Personality Disorders

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In 1980, the American Psychiatric Association (APA) published the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–III; APA, 1980), introducing a multi-axial classification system. Axis II of this new manual was devoted primarily to personality dysfunction, because of the considerable prevalence of maladaptive personality traits in general clinical practice and the substantial impact of these traits on the course and treatment of other mental disorders (Frances, 1980).

In this chapter, we begin by discussing issues in the diagnosis of personality disorders as defined by DSM–IV-TR (APA, 2000). We also include an alternative model for the diagnosis and classification of maladaptive personality functioning, the five-factor model (FFM; Costa & McCrae, 1992). DSM–IV-TR includes ten individual personality disorders, organized into three clusters: (a) paranoid, schizoid, and schizotypal (the odd–eccentric cluster); (b) antisocial, borderline, histrionic, and narcissistic (dramatic–emotional–erratic cluster); and (c) avoidant, dependent, and obsessive–compulsive (anxious–fearful cluster) (APA, 2000). We present what is currently known about five of the more heavily researched personality disorders (i.e., antisocial, borderline, avoidant, schizoid, and dependent) and indicate how the FFM conceptualization of each of them extends our understanding of their diagnosis, epidemiology, etiology, and pathology. Space limitations prohibit detailed coverage of all of the DSM–IV-TR personality disorders, but information concerning these additional personality disorders is provided in the general discussion.

PERSONALITY DISORDER

Virtually all adults with psychological problems have a characteristic manner of thinking, feeling, behaving, and relating to others that was present before the onset of an Axis I disorder, and, for many of these persons, these personality traits are so maladaptive that they constitute a personality disorder. A personality disorder is defined in DSM–IV-TR as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the
individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (APA, 2000, p. 686).

The prevalence of personality disorders within clinical settings is estimated to be above 50% (Mattia & Zimmerman, 2001). Perhaps 60% of inpatients within some clinical settings are diagnosed with borderline personality disorder (APA, 2000; Gunderson, 2001). Antisocial personality disorder may be diagnosed in up to 30% of inmates within a correctional setting (Wediger & Corbitt, 1995). The course and treatment of most other disorders is substantially altered by the presence of a comorbid personality disorder (Dolan-Sewell, Krueger, & Shea, 2001), yet the prevalence of personality disorder is generally underestimated in clinical practice (Zimmerman & Mattia, 1999). This situation may be due to a lack of time to provide systematic or comprehensive evaluations of personality functioning (Wediger & Coker, 2001), or perhaps to a reluctance to diagnose them because insurance companies may consider personality disorders untreatable (Zimmerman & Mattia, 1999).

It is estimated that 10% to 15% of the general population would meet criteria for one of the ten DSM-IV personality disorders (Mattia & Zimmerman, 2001; Torgesen, Kringle, & Cramer, 2001). Table 10.1 provides prevalence data reported by the best available studies to date for estimating the prevalence of individual personality disorders within the community. These prevalence estimates are generally close to those provided in DSM-IV-TR, although there is variation across studies due to differences in setting and assessment instruments.

A common misconception concerning personality disorders is that they are untreatable. This is not the case. Personality dysfunction can be the focus of treatment (Beck et al., 1990; Gabbard, 1994; Markovitz, 2001). Personality disorders are among the most difficult disorders to treat, however, because they involve well-established behaviors that may be integral to a client’s self-image (Stone, 1993). Nevertheless, psychosocial and pharmalogic treatments can produce clinically and socially meaningful changes, (Perry, Banon, & Ianni, 1999; Sanislow & McLaughlan, 1998), although the development of an ideal or fully healthy personality structure is unlikely. Given the considerable social, public health, and personal costs associated with some of the personality disorders, such as antisocial and borderline, even small improvements in functioning and reductions in symptomatology can be important.

There is considerable personality disorder diagnostic comorbidity (Bornstein, 1998; Lilienfeld, Waldman, & Israel, 1994; Oldham et al., 1992; Wediger & Trull, 1998). Patients who are diagnosed with one personality disorder are likely to meet the diagnostic criteria for at least one other personality disorder. Table 10.2 provides DSM-III-R (APA, 1987) co-occurrence statistics, obtained for the development of DSM-IV. Diagnostic co-occurrence is so common and so extensive that most personality disorder researchers believe that a dimensional description provides a clearer and more accurate picture of personality dysfunction (Cloninger, 2000; Livesley, 1998; Oldham & Skodol, 2000; Wediger, 2000).

One approach has been to apply a broader dimensional model of general personality functioning to the study of personality disorders. Five broad domains of personality functioning have been identified empirically through the study of the languages of a number of different cultures (de Raad, di Blas, & Perugini, 1999; John & Srivastava, 1999). Language can be understood as a sedimentary deposit of the observations of persons over the thousands of years of the language’s development and transformation. The most important domains of personality functioning are those with the greatest number of terms to describe and differentiate their various manifestations and nuances, and the structure of personality is evident in the empirical relationship among the trait terms (Goldberg, 1993). Such lexical analyses of languages have typically identified five fundamental dimensions of personality: neuroticism (or negative affectivity) versus emotional stability, introversion versus extraversion, conscientiousness (constraint) versus undependability, antagonism versus agreeableness, and closedness versus
### TABLE 10.1

**Epidemiology of Personality Disorders**

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<tr>
<th>Sample</th>
<th>N</th>
<th>Int</th>
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<th>SZD</th>
<th>STP</th>
<th>ATS</th>
<th>BDL</th>
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*Note: N = number of persons in study; Int = interview that was used; Edition of Diagnostic and Statistical Manual that was used (DSM-III or DSM-III-R); PRN = paranoid; SZD = schizoid; STP = schizotypal; ATS = antisocial; BDL = borderline; HST = histrionic; NCS = narcissistic; AVD = avoidant; DPD = dependent; OCP = obsessive-compulsive; R-HN = relatives of hypnormal (persons without history of mental disorder); R-SCID = relatives of persons with obsessive-compulsive anxiety disorder; Men(47) = males of approximate age of 47; R-DP = relatives of persons with depression; Stdts = students; Comm = community; IPDE = International Personality Disorder Examination; SIDP = Structured Interview for Personality Disorder (Plofch et al., 1997); SCID-II = Structured Clinical Interview for DSM personality disorder (First et al., 1997); Clinical = unstructured or unspecified semi-structured interview; uncommon = uncommon.*
### TABLE 10.2

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**Note:** Sites used DSM-III-R criterion sets. Data obtained for purposes of informing the development of the DSM-IV personality disorder diagnostic criteria (Widiger & Trull, 1998). Read table as follows: 8% of persons diagnosed with paranoid personality disorder met DSM-III-R criteria for schizoid; 38% of persons diagnosed with schizoid personality disorder met DSM-III-R criteria for paranoid.

openness to experience (Costa & McCrae, 1992). Each of these five broad domains can be differentiated further in terms of underlying facets. For example, the facets of antagonism versus agreeableness include suspiciousness versus trusting gullibility, callous tough-mindedness versus tender-mindedness, confidence and arrogance versus modesty and meekness, exploitation versus altruism and sacrifice, oppositionalism and aggression versus compliance, and deception and manipulation versus straightforwardness and honesty (Costa & McCrae, 1992).

Each of the DSM-IV personality disorders can be readily understood as maladaptive and extreme variants of these personality dimensions that are present in all persons to differing degrees (Widiger, Trull, Clarkin, Sanderson, & Costa, 1994/2002). Table 10.3 provides two descriptions of the DSM-IV-TR personality disorders in terms of this five-factor model. Widiger et al. (1994/2002) used the DSM-IV diagnostic criteria sets to develop their hypothetical FFM profiles. Lynam and Widiger (2001) obtained FFM ratings of prototypic cases by researchers of each personality disorder. From the perspective of DSM-IV-TR, paranoid personality disorder (PPD) is comprised of high angry hostility and low levels of trust, straightforwardness, compliance, and modesty. Researchers describe PPD similarly, but also add low levels of warmth, gregariousness, openness to actions, openness to values, altruism, and tender-mindedness.

The divergence between the DSM-IV-TR and researcher FFM descriptions is particularly evident for the histrionic and obsessive-compulsive personality disorders. The researchers rated individuals with obsessive-compulsive personality dysfunction as being extremely low in impulsiveness and excitement seeking, two aspects that are not included in DSM-IV-TR criteria. They also rated individuals with histrionic personality dysfunction as very low in self-consciousness and high in impulsivity, aspects also not included in DSM-IV-TR. Lynam and Widiger (2001) concluded that the expert consensus FFM profiles may provide a more complete description than is provided by DSM-IV-TR.

