Personality Disorders

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From the Case of Ted Bundy

Theodore Robert Bundy seemed destined to live a charmed life; he was intelligent, attractive, and polished. He had been a Boy Scout in his youth and later an honor student in psychology at the University of Washington. He also served as a work-study student in a Seattle crisis clinic. One of Bundy’s psychology professors wrote of him: “He conducts himself more like a young professional than a student. I would place him in the top one percent of the undergraduates with whom I have interacted” (quoted in Leyton, 1986). While still in his 20s, Bundy was also named assistant to the chairman of the Washington State Republican Party and was lauded as an “up-and-comer” in political circles.

Of course, this rosy biography omits the fact that Ted Bundy hunted down, raped, and killed young women for the sheer thrill of possessing and controlling them. It was early in January, 1974, when Ted Bundy attacked his first victim: a young woman who Bundy maimed while she was asleep, leaving her with permanent brain damage. From 1974 through 1978, Bundy stalked, sexually assaulted, and killed as many as 36 victims in Washington, Oregon, Utah, Colorado, and Florida. He used his good looks and charm as lures to trap his victims. Looking
helpless and harmless—he would walk on crutches or wear a fake cast on his arm—Bundy would enlist the aid of a young woman and, after securing her trust, would choke her to death and mutilate and sexually abuse her body before disposing of it in a remote area. No one knows for sure how many women he killed, because he never gave a complete confession.

Who was the real Ted Bundy? Were there early signs that he was capable of such carnage? Was Bundy mentally ill, and, if so, what diagnosis should he have received?

Beneath the superficial charm of Bundy’s overt behavior lurked a far different person, one who was driven by a lust to dominate people and who was incapable of feeling guilt. In Bundy’s own words, he was the “most cold-hearted son of a bitch you’ll ever meet” who didn’t “feel guilt for anything” and felt “sorry for people who feel guilt” (quoted in Jeffers, 1991).

Bundy’s quest for domination may have begun with his shame for having been the illegitimate son of his 22-year-old mother and a sailor with whom she had had a brief sexual encounter—Bundy was born in 1946 in the Elizabeth Lund Home for Unwed Mothers in Burlington, Vermont. From an early age he was embarrassed by his illegitimacy and his family’s poverty. He told people how humiliated he was to be seen riding in his step-father’s run-down Rambler. As a juvenile, he constantly sought to create an impression of being a sophisticated and successful member of the upper class who deserved admiration. He went to great lengths to further this impression, even wearing fake mustaches and makeup to change his appearance. He stole cars in high school to maintain his image and occasionally affected an English accent. He sought out women whose physical appearance satisfied his craving for escaping what he called his “common” origins. He was never interested in an emotionally close relationship with these women; his main desire was to be seen with them and to have other people admire him for being with an attractive woman.

Despite the time he spent creating the right impression, Bundy was not popular in high school, and he knew it. He told interviewers, “In junior high everything was fine, but I got to high school and I didn’t make any progress. I felt alienated from my old friends. They just seemed to move on and I didn’t . . . I wasn’t sure what was wrong and what was right. All I knew was that I felt a bit different” (quoted in Leyton, 1986). As time passed, Bundy’s snobbery and social pretensions grew insatiable. He wanted to possess certain women in order to gratify his need for power and control. His preferred victims were upper-class sorority women who became, in their final hours, Bundy’s ultimate possessions, mere objects with whom he could do whatever he wished.

In 1980, Bundy was tried for the murder of two sorority sisters at the University of Florida. Apparently convinced of his brilliance and legal acumen obtained while attending two different law schools, Bundy served as his own attorney in the trial. Like many antisocial personalities, Bundy overestimated his skills; he was convicted of the sorority sisters’ murders and the kidnapping, murder, and mutilation of a 12-year-old Florida girl.

If we were proposing a moral taxonomy of behavior we would no doubt reserve a particularly ignominious corner for Ted Bundy. But in a formal classification of mental disorders, where should he be placed? Bundy did not hear voices or see visions; he was not out of touch with reality; he did not experience any pronounced physical problems, nor did he suffer attacks of anxiety or bouts of depression. Instead, Ted Bundy’s problems seemed to be part and parcel of his personality, that unique pattern of consistency in behavior that distinguishes each person from every other. The way we interact with friends and family, the attitudes we hold toward work, and the approach we use to solve life’s problems all reveal our personalities. Bundy represented an extreme example of what is called antisocial personality disorder, one of ten patterns that the DSM-IV identifies as personality disorders.
A personality disorder is an enduring pattern of inner experience and behavior that is extremely inflexible, deviates markedly from the expectations of a person’s culture, and causes personal distress or behavioral impairment. These problematic patterns can be traced to adolescence or even childhood. People diagnosed with personality disorders have some consistently distorted ways of thinking, expressing emotions, controlling behavior, or interacting with others that impair their adjustment to everyday demands and often lead to misery for others. People who have antisocial personalities such as Bundy’s can maintain a facade of coolness and charm, but behind it lies a long-standing core of aggressiveness and deceit with no regard or empathy for the rights of others.

