-TR* notes that the emotional expression of individuals with histrionic PD (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.

Narcissistic Personality Disorder

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

A person with NPD usually requires constant attention and admiration, and may become furious with others who do not shower them with compliments or accolades. They typically have fragile self-esteem, so their self-importance might alternate with feelings of unworthiness. They frequently either experience feelings of envy of other people, or imagine that others are envious of them. The sense of entitlement that is central to NPD often precludes the recognition of

others' abilities, needs, feelings, or concerns. Individuals with this disorder might discuss their own problems or concerns in lengthy detail, yet react with insensitivity or impatience to the problems of others. To others, these individuals appear cold, disinterested, disdainful, snobbish, or patronizing.

Cluster C (Anxious-Fearful)

Avoidant Personality Disorder

According to *DSM-IV-TR*, persons with avoidant personality disorder (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 subtle cues that suggest criticism or rejection and typically feel extremely hurt when they detect such behavior.

Dependent Personality Disorder

According to the *DSM-IV-TR*, the central characteristic of dependent personality disorder (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 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. 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.

Obsessive-Compulsive Personality Disorder

The *DSM-IV-TR* describes obsessive-compulsive personality disorder (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, and their rigidity and stubbornness about these trivia often create difficulty for them 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. The *DSM* further notes that individuals with OCPD might be reluctant to throw away worthless and un sentimental 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.

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. Most

theories of PDs acknowledge that they are at least partially genetically determined and that temperamental and behavioral abnormalities during childhood can precede their development. These predispositions are believed to interact with environmental experience to shape personality during the early years of development. Environmental factors are believed to range in severity and influence as a function of biological predispositions and protective factors. Trauma can often be considered a predisposing factor to the development of personality disorders; however, it is not necessary nor sufficient for the development of PDs.

The evidence for a genetic contribution to the development of personality pathology, while plausible and generally accepted, is mixed. A number of studies have focused on the heritability of personality traits that theoretically relate to PDs, such as neuroticism or extraversion. Few studies have examined the heritability of specific PD diagnoses. The heritability of specific PDs has been found to vary, with schizotypal PD most strongly linked to genetic influences, antisocial PD linked to both environmental and genetic factors, and borderline and narcissistic PDs 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. Joel Paris suggested that the etiology of PDs is unlikely to be underpinned by simple, linear, narrow-causal processes; complex interactive processes among variables are likely to be involved in the etiology of PDs.

Prevalence and Comorbidity

Prevalence estimates for *DSM-IV* personality disorders vary according to the definition of personality disorder and the type of sample used. For example, Myrna M. Weissman found that pre-*DSM-III* era epidemiologic studies of PDs yielded overall rates between 6% and 10% in the general population, but the *DSM-IV* estimated prevalence rates of 10% to 20%. Similarly, community studies typically have found lower estimates of PD prevalence than does research based on clinical samples. Community studies of the prevalence of *DSM-III* or *DSM-III-R* PDs (almost all of which were conducted in the United

States, Europe, and Australia) reported overall rates between 5.9% and 22.5%.

In contrast, studies using structured diagnostic assessments have found that 20% to 40% of psychiatric outpatients and about 50% of psychiatric inpatients meet criteria for a personality disorder. Even in primary care settings, Patricia R. Casey and Peter Tyrer found that about a third of people attending general practitioners (GPs) have a personality disorder. The vast majority of patients were not presenting for personality difficulties, but presented as problematic medical patients. Cluster C PDs are the most common PDs encountered in primary care settings. The tendency of personality disorders to co-occur with other psychiatric (and physical) diagnoses likely contributes to the discrepancy between community and patient estimates.

The most frequent personality disorders in community samples are dependent, borderline, schizotypal, and obsessive-compulsive PDs, whereas the least common are schizoid and avoidant PDs. In clinical samples, however, individuals with avoidant PD can be found frequently, as can those with most other PDs. Notably, individuals with schizoid PD are not found frequently in samples, probably because of the low prevalence of schizoid PD in the community and the ego-syntonic nature of its symptoms. It is important to note that personality disorders associated with more severe impairment or with disrupted social behavior (for example, schizotypal, paranoid, or antisocial PDs) often prompt inpatient care or intensive treatment in other settings, such as substance abuse treatment facilities.