### FIVE PERSONALITY DISORDERS AND THEIR FIVE-FACTOR FORMULATIONS

We now turn our attention to five DSM-IV-TR personality disorders: antisocial, schizoid, borderline, avoidant, and dependent. We describe for each of them what is known about their
10. PERSONALITY DISORDERS

### TABLE 10.3

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<th>Personality Disorder</th>
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<th>SZT</th>
<th>ATS</th>
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Antisocial Personality Disorder

**Definition.** DSM-IV-TR defines antisocial personality disorder (ASPD) as a pervasive pattern of disregard for and violation of the rights of others (APA, 2000). This disorder has also been referred to as psychopathy (Hare et al., 1991), sociopathy, or dissocial (World Health...
personality disorder. Its primary diagnostic criteria include criminal activity, deceitfulness, impulsivity, aggression, reckless irresponsibility, and indifference to the mistreatment of others.

**Etiology and Pathology.** Twin, family, and adoption studies have provided substantial support for a genetic contribution to the etiology of the criminal, delinquent tendencies of persons meeting criteria for ASPD (Nigg & Goldsmith, 1994; Stoff, Breiling, & Maier, 1997). Exactly what is inherited in ASPD, however, is not known; it could be impulsivity, antagonistic callousness, or abnormally low anxiousness.

One influential theory for the etiology of ASPD is that it results from abnormally low levels of behavioral inhibition and high levels of behavioral activation systems that are important for normal, adaptive functioning (Fowles, 2001; Widiger & Lynam, 1998). The behavioral inhibition system (BIS) is said to inhibit behavior in response to punishment, in opposition to a behavioral activation system (BAS) that activates behavior in response to reward. The observed symptoms of ASPD could be evidence of a malfunctioning BIS acting in concert with a normal or strong BAS. In this manner, normal sensitivity and anxiety in response to threatening and stressful situations may be reduced or altogether absent. Low arousal would also help minimize feelings of guilt or remorse and increase resistance to aversive conditioning. An electrodermal response hyporeactivity in psychopaths may be particularly associated with a deficit in anticipatory anxiety and worrying, though the alarm reactions of flight versus fight are intact (Fowles, 2001; Stoff et al., 1997).

Substantial research also supports the contributions of environmental factors such as modeling by family members and peers (Stoff et al., 1997), though no one environmental factor appears to be specific to its development. Excessively harsh or erratic discipline, and an environment in which feelings of empathy are discouraged (if not punished) and tough-mindedness, aggressiveness, and exploitation are encouraged (if not reinforced), have each been associated with the development of ASPD (Sutker & Allain, 2001). It is possible that persons with ASPD may have had any feelings of anxiety, guilt, and remorse extinguished through progressive, cumulative experiences of harsh aggression, abuse, and exploitation.

Some distress-proneness (FFM anxiousness or neuroticism) and attentional self-regulation (FFM constraint or conscientiousness) may be necessary to develop an adequate sense of guilt or conscience. Normal levels of neuroticism promote the internalization of a conscience by associating wrongdoing or misbehavior with distress and anxiety, and the temperament of self-regulation helps modulate impulses into socially acceptable channels (e.g., counting to 100 when angry) (Clark, Kochanska, & Ready, 2000; Fowles & Kochanska, 2000; Kochanska & Murray, 2000; Rothbart & Ahadi, 1994). High levels of arousal at age 15 have been shown to serve as a protective factor against criminal activities at age 30 in persons at high risk for becoming criminals (Raine, Lencz, & Mednick, 1995; Raine, Reynolds, Venables, Mednick, & Farrington, 1998). Additional factors, such as high intelligence, may also help to avoid the development of ASPD by offering the possibility of alternative life paths. In sum, ASPD appears to be the result of a constellation of factors, including genetic predisposition, experiences within the family environment, and sociological factors, coupled with a lack of preventive factors (Stoff et al., 1997; Sutker & Allain, 2001).

**Differential Diagnosis.** The predominant instrument for the assessment of the antisocial/psychopathic personality disorder is the Psychopathy Checklist–Revised (PCL–R; Hare, 1991). The PCL–R assesses a few additional psychopathic personality traits such as glibness, superficial charm, callousness, and arrogance, beyond the criminal, exploitative, remorseless, and irresponsible behaviors that define DSM–IV antisocial personality.
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At times, ASPD is difficult to differentiate from a substance-dependence disorder because many persons with ASPD develop a substance-related disorder, and many persons with substance dependence engage in antisocial acts. However, the requirement that conduct disorder be present before the age of 15 usually ensures the onset of ASPD before the onset of a substance-related disorder. If both were evident before the age of 15, then it is likely that both disorders are now present and both diagnoses should be given. Often, ASPD and substance dependence interact, exacerbating each other's development (Myers, Stewart, & Brown, 1998; Sher & Trull, 1994; Stoff et al., 1997; Sutker & Allain, 2001).

Epidemiology and Comorbidity. The National Institute of Mental Health Epidemiologic Catchment Area (ECA) study estimated that 3% of males and 1% of females meet DSM criteria for ASPD (Robins, Tipp, & Przybeck, 1991). Subsequent studies have replicated this rate, but it has also been suggested that the ECA finding may have underestimated the prevalence in males, because of failure to consider the full range of ASPD features. Other estimates have been as high as 6% in males (Kessler et al., 1994; Robins et al., 1991). Within prison and forensic settings, the rate of ASPD has been estimated to be 50% (Hare, Hart, & Harpur, 1991; Robins et al., 1991). However, the ASPD criteria may inflate the prevalence within such settings because of the emphasis on overt acts of criminality, delinquency, and irresponsibility (Sutker & Allain, 2001; Widiger et al., 1996). More specific criteria for psychopathy provided by the PCL-R obtain a more conservative estimate of 20% to 30% of male prisoners meeting criteria for ASPD (Hare et al., 1991), by placing relatively less emphasis on the history of criminal behavior and more emphasis on personality traits associated with this criminal history (e.g., callousness and arrogance).

ASPD is much more common in men than in women (Corbitt & Widiger, 1995; Robins et al., 1991). A sociobiological explanation for the differential sex prevalence is the presence of a genetic advantage for social irresponsibility, infidelity, superficial charm, and deceit in males that contributes to a higher likelihood of developing features of ASPD (i.e., males with these traits are more likely to have offspring than males without these traits) (Stoff et al., 1997; Sutker & Allain, 2001). ASPD and histrionic personality disorder (HPD) may also share a biogenetic disposition (possibly toward impulsivity or sensation seeking) that is mediated by gender-specific biogenetic and sociological factors toward respective gender variants (Hamburger, Lilienfeld, & Hogben, 1996; Lilienfeld & Hess, 2001). ASPD and HPD share a variety of behavioral and personality characteristics (e.g., superficial charm, shallow emotions, manipulativeness, and self-centeredness) that may be expressed as antisocial personality disorder in males and histrionic personality disorder in females.

Five-Factor Model Reformulation. Antisocial PD can be understood primarily as excessive, maladaptively low conscientiousness and low agreeableness (see Table 10.3). Specifically, these individuals would be described as aimless, unreliable, lax, negligent, and hedonistic (low in the facets of self-discipline and deliberation; Costa & McCrae, 1983), as well as manipulative, exploitative, and ruthless (low in straightforwardness, altruism, compliance, and tender-mindedness).

One issue surrounding the DSM diagnosis of ASPD has been the failure to include all of the personality traits of psychopathy identified originally by Clonkley (1941/1988), emphasizing instead those traits that could most easily be identified by objectively observed behaviors (e.g., irresponsible and/or illegal acts). Psychopathy researchers (Harpur, Hart, & Hare, 2002; Patrick et al., 1993) have argued that an emotionally detached interpersonal style is integral to the diagnosis of the disorder, that the DSM definition of ASPD fails to capture these features in the diagnostic criteria, and that these features are relevant and important to clinical treatment.
Table 10.3 illustrates the differences between the DSM-IV and PCL-R conceptualizations of this disorder. The FFM description of antisocial personality disorder by the researchers (Lynam & Widiger, 2001) includes the PCL-R components of glitl charm (abnormally low self-consciousness), arrogance (low modesty), and callous lack of empathy (tough-mindedness) that are not represented within the DSM-IV diagnostic criteria for this disorder. In fact, the researchers' FFM description also includes the absence of anxiousness that was included in the original conceptualization of this disorder by Cleckley (1941/1988) but was excluded from the PCL-R (Lilienfeld, 1994). Considerable evidence supports the FFM conceptualization of ASPD (Forth, Brown, Hart, & Hare, 1996; Hart & Hare, 1994; Lynam, 2002; Miller, Lynam, Widiger, & Leukefeld, 2001; Widiger & Lynam, 1998). These studies have shown that the FFM does provide a comprehensive and clinically valid description of the antisocial or psychopathic personality, and that the FFM conceptualization of ASPD maps well onto measures of psychopathy and ASPD.