The degree of damage associated with a personality disorder can be as severe as Bundy’s or as mild as the annoyance caused by quirky characters. When Ted Knight of the Mary Tyler Moore Show alienated his newsroom colleagues with his self-centered pompousness, he was displaying classic patterns of narcissistic personality disorder. Table 12.1 lists other portrayals of personality disorders in well-known movies.

Because the developers of the DSM worried that personality disorders might be overshadowed by the Axis I disorders, the DSM-IV places personality disorders on a separate axis—Axis II—to draw special attention to them. As shown in Figure 12.1 on page 410, Axis I groups the ten personality disorders in three clusters based on similarities in their characteristics: (1) odd/eccentric, (2) dramatic/emotional/erratic, and (3) anxious/fearful. An eleventh category—personality disorder not otherwise specified—is used for personality disturbances that do not meet the criteria for any specific disorder.

In this chapter we will describe the clinical characteristics of each of the ten personality disorders included in the DSM-IV and examine what is known about their causes and treatments. First, though, we will take a closer look at the concept of personality disorder and why these disorders are particularly difficult to diagnose and treat.

### TABLE 12.1 Axis II Goes to the Movies

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>Humphrey Bogart’s portrayal of Captain Queeg in The Caine Mutiny (1954)</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>Robert de Niro as the weird cabbie in Taxi Driver (1976)</td>
</tr>
<tr>
<td>Histrionic</td>
<td>Vivian Leigh’s Scarlet O’Hara in Gone with the Wind (1939); Jackie Gleason’s Ralph Crandem in the TV series The Honeymooners</td>
</tr>
<tr>
<td>Borderline</td>
<td>Diane Keaton in Looking for Mr. Goodbar (1977); Jessica Lange in Frances (1988)</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Alex as played by Malcolm McDowell in A Clockwork Orange (1971)</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Woody Allen in Zelig (1983)</td>
</tr>
<tr>
<td>Dependent</td>
<td>Meryl Streep’s portrayal of Sophie in Sophie’s Choice (1982)</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>Jack Lemon as Felix Unger in The Odd Couple (1968)</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Hyler presents no cinematic example of a schizoid personality. Can you think of an example? What about William Hurt’s character in The Accidental Tourist?</td>
</tr>
</tbody>
</table>

Defining Characteristics and Prevalence of Personality Disorders

Personality disorders differ in several important ways from Axis I disorders. Unlike the symptoms of Axis I mental disorders (which may come and go and vary in intensity over time) personality disorders do not usually involve distinct episodes or periods in which clinical symptoms are obvious. Instead, the central characteristic of personality disorders is long-lasting, extreme, and rigid personality traits that are maladaptive. A personality trait is a psychological attribute that is relatively stable over time and across different situations. Personality traits distinguish one person’s typical behavior from that of others. For example, people who show a high degree of the trait of extroversion tend to be outgoing, energetic individuals who feel comfortable in many different social situations and seem to make friends easily.

Everyone knows someone whose personality seems odd, but personality disorders involve more than eccentricity. For a personality disorder to be diagnosed, an individual’s personality traits must be maladaptive. Almost any trait, when it becomes too rigid and extreme, can cause problems for an individual and for society. For example, extroverted people can be too extroverted, becoming annoying pests who talk too much or fail to respect other people’s privacy. Accordingly, the DSM-IV defines a personality disorder in terms of personality traits that are “inflexible and maladaptive and [that] cause significant functional impairment and subjective distress” (APA, 1994, p. 630).

The long-term, ingrained patterns of behavior seen in personality disorders are related to four other important features of these disorders.

1. People with personality disorders often do not see themselves as troubled, let alone as suffering from a mental disorder. Thus, personality disorders are sometimes said to be ego-syntonic, meaning that those who display them tend to experience them not as aberrations but as natural parts of themselves. The extreme traits associated with the disorder just feel like part of the person’s basic personality structure. Indeed, many people with personality disorders think that their only problem is that other people mistreat or misunderstand them. However, not all personality disorders are ego-syntonic; in some cases individuals are aware that extreme traits are causing them trouble and feel a desperate need to gain better control of their behavior.

2. Personality disorders are usually difficult to treat—in many cases, more difficult than Axis I disorders. Part of this difficulty stems from the fact that clients who believe that their problems are due to the actions of others are usually reluctant to seek or cooperate in treatment.

3. Personality disorders are often more distressing for others than for the person displaying them. All mental disorders tax the resources and patience of friends and relatives, but personality disorders are particularly troubling to others. As the case of Ted Bundy illustrates, a severe personality disorder can leave a trail of disaster in its wake.