Comorbidity is high between personality disorders and Axis I disorders as well as among personality disorders themselves, a fact that is generally considered problematic for the validity of the *DSM-IV* personality disorder diagnoses. In Cluster A, up to two-thirds of patients with paranoid PD in clinical samples meet criteria for another PD, most frequently the schizotypal, narcissistic, borderline, or avoidant PD. Paranoid PD co-occurs somewhat less frequently with Axis I disorders than do other PDs. Schizoid PD is consistently comorbid with schizotypal and avoidant PDs. Schizotypal PD is frequently comorbid with eating disorders and psychotic disorders on Axis I, and with borderline, avoidant, paranoid, and schizoid PDs on Axis II. In fact, Maria Grazia Marinangeli and colleagues estimated that schizotypal PD is the most frequently co-occurring PD, as it was significantly comorbid with all PDs except for avoidant and dependent in their study.

Within Cluster B, antisocial PD is frequently comorbid with borderline, narcissistic, histrionic, and schizotypal PDs. On Axis I, research has demonstrated that antisocial PD has a particularly strong association with substance use disorders. Borderline PD co-occurs consistently with antisocial PD; Marinangeli and colleagues found five Axis II disorders to be significantly comorbid with borderline PD. On Axis I, borderline PD frequently occurs alongside mood disorders and panic disorder. Histrionic PD is consistently comorbid with borderline and narcissistic PDs. Some studies have also found histrionic PD to co-occur substantially with antisocial and dependent PDs.

Cluster C disorders also show extensive patterns of comorbidity. Avoidant PD is often comorbid with dependent PD on Axis II, and with mood, anxiety, and eating disorders on Axis I. Dependent PD is substantially comorbid with mood, anxiety, and psychotic disorders on Axis I, and with borderline and avoidant PDs on Axis II. Dependent PD is also frequently comorbid with paranoid PD and obsessive-compulsive PD. The results of studies on the comorbidity of obsessive-compulsive PD (OCPD) with other disorders are inconsistent. The majority of patients with obsessive-compulsive disorder (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.

Course and Prognosis

PDs are thought to have an onset in late adolescence or early adulthood and are assumed to persist throughout the life span, although there is a relative paucity of empirical evidence to support these notions. Recent research suggests that personality can change significantly over time, and PDs might not be as temporally stable as once thought. However, research also indicates that different PDs have different levels of stability across the life span.

Generally, research has demonstrated that people with Cluster A disorders do not typically improve significantly over time; however, some treatment gains have been documented for persons with schizotypal PD. There is evidence that many patients with antisocial and borderline PDs recover as they grow older, although they typically continue to experience severe interpersonal dysfunction and other forms of

psychopathology. Narcissistic PD may also remit with age. Research has generally shown, however, that individuals with Cluster C disorders do not tend to recover as they age.

Treatment Implications

Although patients with PDs are notoriously difficult to treat, a meta-analysis conducted by J. Christopher Perry and his colleagues suggested that psychotherapy is an effective treatment for PDs. Psychotherapy is associated with a rate of recovery that is seven times faster than the recovery rate typically observed when psychotherapy is not received. In general, longer treatments yielded greater effect sizes. Effect sizes in a meta-analysis indicate the overall strength of an effect. For example, an effect size of 0.8 would be considered large. Another recent meta-analysis by Falk Leichsenring and Eric Leibing 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 cognitive-behavioral therapy, in which the corresponding effect sizes were 1.00, 1.20, and 0.87, respectively. However, such 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.

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, usually excluding 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.

There are a number of controlled studies for avoidant PD. 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. Several studies have examined particular treatments for Cluster C PDs with mixed results. The majority of psychotherapy outcome research for PDs has focused on borderline PD. A number of therapies

have received empirical support, including psychoanalytically oriented partial hospitalization, cognitive therapy, and dialectical behavior therapy.

There is strong evidence that the presence of PDs negatively affects the outcome of treatment for various Axis I disorders, such as major depression, anxiety, posttraumatic stress disorder, eating disorders, substance use disorders, and bipolar disorder. 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.

PDs are highly prevalent, extensively comorbid with other psychiatric disorders, and difficult to treat. Although there are studies supporting the treatment efficacy for specific PDs, such as borderline PD and avoidant PD, many studies are difficult to interpret because they studied samples with mixed PDs. At present, the most conclusive evidence exists for cognitive-behavioral and psychodynamic treatments for borderline PD, 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. Little, however, is known about the specific mechanisms of action in these treatments. Anthony Bateman and Peter Fonagy have suggested 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.