The five-factor conceptualization of this disorder also clarifies other issues surrounding this diagnosis. PCL-R psychopathy is conceptualized as encompassing two broad factors (Hare, 1991; Harpur et al., 2002). The first factor, considered by some to represent the core of the disorder, includes items describing a callous and remorseless use of others; the second includes items describing deviant and impulsive behaviors. The two-factor structure has often been used in research, but has been criticized for the failure to offer a psychological conceptualization of the second factor and for relegating it to an undeserved secondary status (Lilienfeld, 1994; Rogers & Bagby, 1994). “This overlooks the fact that [the second factor] includes several personality dimensions, such as impulsivity, irresponsibility, and sensation-seeking” (Lynam, 2002, p. 337). A reinterpretation of the PCL-R in terms of the FFM allows the first factor to be understood as almost pure antagonism; the more confusing nature of the second factor occurs because it is a mixture of low conscientiousness with some antagonism, neuroticism, and extraversion (Lynam, 2002).

Researchers have for many years been attempting to identify the single, core pathology of psychopathy, and a variety of compelling but inconsistent models have been proposed. These alternative conceptualizations can be integrated and their inconsistencies addressed by the FFM. Their apparent inconsistency may reflect that each alternative model of pathology focuses on a different facet and at times even a different domain of the FFM. Lykken (1957), Fowles (1993), and Patrick, Bradley, and Lang (1993) have argued that the primary deficit of psychopathy lies in poor fear conditioning and electrodermal hypoarousal, a focus of research that places particular emphasis on low neuroticism (i.e., low anxiousness or low vulnerability). Others have argued that a lack of response modulation is the primary deficit, an inability to refrain from acting on first impulse (Newman, Patterson, Howland, & Nichols, 1990; Patterson & Newman, 1993), represented in the FFM domain of conscientiousness/constraint by the facet of deliberation. Cleckley (1941/1988) described the core of psychopathy as “semantic dementia,” referring to a deficit in processing affective language. This deficit can be understood in terms of the antagonism facet of tough-mindedness. It has also been argued that the primary deficit of psychopathic individuals lies in an inability or impairment in processing social information cues (Dodge, 1980; Dodge & Crick, 1990). In an FFM profile of these persons, this feature would be described as extremely high antagonism, particularly deception, aggression, and exploitation. In sum, the personality profile for the prototypic psychopath involves a constellation of personality traits that together provides a quite virulent and at times even lethal mix (i.e., high antagonism, low conscientiousness, low vulnerability, low anxiousness, high assertiveness, high gregariousness, and high excitement seeking).

An FFM conceptualization of ASPD also provides some clarity in regard to the “successful” psychopath. Systematic research has been confined largely to the study of the “unsuccessful”
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Psychopath, which typically means the incarcerated criminal (Sutker & Allain, 2001). However, there is also considerable social and theoretical interest in understanding the psychopath who is equally exploitative, callous, and ruthless, but either manages never to get arrested or convicted, or who pursues a white-collar career that only flirts with the edges of the legal system (Hare, 1993). From the perspective of the FFM, these persons would share many of the traits of the prototypic psychopath (i.e., low anxiousness, high fearlessness, high in assertiveness and gregariousness, and high in the exploitativeness and callousness of antagonism), but would be high rather than low in the facets of conscientiousness (Lynam, 2002). Such persons can be even more dangerous than most of the incarcerated psychopaths because they share the disposition to engage in behavior harmful to others, but also possess the traits (deliberation, competence, and self-discipline) that would contribute to a more “successful” outcome.

The FFM also provides an explanation of the comorbidity of ASPD. Antisocial features are commonly evident in the histrionic and borderline personality disorders, as persons with these disorders display impulsivity, excitement seeking, self-centeredness, manipulativeness, irresponsibility, and a low frustration tolerance. However, the histrionic and borderline diagnoses are not typically characterized by a cold, calculating violation of others’ rights through criminal activity (low altruism and tender-mindedness). Persons with narcissistic personality disorder are characterized by an antisocial lack of empathy and may often exploit and use others (low in altruism). In fact, many of the traits of narcissistic personality disorder are evident in psychopathy, including a lack of empathy, glib and superficial charm, and arrogant self-appraisal (low modesty) ( Widiger et al., 1996). However, prototypic narcissistic personality disorder is not characterized by being low in the agreeableness facets of compliance and straightforwardness, nor by being low in the conscientiousness facet of dutifulness.

Treatment. ASPD is considered the most difficult personality disorder to treat (Stoff et al., 1997; Stone, 1993). Individuals with ASPD may be seductively charming and declare their commitment to change, though they usually lack a motivation to change. They do not see the costs associated with antisocial acts (e.g., imprisonment and lack of meaningful interpersonal relationships), and may stay in treatment only as required by an external source, such as a parole officer. Residential programs that provide a carefully controlled environment of structure and supervision, combined with peer confrontation, have been recommended (Gabbard, 1994). However, it is unknown what benefits may be sustained after the ASPD individual leaves this environment. When in inpatient treatment, individuals with ASPD are likely to manipulate and exploit staff and fellow patients ( Gabbard, 1994). Studies have indicated that outpatient therapy is not likely to be successful, but the extent to which persons with ASPD are unresponsive to treatment may have been somewhat exaggerated. Salekin (2002) indicates that the heterogeneity of the definitions of psychopathy (e.g., Cleckley’s vs. Hare’s conceptualization or psychoanalytic vs. behavioral), as well as the polythetic nature of a diagnosis of ASPD, may be significant factors in a therapist’s assessment of the amenability to treatment of an ASPD or psychopathic client. Furthermore, several therapeutic approaches (cognitive-behavioral, psychoanalytic, and a combination of the two) have shown some success in reduction of the severity of psychopathic traits (Salekin, 2002).

Identification and intervention in early childhood is likely to be the most effective treatment for ASPD (Stoff et al., 1997). In adulthood, lengthy incarceration may be the most effective “treatment.” It is known that antisocial behaviors tend to lessen as the individual ages (Sutker & Allain, 2001). A peer may be able to develop a better rapport with an ASPD individual, because of a greater mutual sense of trust and respect. Because there is some evidence that the ability to form a therapeutic alliance is an important indicator of treatment success, factors such as demographic similarity between therapist and client and the therapist’s positive regard...
for the client should be considered before attempting treatment (Gertsley et al., 1989; Stoff et al., 1997).

Therapists of individuals with ASPD should also bear in mind that they may have considerable negative feelings toward clients with extensive histories of aggressive, exploitative, and abusive behaviors toward others. Rather than attempting to develop a sense of conscience in these individuals, therapeutic techniques should be focused on rational and utilitarian arguments against repeating past behavior. These approaches would focus on the tangible, material value of prosocial behavior (Beck et al., 1990). Some research has indicated that impulsive aggression might be treated with lithium, though its effect on other ASPD symptomatology remains to be seen (Markovitz, 2001).

Schizoid Personality Disorder

**Definition.** Schizoid personality disorder (SZPD) is defined in DSM–IV as a pervasive pattern of social detachment and restricted emotional expression (APA, 2000). Its primary diagnostic criteria include a lack of desire for close relationships, consistent preference for solitary activities, lack of interest in sexual contact with others, anhedonia, and emotional detachment.

**Etiology and Pathology.** There has been little systematic research on the etiology and pathology of schizoid personality disorder. There are theoretical speculations that it might be the result of a sustained history of modeling and reinforcement by parental figures of interpersonal withdrawal, indifference, and detachment (Bernstein & Travaglini, 1999), but no studies have been conducted to assess the validity of these theories.

Schizoid personality disorder has also been conceptualized as a subthreshold or characterologic variant of a spectrum of schizophrenic pathology. A fundamental distinction of schizophrenic symptomatology is between positive and negative symptoms. Positive symptoms include hallucinations, delusions, inappropriate affect, and loose associations; negative symptoms include flattened affect, aloxia, anhedonia, and avolition. Subthreshold variants of the positive symptoms might include the cognitive and perceptual aberrations that are relatively specific to the schizotypal personality disorder, which is conceptualized by most researchers to be a characterologic variant of schizophrenia (Miller, Useda, Trull, Burr, & Minks-Brown, 2001). Schizoid personality disorder might likewise involve subthreshold variants of the negative symptoms of schizophrenia, including flattened affectivity, anhedonia (takes pleasure in few, if any, activities), and avolition (social withdrawal and isolation). There is strong support for a genetic relationship between schizotypal personality disorder and schizophrenia, which is not surprising as its diagnostic criteria were developed on the basis of interviews with biological relatives of persons with schizophrenia (Miller, M. B., et al., 2001). However, the evidence for a genetic relationship between schizoid personality disorder and schizophrenia is not strong (Bernstein & Travaglini, 1999; Miller, M. B., et al., 2001).

**Epidemiology and Comorbidity.** Approximately half of the general population exhibits introversion within the normal range of functioning. Only a small minority of the population meets criteria for schizoid personality disorder (Mattia & Zimmerman, 2001). Estimates of the prevalence of SZPD within the general population have been less than 1% (see Table 10.2) and SZPD is among the least frequently diagnosed personality disorders within clinical settings. Many of the persons who were diagnosed with SZPD before DSM–III are probably now diagnosed with either the avoidant or the schizotypal personality disorders (Widiger, Frances, & Spitzer, 1988), and prototypic (pure) cases of SZPD are likely to be quite rare within the population.
Course. Individuals with SZPD will have been socially isolated and withdrawn as children and adolescents. They may not have been accepted well by their peers, and may have even been ostracized (APA, 2000). As adults, they will have few friendships. Those friendships that do develop are likely to have been initiated by their peers or colleagues. They will have had few sexual or intimate relationships (if any) and may never marry. The extent to which the other person desires or needs emotional support, warmth, and intimacy will likely determine the success of a relationship. Persons with SZPD may do well and even excel within an occupation, as long as substantial social interaction is not required. These individuals may eventually find employment and a relationship that is relatively comfortable, but they could also drift from one job to another and remain isolated throughout much of their life. If they become a parent, they are likely to have considerable difficulty providing warmth and emotional support, and may appear detached and disinterested.

Five-Factor Model Reformulation. Conceptualizing schizoid personality disorder as a maladaptive variant of normal introversion provides empirical support for genetic contributions to its etiology (Plomin & Caspi, 1999) and an empirically supported neuropathology (Depue, 1996). FFM extraversion versus introversion is characterized by some researchers as a domain of positive affectivity (Watson & Clark, 1997). Positive affectivity is aligned with extraversion, just as negative affectivity is aligned with neuroticism. Positive emotionality is included as one of the FFM facets of extraversion. Watson and Tellegen (1985) emphasize the positive emotional component of extraversion, as they hypothesize that it provides the motivating force of extraverted behavior. Depue (1996) and his colleagues have conducted considerable research to support the hypothesis that the BAS (or what he refers to as the behavioral facilitation system) is a fundamental domain of personality functioning governed by dopaminergic activity within the mesolimbic system. The BAS may provide the general motivation or incentive to engage in goal-directed behavior and the physical and mental energy, self-confidence, and optimism to sustain necessary expectations for eventual successful outcomes (Depue, 1996; Rothbart & Ahadi, 1994). There are considerable individual differences in the level of activity along the pathways of the behavioral activation system, providing the neurological substrate for the broad personality domain of extraversion versus introversion (Watson & Clark, 1997). Persons at the lowest levels will experience little pleasure in activities (i.e., experience anhedonia), will be indifferent to the praise of others, will be socially withdrawn and inactive, will lack close friends, will show an emotional coltines, detachment, and flattened affectivity, and will likely be diagnosed as having schizoid personality disorder.

Considerable research supports the use of the FFM to describe schizoid personality disorder (Clark & Livesley, 1994; Costa & McCrae, 1990; Dyce & O’Connor, 1998; Lynham & Widiger, 2001; Sellz, Budman, Demby, & Merry, 1993; Trull et al., 1998; Widiger & Costa, 2002; Wiggins & Pincus, 1989). Most studies have found that low scores on the domain of extraversion are associated with and characteristic of schizoid personality dysfunction.

A five-factor formulation of schizoid personality disorder can provide clinicians with information necessary for differential diagnosis of the disorder. SZPD can be confused with the schizotypal and avoidant personality disorders, as both involve social isolation and withdrawal (Kalous, Bernstein, & Siever, 1993). Schizotypal personality disorder, however, includes cognitive-perceptual aberrations and could be best described by the facets of high anxiousness, high openness to fantasy, and high self-consciousness. The major distinction with avoidant personality disorder is the absence of an intense desire for intimate social relationships. Avoidant persons can also be described as high in anxiousness and self-consciousness, whereas the schizoid person is largely indifferent to the reactions or opinions of others.
Treatment. It is rare for prototypic cases of SZPD to enter treatment, whether for their schizoid traits or an Axis I disorder. Their lack of social interaction is likely to be more worrisome to relatives or colleagues than it is to themselves, and their lack of interest in interpersonal contact will often prevent treatment entry. If a person with schizoid personality disorder presents for treatment of an Axis I disorder (substance dependence, for example), an effective therapist will likely provide treatment in a businesslike (versus interpersonally engaging) style (Stone, 1993). An approach that includes education and feedback concerning others’ perceptions of them is likely to be acceptable to those with SZPD. In this respect, group therapy may be useful for these individuals, though the group may need to be especially patient with and accepting of schizoid detachment and flat affect.

Borderline Personality Disorder

Definition. Borderline personality disorder (BPD) is a pervasive pattern of impulsivity and instability in interpersonal relationships and self-image (APA, 2000). Its primary diagnostic criteria include extreme efforts to avoid abandonment; instability in relationships, affect, and identity; and reckless impulsivity.

Etiology and Pathology. There are studies supportive of BPD as a disorder with a genetic disposition that cannot be accounted for by other comorbid disorders. Many studies have also suggested a genetic history comorbid with mood and impulse control disorders (Silk, 2000; Torgesen, 2000). There is also substantial empirical support for a childhood history of physical and/or sexual abuse, parental conflict, loss, and neglect (Johnson, Cohen, Brown, Smalies, & Bernstein, 1999; Zanarini, 2000). Past traumatic events are present in many (if not most) cases of BPD, contributing to the comorbidity with posttraumatic stress and dissociative disorders (Brodsky, Cloitre, & Dutil, 1995; Gunderson, 2001; Hefferman & Cloitre, 2000), but the nature of these events and the age at which they occurred appear to vary. BPD may involve the interaction of a genetic disposition toward an emotionally unstable temperament with a cumulative and evolving series of intensely pathogenic relationships (Gunderson, 2001; Morey & Zanarini, 2000).

The pathogenic mechanisms of BPD are addressed in numerous theories. Most concern issues regarding abandonment, separation, and/or exploitative abuse; thus, “frantic efforts to avoid abandonment” is the first item in the DSM–IV–TR diagnostic criterion set (Gunderson, Zanarini, & Kischel, 1991; Mattia & Zimmerman, 2001). Intense, disturbed, and/or abusive relationships with the significant persons of their past will have been a constant in the life of persons with BPD (Gunderson, 2001). Therefore, the development of malevolent perceptions and expectations of others (Ornduff, 2000) is not surprising. These expectations, along with an impairment in the ability to regulate affect (Linehan, 1993), may contribute to the perpetuation of intense, hostile, and unstable relationships. Neurochemical dysregulation is evident in individuals with BPD, but whether this dysregulation is a result, cause, or correlate of prior interpersonal traumas (Gunderson, 2001; Silk, 2000) remains unclear.

Differential Diagnosis. Zanarini, Gunderson, Frankenburg, and Chauncey (1989) developed a semistructured interview for the assessment of borderline personality disorder, the Diagnostic Interview for Borderlines–Revised (DIB–R). The DIB–R provides a thorough evaluation of the components of borderline personality, covering the affective dysregulation and perceptual aberrations of the disorder that might not be assessed as well in more general personality disorder interviews (Widiger & Coker, 2001).
Most persons with BPD develop mood disorders (Links, Heslegrave, & van Reekum, 1998), and it can be difficult to differentiate BPD from a mood disorder if the assessment is confined to the current symptomatology (Gunderson, 2001; Widiger & Coker, 2001). The diagnostic criteria of BPD require that the borderline symptomatology be evident since adolescence, which should differentiate BPD from a mood disorder in all cases other than a chronic mood disorder. If a chronic mood disorder is present, then the additional features of transient, stress-related paranoid ideation, dissociative experiences, impulsivity, and anger dyscontrol that are evident in BPD should be emphasized in the diagnosis (Gunderson, 2001).