*Kenneth N. Levy, William D. Ellison,
and Lori N. Scott*

See also Cognitive-Behavioral Therapy (v2); *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (v2); Dialectical Behavior Therapy (v2); Psychoanalysis and Psychodynamic Approaches to Therapy (v2); Psychopathology, Assessment of (v2)

Further Readings

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text rev.). Washington, DC: Author.
- Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry*, *156*, 1563–1569.
- Girolamo, G. de, & Reich, J. H. (1993). *Personality disorders: Epidemiology of mental disorders and psychosocial problems*. Geneva: World Health Organization.
- 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.
- Gunderson, J. G., Weinberg, I., Daversa, M. T., Kueppenbender, K. D., Zanarini, M. C., Shea, M. T., et al. (2006). Descriptive and longitudinal observations on the relationship of borderline personality disorder and bipolar disorder. *American Journal of Psychiatry*, *163*, 1173–1178.
- 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.
- Levy, K. N., Kelly, K. M., Meehan, K. B., Reynoso, J. S., Weber, M., Clarkin, J. F., et al. (2006). Change in attachment patterns and reflective function in a randomized control trial of Transference Focused Psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, *74*, 1027–1040.
- Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, *63*, 757–766.
- Nigg, J., & Goldsmith, H. (1994). Genetics of personality disorders: Perspectives from personality and psychopathology research. *Psychological Bulletin*, *115*, 346–380.
- 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*, 571–578.
- Paris, J. (2003). Personality disorders over time: Precursors, course, and outcome. *Journal of Personality Disorders*, *17*, 479–488.
- Perry, J. C., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy for personality disorders. *American Journal of Psychiatry*, *156*, 1312–1321.

- 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*, *169*, 2036–2041.
- Westen, D., & Shedler, J. (1999). 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.
- Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of *DSM-IV* personality disorders in psychiatric outpatients. *American Journal of Psychiatry*, *162*, 1911–1918.

PERSONALITY THEORIES

Personality theories attempt to identify personal characteristics people share and to determine the factors that produce their unique expression by any given person. Sigmund Freud developed the first theory of personality, *psychoanalysis*, from his profound insight that emerged in the early 1890s as he treated patients with neurotic disorders: forces that exist in the unconscious determine human behavior. Over the next 40 years he formulated the most influential personality theory in the 20th century. Freud argued that people's behavior reflects the outcome of a lifelong struggle in which repressed unacceptable sexual and aggressive instincts in the id are redirected toward acceptable expression by the forces of reason in the ego and of conscience in the superego. These instincts sustain the self throughout life, at the cost, however, of directing aggression toward others.

Freud's ideas attracted numerous young European intellectuals in the early 20th century, the most prominent being Carl Jung and Alfred Adler. Both departed from his orthodoxy to develop their own theories, *analytical psychology* and *individual psychology*, respectively. Jung partitioned the psyche, as he called the mind, into the conscious ego, the personal unconscious, and the collective unconscious. He posited that inherent in each person is a lifelong process of individuation during which differentiation from others and a balancing of the opposing forces of the psyche (e.g., rationality/irrationality, masculinity/femininity) are sought. If attained, an integrated self emerges.

Adler reasoned that each individual struggles throughout life to overcome feelings of inferiority that

arise during the first few years of life as the child, helpless and completely dependent, compares itself to its more capable caretakers. The child responds to these feelings unconsciously by striving for superiority (personal competence), formulating rudimentary life goals that give this striving a focus, and structuring a style of life to attain these goals.

The ego, according to Freud, has no independent functions. It acts only as a mediator to satisfy the instinctual demands of the id. Freud's daughter, Anna, and Margaret Mahler expanded the concept of the ego in the mid-20th century to include functions that guide the person's competence in mastering life's demands, particularly those related to social interactions. Their work focused on the study and treatment of children and gave rise to *psychoanalytic ego psychology*.

Erik Erikson elaborated this concept further in the second half of the 20th century. He postulated that ego development is bound closely to changing social institutions and values. Central to his theory is the development of ego identity, a process that begins in adolescence and continues throughout life. Erikson reasoned that ego development occurs via a series of genetically predetermined stages (critical periods). During each stage specific developmental crises of increasing social complexity are faced. Society ensures that the process unfolds in the proper order and at the proper pace.

Object relations theorists elaborated the concept of the ego and transformed core psychoanalytic concepts. Prominent among these theorists were Melanie Klein, David W. Winnicott, and Heinz Kohut. They emphasized the enduring influence of interpersonal relations on a person's unconscious processes and the impact of these relations on the development of a person's inner world, especially on the infant's interpersonal strivings for safety, love, empathy, admiration, and trust. Harry Stack Sullivan, an *interpersonal theorist*, viewed the mother's relationship with the infant as crucial to the child's developing self system. Karen Horney, a *social psychoanalytic theorist*, emphasized the critical influence of the parents on the developing child's self-images and tendencies to move away from, toward, or against others.

From the 1930s to the 1950s, John Dollard and Neal E. Miller transformed Freud's psychoanalytic concepts into the language of stimulus-response psychology. Their work, *psychodynamic social learning theory*, produced the *frustration-aggression hypothesis*, a testable behavioral hypothesis of Freud's aggression