**Epidemiology and Comorbidity.** It is estimated that 1% to 2% of the general population would meet the DSM-IV criteria for BPD (see Table 10.1). BPD is the most prevalent personality disorder within most clinical settings (although perhaps not the most prevalent in community settings; see Table 10.1). Approximately 15% of all inpatients (51% of inpatients with a personality disorder) and 8% of all outpatients (27% of outpatients with a personality disorder) will meet criteria for borderline personality disorder. Approximately 75% of persons with BPD will be female (Corbitt & Widiger, 1995; Gunderson, 2001). Persons with BPD will meet DSM-IV-TR criteria for at least one Axis I disorder, ranging from mood (major depressive disorder), anxiety (posttraumatic stress disorder), eating (bulimia nervosa), and substance (alcohol dependence) disorders to dissociative (dissociative identity disorder) or psychotic (brief psychotic) disorders (Gunderson, 2001; Links et al., 1998; Zanarini et al., 1998a).

**Course.** Individuals with BPD are likely to have been emotionally unstable, impulsive, and hostile as children. As adolescents, their intense affectivity and impulsivity may contribute to involvement with rebellious groups, along with a variety of Axis I disorders, including eating disorders, substance abuse, and mood disorders. BPD is often diagnosed in children and adolescents. However, considerable caution should be used when diagnosing, as some of the symptoms of BPD (e.g., identity disturbance, hostility, and unstable relationships) could be confused with a normal adolescent rebellion or identity crisis (Ad-Dab’bagh & Greenfield, 2001; Gunderson, 2001).

As adults, persons with BPD may be repeatedly hospitalized, because of their affect and impulse dyscontrol, psychotic-like and dissociative symptomatology, and risk of suicide and suicide attempts (Gunderson, 2001; Zanarini et al., 1998a). These individuals are at a high risk for developing depressive, substance-related, bulimic, and posttraumatic stress disorders. The risk of suicide is increased with a comorbid mood disorder and substance-related disorder. It is estimated that 5% to 10% of persons with BPD will have committed suicide by the age of 30 (Gunderson, 2001). Intimate relationships tend to be very unstable and explosive, and employment history is generally poor (Daley, Burge, & Hammann, 2000; Stone, 2001). As the person reaches the age of 30, affective liability and impulsivity may begin to diminish. These symptoms may lessen earlier if the person becomes involved with a supportive and patient sexual partner (Stone, 2001). Some, however, may obtain stability by abandoning the effort to obtain a relationship, opting instead for a lonelier but less volatile life. Occurrence of a severe stressor, however, can easily disrupt the lessening of symptomatology, resulting in a brief psychotic, dissociative, or mood disorder episode.

**Five-Factor Model Reformulation.** Borderline PD is primarily composed of excessively high neuroticism. In particular, these individuals are at the very highest range of anxiousness, angry hostility, depressivelessness, impulsiveness, and vulnerability. Borderline clients will also likely be low in the agreeableness facets of trust and compliance and low on the conscientiousness facet of competence.
Table 10.4 provides 22 correlations between the domains of the FFM and BPD symptomatology reported across 13 studies. The median correlations are .47 (neuroticism), .00 (extraversion), .00 (openness), .26 (agenticity), and -.21 (conscientiousness), consistent with the expectations (Lynam & Widiger, 2001; Widiger et al., 1994/2002). A median correlation of only .47 with neuroticism might appear to be lower than what should be obtained. However, it is useful to compare this correlation with the convergent validity of alternative measures of borderline personality disorder. Widiger and Coker (2001) reported a median convergent validity coefficient for borderline personality disorder of .53 across forty-five studies. In other words, FFM neuroticism is correlated with borderline personality disorder symptomatology almost as high as any two measures of borderline symptomatology are correlated with one another.

Two studies have focused specifically on the FFM conceptualization of borderline personality disorder. Clarkin, Hull, Cantor, and Sanderson (1993) explored empirically the FFM conceptualization of BPD in a sample of sixty-two female inpatients with BPD diagnoses provided by clinicians at Cornell University Medical Center using the Structured Clinical Interview for DSM personality disorder (SCID–II), a semistructured interview for the assessment of personality disorders (First, Spitzer, Gibbon, & Williams, 1995). Despite the restrictions in range on borderline symptomatology within this sample (i.e., all participants met criteria for BPD), Clarkin et al. confirmed a close correspondence between the facets of the five-factor model and borderline symptomatology. The findings of Clarkin et al. (1993) were subsequently replicated by Wilberg, Urnes, Priis, Pederson, and Karterud (1999). Wilberg et al. administered the Revised NEO Personality Inventory (NEO–PI–R; Costa & McCrae, 1992) to a sample of sixty-three persons participating in a day hospital group psychotherapy program for poorly functioning outpatients with personality disorders. Wilberg et al. obtained assessments of the diagnostic criteria for BPD after the 18-week treatment ended, based in part on data obtained from an administration of the SCID–II at the time of admission, as well as the impressions of the clinicians during the course of treatment. Wilberg et al. (1999) confirmed the predicted relations with neuroticism, as well as low conscientiousness, low trust, and low straightforwardness.

The FFM conceptualization of BPD is helpful in explaining its substantial prevalence and diagnostic comorbidity. Persons with BPD are likely to meet DSM–IV criteria for at least one other personality disorder, particularly histrionic, dependent, antisocial, schizotypal, and passive-aggressive (see Table 10.3; Links et al., 1998; Zanarini et al., 1998b). Researchers and clinicians have at times responded to this extensive co-occurrence by imposing a diagnostic hierarchy whereby other disorders are not diagnosed in the presence of BPD because BPD is generally the most severely dysfunctional personality disorder (Gunderson et al., 2000). A potential limitation of this approach is that it “resolves” the complexity of personality by largely ignoring it. This approach fails to recognize the presence of maladaptive personality traits that could be important for understanding a patient’s dysfunctions and for developing an optimal treatment plan (Zimmerman & Mattia, 1999). Neuroticism, as a characteristic level of emotional instability (i.e., vulnerability to stress, impulse dyscontrol, anxiousness, depressiveness, and other components of negative affectivity) is almost ubiquitous within clinical populations. A diagnostic category defined primarily by and including essentially all of the facets of neuroticism should be highly prevalent within clinical settings. In addition, all of the other DSM–IV–TR personality disorders include at least some components of neuroticism, and the variants in symptomatology accounted for by neuroticism explain much of the comorbidity of BPD with other personality disorders (Lynam & Widiger, 2001).

The five-factor model can also help shed light on the controversy over the pathology and etiology of borderline personality disorder. Zanarini (2000) has argued that the central
TABLE 10.4
Correlations of Borderline Personality Disorder With Domains of the FFM

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample</th>
<th>Measures</th>
<th>BPD</th>
<th>FFM</th>
<th>N</th>
<th>E</th>
<th>O</th>
<th>A</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wiggins &amp; Pincus (1989)</td>
<td>550 stdts</td>
<td>MMPI, NEOPI</td>
<td>.66***</td>
<td>.00</td>
<td>.13**</td>
<td>-.21***</td>
<td>-.20***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costa &amp; McCrac (1990)</td>
<td>274 comm</td>
<td>MMPI, NEOPI</td>
<td>.47***</td>
<td>.19**</td>
<td>.09</td>
<td>-.21***</td>
<td>-.32***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costa &amp; McCrac (1990)</td>
<td>207 comm</td>
<td>MCMII, NEOPI</td>
<td>.52***</td>
<td>-.22***</td>
<td>-.10</td>
<td>.14*</td>
<td>-.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costa &amp; McCrac (1990)</td>
<td>62 comm</td>
<td>MCMII, NEOPI</td>
<td>.46**</td>
<td>-.09</td>
<td>-.16</td>
<td>-.22</td>
<td>-.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trull (1992)</td>
<td>54 pts</td>
<td>MMPI, NEOPI</td>
<td>.61***</td>
<td>.13</td>
<td>.18</td>
<td>-.45***</td>
<td>-.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trull (1992)</td>
<td>54 pts</td>
<td>PDQR, NEOPI</td>
<td>.60***</td>
<td>.19</td>
<td>.28*</td>
<td>-.39**</td>
<td>-.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trull (1992)</td>
<td>54 pts</td>
<td>SIDPR, NEOPI</td>
<td>.48***</td>
<td>.04</td>
<td>-.08</td>
<td>-.46***</td>
<td>-.31*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Söldz et al. (1993)</td>
<td>102 pts</td>
<td>MCMII, 50-BSRS</td>
<td>.56***</td>
<td>.04</td>
<td>-.02</td>
<td>-.26**</td>
<td>-.34**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Söldz et al. (1993)</td>
<td>102 pts</td>
<td>PDE, 50-BSRS</td>
<td>.42***</td>
<td>.06</td>
<td>.20*</td>
<td>-.13</td>
<td>-.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West (1993)</td>
<td>457 stdts</td>
<td>MMPI, NEOPI</td>
<td>.43***</td>
<td>.09</td>
<td>.02</td>
<td>-.21***</td>
<td>-.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West (1993)</td>
<td>457 stdts</td>
<td>PDQR, NEOPI</td>
<td>.49***</td>
<td>-.20***</td>
<td>-.01</td>
<td>-.34***</td>
<td>-.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yeung et al. (1993)</td>
<td>224 comm</td>
<td>SIDP, NEOPIFFI</td>
<td>.23***</td>
<td>-.03</td>
<td>-.01</td>
<td>-.28***</td>
<td>-.18**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coolidge et al. (1994)</td>
<td>233 stdts</td>
<td>CATI, NEOPI</td>
<td>.66***</td>
<td>-.16*</td>
<td>.16*</td>
<td>-.29**</td>
<td>-.22**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyer et al. (1994)</td>
<td>80 pts</td>
<td>MCMII, 23BBB</td>
<td>.36***</td>
<td>-.10</td>
<td>.00</td>
<td>-.07</td>
<td>-.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duysens &amp; Diekstra (1996)</td>
<td>450 comm</td>
<td>VKP, 23BBB</td>
<td>.29***</td>
<td>-.16</td>
<td>.10</td>
<td>-.33***</td>
<td>-.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duysens &amp; Diekstra (1996)</td>
<td>210 comm</td>
<td>VKP, 23BBB</td>
<td>.46***</td>
<td>.01</td>
<td>-.14</td>
<td>-.30***</td>
<td>-.24**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ball et al. (1997)</td>
<td>363 pts</td>
<td>SCID, NEOPIFFI</td>
<td>.41***</td>
<td>-.02</td>
<td>.08</td>
<td>-.19***</td>
<td>-.20**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blais (1997)</td>
<td>100 pts</td>
<td>Clinician, Adjectives</td>
<td>.37***</td>
<td>.04</td>
<td>.00</td>
<td>-.09</td>
<td>-.21**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyce &amp; O'Connor (1998)</td>
<td>614 stdts</td>
<td>MCMII, NEOPIFR</td>
<td>.64***</td>
<td>-.27***</td>
<td>.01</td>
<td>-.31***</td>
<td>-.35**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trull et al. (2003)</td>
<td>232 mixed</td>
<td>PDQR, SIFFM</td>
<td>.62***</td>
<td>-.25**</td>
<td>.28**</td>
<td>-.12</td>
<td>-.35**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001

Note: BPD = borderline personality disorder; FFM = five-factor model; N = neuroticism; E = extraversion; O = openness; A = agreeableness; C = conscientiousness; stdts = students; comm = community; pts = patients; MMPI = Minnesota Multiphasic Personality Inventory; MCMII = Millon Clinical Multiaxial Inventory; PDQR = Personality Diagnostic Questionnaire-Revised; SIDPR = Structured Interview for Personality Disorders-Revised; PDQ = Personality Disorder Examination; CATI = Coolidge Axis II Inventory; VKP = Vragenlijst voor Kennmerken van de Persoonlijkheid; SCID-II = Structured Clinical Interview for DSM-IV Personality Disorders; Clinician = ratings by structured clinical interviews; NEOPIFR = NEO Personality Inventory Revised; 23BBB = 23 Bipolar Big Five Questionnaire, Five Personality Factor Test; SIFFM = Structured Interview for the Five Factor Model.
pathology of BPD is equivalent to an excessively high level of impulsivity (a facet of neuroticism), leading those with the disorder to make one disastrously impulsive decision after another. Linehan (1993) has argued that the central pathological feature of the borderline patient is an excessively high level of vulnerability (also a facet of neuroticism), which leaves the patient with no "emotional skin" (p. 44) to deal with problems. In contrast to the current DSM diagnostic criteria hierarchy, a five-factor view does not necessitate a single, central pathology or feature. Rather, the entire domain of neuroticism is important in the consideration of borderline personality disorder, and the patient's level on each facet is related to its clinical importance.

Treatment. Clients with BPD tend to form relationships with therapists that are similar to their other relationships, insofar as the relationships have the potential for being tremendously intense, volatile, and disruptive. The American Psychiatric Association (2001) has published practice guidelines for the psychotherapeutic and pharmacologic treatment of persons with borderline personality disorder. Because borderline patients can present with significant suicide risk, a thorough evaluation of the potential for suicidal ideation and activity should have the initial priority. Also, many patients with borderline personality disorder have comorbid Axis I disorders, some of which might take priority (e.g., major depressive disorder, substance dependence, or dissociative disorder). Borderline patients are often highly motivated for treatment, but their relationship with the therapist might become as intense as his or her relationships with other significant persons. Ongoing consultation with colleagues is recommended to address the therapist's negative reactions (e.g., distancing, rejecting, or abandoning the patient in response to feelings of anger or frustration) as well as positive reactions (e.g., fantasies of being the therapist who in fact rescues or cures the patient, romantic or sexual feelings in response to a seductive patient). Immediate and historical issues should be addressed in therapy, and the client should feel safe expressing and addressing anger, bitterness, and depression. Weekly meetings should be provided. Sessions should emphasize the building of a strong therapeutic alliance, monitoring self-destructive and suicidal behaviors, validation of suffering and abusive experience (but also help the client take responsibility for actions), promotion of self-reflection rather than impulsive action, and setting limits on self-destructive behavior (APA, 2001). The tendency of borderline patients to engage in "splitting" (polarization of an emotional response) should also be carefully monitored and addressed (e.g., devaluation of prior therapists, coupled with idealization of current therapist).

Dialectical behavior therapy (DBT; Linehan, 1993) has been shown empirically to be an effective treatment of BPD. The dialectical component of DBT was derived largely from Zen Buddhist principles of overcoming suffering through acceptance. Mastery of conflict is achieved in part through no longer struggling or fighting adversity; pain is overcome when it is no longer fought. DBT initially focuses on reducing self-harm and suicidal urges and behaviors that disrupt treatment (substance abuse, avoidance). After mastery of these issues, DBT teaches individuals with BPD a new set of coping skills focused on emotional control and interpersonal issues. Individuals in DBT attend regular sessions with an individual therapist and discuss problems in using the skills. These sessions are augmented with a didactic skills-training group. The APA (2001) concluded that psychodynamic psychotherapy has obtained empirical support for the treatment of BPD that is equal to DBT, but this conclusion has since been disputed (Sanderson, Swenson, & Bohus, 2002).

Avoidant Personality Disorder

Definition. Avoidant personality disorder (AVPD) involves a pervasive pattern of timidity, inhibition, inadequacy, and social hypersensitivity (APA, 2000). Its primary diagnostic
impulsivity (a facet of novelty-impulsive decision making) and the nature of the borderline personality disorder), which leaves the contrast to the current DSM a single, central pathol- in the consideration of the relationship. Etiology and Pathology. There have not been any systematic studies on the heritability or psychosocial etiology of AVPD (Bernstein & Travaglini, 1999; Nigg & Goldsmith, 1994). There are a number of theoretical models for its etiology and pathology. AVPD may involve elevated peripheral sympathetic activity and adrenocortical responsiveness, resulting in excessive autonomic arousal, fearfulness, and inhibition (Siever & Davis, 1991). Cognitive models emphasize an excessive self-consciousness and cognitive schemas of inadequacy and inferiority (Beck et al., 1990; Dreessen, Arntz, Hendriks, Keune, & van den Hout, 1999).

Differential Diagnosis. The most difficult differential diagnosis for AVPD is with generalized social phobia (Tillfors, Fumak, Ekholm, & Fredrikson, 2001; van Velzen, Emmelkamp, & Schoeling, 2000; Widiger, 2001). Both disorders involve timidity, anxiety, and an avoidance of social situations, and both may have been present since late childhood or adolescence. In fact, many persons with AVPD initially seek treatment for social phobia. To the extent that the behavior pattern pervades the person’s everyday functioning and has been evident since childhood, the diagnosis of a personality disorder would be more accurate.

Epidemiology and Comorbidity. Timidity, shyness, and social anxiety are not uncommon problems (Crozier & Alden, 2001), and AVPD is one of the more prevalent personality disorders within clinical settings. Approximately 5% to 25% of all patients would meet criteria for AVPD (APA, 2000; Mattia & Zimmerman, 2001). However, only 1% to 2% of the general population would meet criteria for avoidant personality disorder (see Table 10.2). It appears to occur equally among males and females, with some studies reporting more males and others reporting more females (Corbitt & Widiger, 1995).

Course. Adolescence is a particularly difficult developmental period for persons with AVPD, because of the emphasis on peer relationships and popularity. Avoidance of social situations inhibits the development of adequate social skills, further handicapping any eventual efforts to develop relationships. Persons with AVPD may enjoy occupational success, finding considerable gratification and esteem through a job or career that requires little interaction or public performance. A job may serve as a distraction from intense feelings of loneliness and insecurity. Persons with AVPD may be very responsible, empathic, and affectionate parents, but may unwittingly impart feelings of social anxiousness and awkwardness. As the person ages, symptoms of AVPD lessen in intensity.

Five-Factor Model Reformulation. AVPD is conceptualized in terms of the FFM as being a maladaptive variant of the domain and facets of neuroticism (particularly the facets of anxiousness, self-consciousness, and vulnerability) and introversion (abnormally low gregariousness, low assertiveness, and low excitement seeking; see Table 10.3). Widiger (2001) presented data from thirteen studies supportive of this conceptualization of AVPD, and noted that similar patterns of findings have been obtained in clinical, community, and college populations. Avoidant personality traits, assessed by a variety of methods, are consistently and often highly correlated with neuroticism and introversion, but are rarely correlated with any of the other domains of personality. Two of the studies reported results for the facets of neuroticism and introversion. Dyce and O’Connor (1998) reported correlations of .49, .62, and .46 (respectively) with the neuroticism facets of anxiousness, self-consciousness, and vulnerability ($p < .001$); $-.37$, $-.29$, and $-.24$ with the extraversion facets of gregariousness, activity, and
excitement seeking ($p < .001$). Trull, Widiger, and Burr (2001) reported correlations of .43, .70, and .56 (respectively) with the neuroticism facets of anxiousness, self-consciousness, and vulnerability ($p < .001$); $-.33, -.45,$ and $-.40$ with the extraversion facets of gregariousness, activity, and excitement seeking ($p < .001$).

Conceptualizing avoidant personality disorder as a maladaptive variant of introversion also provides an empirically based understanding of its etiology. There is considerable empirical support for the heritability of introversion and neuroticism (Plomin & Caspi, 1999). In childhood, neuroticism appears as a distress-prone or inhibited temperament (Rothbart & Ahadi, 1994). Parents may exacerbate shyness, timidity, and interpersonal insecurity through overprotection and excessive cautionousness (Schmidt, Polak, & Spooner, 2001). Overprotective parental behavior, coupled with a distress-prone temperament, has been shown to contribute to the development of social inhibition and timidity (Burgess, Rubin, Chea, & Nelson, 2001; Rothbart & Ahadi, 1994). The neuropathology of AVPD may also be clarified if it is understood as being a maladaptive variant of general neuroticism and introversion. Just as ASPD may involve deficits in the functioning of a behavioral inhibition system, AVPD may involve excessive functioning of this same system (Depue, 1996). The pathology of AVPD, however, may also be more psychological than neurochemical, with the timidity, shyness, and insecurity being a natural result of a cumulative history of embarrassing, denigrating, and devaluing experiences (Schmidt et al., 2001).

A five-factor formulation of this disorder can also aid the clinician in differential diagnosis of avoidant personality. For example, many persons with AVPD may also meet criteria for dependent personality disorder (DPD, see below). This diagnosis might appear contradictory, given that AVPD involves social withdrawal whereas DPD involves excessive social attachment. However, if an individual with AVPD is able to obtain a relationship, he or she will often cling to this relationship in a dependent manner. Both disorders include abnormally high levels of the neuroticism facets of anxiousness, self-consciousness, and vulnerability. A distinction between AVPD and DPD is best made when the person is seeking a relationship. Avoidant individuals tend to be very shy and inhibited (and are therefore slow to get involved with someone), whereas dependent individuals desperately seek another relationship as soon as one ends (i.e., avoidant persons are high in introversion whereas dependent persons are high in extraversion).

**Treatment.** Many persons with AVPD present for treatment of social phobia or other anxiety disorders related to their avoidant traits. A thorough initial assessment will indicate that the individual suffers not simply from shyness or dyscontrolled anxiousness, but rather from a pattern of interpersonal insecurity, low self-esteem, and feelings of inadequacy.

Social skills training, systematic desensitization, and a hierarchy of in vivo exposure to feared social situations have been shown to be useful in the treatment of AVPD (Beck et al., 1990; Stone, 1993). It is also important for the therapist to address insecurities concerning attractiveness, rejection, and intimacy (Gabbard, 1994). Individuals with AVPD may be hesitant to discuss these issues, feeling that they may “waste the therapist's time with stupid concerns.” Therapists should be especially empathic with such individuals, and use of cognitive techniques to address such insecurities may be useful. Supportive groups may be helpful for individuals with AVPD. A group environment may provide an understanding of the irrationality of their expectations and perceptions concerning interpersonal contact.

Pharmacologic treatment of AVPD may include anxiolytic and/or antidepressant medication. Though AVPD clients should be monitored for dependence on anxiolytic medication, these medications may be especially useful in initial attempts to overcome social anxiety (e.g., in vivo exposures).
10. PERSONALITY DISORDERS

Dependent Personality Disorder

**Definition.** Dependent personality disorder (DPD) involves a pervasive and excessive need to be taken care of that leads to submissiveness, clinging, and fears of separation (APA, 2000; Bornstein, 1999; Pincus & Wilson, 2001). Its primary diagnostic criteria include extreme difficulty making decisions without others' input, need for others to assume responsibility for most aspects of daily life, extreme difficulty disagreeing with others, inability to initiate projects due to lack of self-confidence, and going to excessive lengths to obtain the approval of others.

**Etiology and Pathology.** Insecure interpersonal attachment (Bornstein, 1999; Pincus & Wilson, 2001; Stone, 1993) is central to the etiology and pathology of DPD. Insecure attachment and helplessness may be generated through a parent–child relationship, perhaps by a clinging parent or a continued infantilization during a time in which individuation and separation normally occurs (Gabbard, 2000; Thompson & Zuroff, 1998). However, the combination of an anxious and/or inhibited temperament with inconsistent or overprotective parenting may also generate or exacerbate dependent personality traits (Bornstein, 1999; O'Neill & Kendler, 1998; Rothbart & Ahadi, 1994). Unable to generate feelings of security and confidence for themselves, dependent persons may rely on a parental figure or significant other for constant reassurance of their worth. Eventually, persons with DPD may come to believe that their self-worth is defined by their importance to another person (Beck et al., 1990).

**Differential Diagnosis.** Excessively dependent behavior may be seen in persons who have developed debilitating mental and physical conditions, such as agoraphobia, schizophrenia, severe injuries, or dementia. However, a diagnosis of DPD requires the presence of the dependent traits since late childhood or adolescence (APA, 2000). One can diagnose the presence of a personality disorder at any age during a person's lifetime, but if (for example) a DPD diagnosis is given to a person at the age of 75, this presumes that the dependent behavior was evident since the age of approximately 18 (i.e., predates the onset of a comorbid mental or physical disorder).

Differences in personality due to differing cultural norms should not be confused with the presence of a personality disorder (Alarcon, 1996; Alarcon & Foulks, 1997; Bornstein, 1999). Cultural groups differ greatly in the degree of importance attached to deferent behavior, politeness, and passivity. The diagnosis of DPD requires that the dependent behavior result in clinically significant functional impairment or distress.

**Epidemiology and Comorbidity.** DPD is estimated to occur in 5% to 30% of patients and 2% to 4% of the general community (Mattia & Zimmerman, 2001) and is one of the most prevalent personality disorders (APA, 2000). Studies have indicated that dependent personality traits are a risk factor for the development of depression in response to interpersonal loss (Hammen et al., 1995; Robins, Hayes, Block, Kramer, & Villena, 1995; Widiger, Verheul, & van den Brink, 1999).

**Course.** To the extent that independent responsibility and initiative are required, job functioning will be impaired or unsatisfactory. Individuals with DPD are prone to mood disorders throughout life, particularly major depression and dysthymia, and to anxiety disorders, particularly agoraphobia, social phobia, and panic disorder. However, the severity of the symptomatology tends to lessen with age, particularly if the person has obtained a reliable, empathic partner.
Five-Factor Model Reformulation. The dependent personality can primarily be characterized by maladaptively high levels of agreeableness and the neuroticism facets of anxiousness, self-consciousness, and vulnerability. Persons with DPD will have been excessively submissive as children and adolescents, and some may have had a chronic physical illness or a separation anxiety disorder during childhood (APA, 2000). Persons with DPD fear intensely the loss of care and support from others, particularly a person to whom they have an emotional attachment (Bornstein, 1999; Stone, 1993). They are unable to be alone, as their sense of self-worth, value, or meaning is obtained through the presence of a relationship. They have few other sources of self-esteem and experience perpetual doubts and insecurities regarding the current source of support. Persons with DPD require constant reassurance that any particular relationship will continue, fearing that at some point they may again be alone (Overbosch, 1996). As well, persons with dependent symptomatology would likely be described as maladaptively low in the facet of assertiveness and abnormally high in warmth. Persons with DPD may become quickly attached to persons who are unreliable, unempathic, and even exploitative or abusive. More desirable partners may be driven away by excessive clinging and constant demands for reassurance.

Researchers have found an association between the FFM domain of agreeableness and dependent personality disorder symptomatology (Costa & McCrae, 1990; Dyce & O'Connor, 1998; Hyer et al., 1994). McCrae and Costa (1987) state that extremely high scores on agreeableness may describe a "dependent and fawning" (p. 88) person. Some studies have not confirmed the association (Bornstein & Cecero, 2000) between maladaptive agreeableness and dependent symptomatology. However, it appears that the few anomalous results reflect the fact that the most common measure of the FFM, the NEO-PI-R, does not represent maladaptively high agreeableness sufficiently to obtain consistent confirmation of this relationship (Haigler & Widiger, 2001).

A controversial issue in the diagnosis of dependent personality disorder is its differential sex prevalence (Bornstein, 1999; Widiger, 1998). DPD is diagnosed more frequently in females. Some researchers have argued that the more frequent diagnosis of dependent personality disorder in women reflects a bias in Western culture, and that the disorder pathologizes normal female behavior. The FFM offers a possible resolution to this issue. Researchers have consistently found that women tend to score higher than men on the domain of agreeableness, higher than men on the anxiousness facet of neuroticism, and lower than men on the assertiveness facet of extraversion (Costa & McCrae, 1988, 1992; Feingold, 1994; Trapnell & Wiggins, 1990). Costa, Terracciano, and McCrae (2001) found these differences to be consistent across twenty-six cultures, ranging from very traditional (Pakistan) to modern (The Netherlands). Thus, it is perhaps to be expected that a differential sex prevalence would be observed. This is not to suggest, however, that no gender bias operates in clinical decision making. Gender stereotyping could occur in clinical settings, because of the relation of the personality disorder to common gender differences. In other words, it is the existence of the gender-related traits that contributes to the occurrence of stereotypic perceptions and gender-biased assessments (Widiger, 1998).

Many persons with DPD meet the criteria for histronic and borderline personality disorders (see Table 10.2). Persons with DPD and HPD may both display high scores on the neuroticism facet of self-consciousness and the agreeableness facet of trust, displaying strong needs for reassurance and approval. However, persons with DPD tend to score higher on the agreeableness facet of altruism, modesty, and compliance. Persons with HPD tend to be more flamboyant, assertive, and self-centered (high on the facet of gregariousness and low in modesty and altruism), and persons with BPD tend to be much more dysfunctional and emotionally dysregulated (higher in all facets of neuroticism) (Bornstein, 1999).
10. PERSONALITY DISORDERS

Treatment. Persons with DPD are often in treatment for one or more Axis I disorders, particularly a mood (depressive) or anxiety disorder. These individuals tend to be very agreeable, compliant, and grateful clients, at times to excess. Many individuals with DPD find that the therapeutic relationship satisfies their need for support and concern. The therapist can be perceived as a caring partner who will always be available for the patient. The dependent client may fear successful treatment, because termination may shortly follow. Thus, the client may remain excessively compliant and agreeable to be a patient that the therapist will continue to treat. Therapists should be careful not to unwittingly encourage this subservience, nor to reject the client to be rid of their clinging dependency. Individuals with DPD may have unrealistic expectations of their therapist, making unrealistic demands on the therapist's time.

An important component of treatment is often a thorough exploration of the need for support and its root causes. Cognitive-behavioral techniques can be useful to address feelings of inadequacy and helplessness and to provide training in assertiveness and problem-solving techniques. Group therapy may be useful for persons with DPD, providing interpersonal feedback and modeling autonomous behavior. DPD is not known to respond to pharmacotherapy.

CONCLUSIONS

Maladaptive personality traits can be the focus of clinical treatment and often impair or impede the treatment of other mental disorders. Chart reviews of practitioners suggest that they are not being diagnosed as frequently as they occur, perhaps because it can be difficult to obtain coverage for their treatment. This is regrettable because some maladaptive personality traits (e.g., borderline and antisocial) have substantial social and public health care costs.

The five-factor model offers a compelling alternative to the categorical diagnosis of personality disorders as provided in DSM-IV-TR. Advantages of understanding personality disorders in terms of this dimensional model are the provision of more specific descriptions of individual patients (including adaptive as well as maladaptive personality functioning), the avoidance of arbitrary categorical distinctions, and the ability to bring to bear the extensive amount of research on the heritability, temperament, development, and course of general personality functioning to an understanding of personality disorders.

REFERENCES


16. PERSONALITY DISORDERS

- Accede to information on personality disorders, their classification, and various perspectives.
- Explore the impact of personality disorders on social, occupational, and psychological functioning.
- Examine the diagnostic criteria and assessment methods for personality disorders.
- Understand the treatments available for personality disorders, including individual and group therapies, medication, and psychosocial interventions.
- Investigate the role of personality disorders in mental health outcomes and mortality.


- Emphasizes the importance of recognizing and addressing personality disorders in clinical practice.
- Highlights the challenges in diagnosing and treating personality disorders due to their complexity and variability.
- Discusses the importance of integrated approaches in the management of personality disorders.

16.1: Analytic, relational, and interpersonal therapies

- Analytical therapy: A form of talk therapy that aims to uncover unconscious conflicts and their impact on personality.
- Interpersonal therapy: Focuses on improving social functioning and relationships.
- Relational therapy: A therapy that emphasizes the therapeutic relationship as a means of understanding and change.

16.2: Cognitive-behavioral therapies

- Cognitive-behavioral therapy: Involves identifying and changing negative thought patterns and behaviors.
- Acceptance and commitment therapy: Focuses on accepting one's present circumstances and committing to actions that improve well-being.

16.3: Dynamic therapies

- Psychoanalytic therapy: Based on the theory of psychoanalysis, focusing on unconscious conflicts and their resolution.
- Transference-focused therapy: A therapy that explores and utilizes transference phenomena to promote change.

16.4: Psychodynamic therapies

- Psychodynamic therapy: Involves exploring the patient's unconscious processes and early life experiences.
- Dialectical behavior therapy: A treatment designed to help patients manage intense emotions and reduce self-harm.

16.5: Other therapies

- Mindfulness-based therapies: Focus on present-moment awareness and stress reduction.
- Complementary and alternative therapies: Such as yoga, acupuncture, and herbal medicine, which may be used in combination with traditional therapies.

16.6: Research and evidence-based practices

- The role of research in the understanding and treatment of personality disorders.
- Evidence-based practices and guidelines for the treatment of specific personality disorders.

16.7: Challenges and future directions

- The ongoing challenges in the diagnosis and treatment of personality disorders.
- Potential future developments in the field, including new treatments and technologies.

16.8: Conclusion

- A comprehensive overview of the current understanding and management of personality disorders.
- The importance of continued research and interdisciplinary collaboration in advancing knowledge and practice in this area.


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