4. Personality disorders often appear together and in combination with Axis I mental disorders, particularly anxiety disorders, mood disorders, and substance abuse. For example, 25 to 85 percent of
people diagnosed with one personality disorder also meet the criteria for another one (Widiger & Rogers, 1989; Zimmerman & Coryell, 1989). In terms of Axis I comorbidity, anywhere from 27 to 65 percent of patients with panic disorder or generalized anxiety disorder show a coexisting personality disorder (Brown & Barlow, 1992). Because of this comorbidity, it is often difficult to determine whether a client suffers two or more disorders or whether the problems attributed to an Axis I condition are actually the result of a pervasive personality disorder.

The definition of a personality disorder also implies several things about its course. Just as personality traits begin to stabilize by young adulthood, personality disorders are also usually apparent by that time. By definition, then, the onset of personality disorders occurs no later than young adulthood. However, these disorders often do not come to a clinician’s attention until years later, after a series of difficulties have forced clients into treatment or after they have become motivated to change a life of constant, emotional turmoil. Also, by definition, personality disorders are relatively stable through the years, although certain disorders tend to diminish in severity after the age of 40.

The prevalence of personality disorders in the United States is difficult to estimate, in part because many people with these disorders refuse to acknowledge their problems and avoid contact with clinicians. Another complication stems from the fact that the diagnosis of a personality disorder requires establishing a chronic pattern of problems, which is usually more difficult than diagnosing the acute symptoms of an Axis I disorder.

In large-scale epidemiological surveys, the rate of antisocial personality disorder (the most thoroughly studied of the personality disorders) is placed at somewhere around 3 to 4 percent in the United States (Regier et al., 1988). In addition to antisocial personality disorder, the other most prevalent diagnoses are histrionic and schizotypal, each of which may be seen in as many as 4 percent of the population. A recent summary of the epidemiological evidence suggests that somewhere between 10 and 13 percent of the population have met the criteria for at least one type of personality disorder sometime in their lives (Weissman, 1993).

The picture regarding gender differences is complicated. Most of the personality disorders—paranoid, narcissistic, and antisocial personality disorders being the most obvious examples—are diagnosed more often in men than in women. Borderline personality disorder is the prime example of a personality disorder that is diagnosed more often—about 3 times more often—in women than in men. A few disorders, such as avoidant personality disorder and dependent personality disorder, seem to affect men and women about equally.

Scientists still know very little about cultural differences in the prevalence of personality disorders. The approximate 3 to 4 percent rate of antisocial personality disorder holds true for Canada and New Zealand, but, in Taiwan, the prevalence is less than 0.5 percent. Western European countries report a prevalence rate for all personality disorders combined similar to that of the United States. However, the picture is much less clear in non-European nations, where, until recently, clinicians have been less likely than their Western colleagues to diagnose certain types of personality disorders.
Diagnosing Personality Disorders

The DSM table above lists the criteria for diagnosing a personality disorder. Reliable diagnoses of these disorders is complicated by several factors, including their comorbidity with Axis I disorders.

Personality Disorders and Axis I Disorders. By placing personality disorders on Axis II, the DSM-IV encourages clinicians to diagnose personality disorders in addition to any Axis I disorders that are present. However, clinicians often find it difficult to distinguish Axis I and Axis II disorders, and they are uncertain how best to think about clients with diagnoses on both axes.

Comorbidity between Axis I and Axis II disorders can be understood in several ways (Klein, 1993). First, an Axis I disorder and a personality disorder may simply coexist at the same time. When they do, one disorder is likely to aggravate the other. For example, the general suspiciousness of paranoid personality disorder may cause a person to mistrust and shun medication that is necessary for managing an accompanying bipolar disorder. A depressive disorder may lead a person with dependent personality disorder to feel even more desperate for someone else's guidance.

It is also possible that one of the disorders predisposes a person to develop the other. For example, the emotional instability that is a hallmark of borderline personality disorder may cause a person to react more intensely to major stressors, ultimately leading to a major depressive disorder. In other cases, an Axis I disorder may lead to a personality disorder. A childhood mood disorder may undermine a child's confidence about making new friends or mastering new challenges. As a result, the child may avoid social situations, thereby setting the stage for an avoidant personality disorder.

Another interpretation of comorbidity is that it is an artifact of the criteria used for various diagnoses. Because the diagnostic criteria for several Axis I and Axis II disorders overlap, two diagnoses may be given when only one disorder is present. For example,

- Comorbidity may simply be the result of definitional similarity. Borderline personality disorder shares criteria with mood disorders; the symptoms of antisocial personality disorder and substance abuse are similar; and avoidant personality disorder and the generalized form of social phobia have similar definitions. It is therefore not surprising to find these pairs of disorders often diagnosed together.

- A personality disorder and an Axis I disorder may represent different levels of severity along the same basic dimensions of disturbance. For example,
some clinicians believe that schizotypal personality disorder may be a mild form of schizophrenia and that borderline personality disorder is an early or less-severe manifestation of bipolar or cyclothymic disorder. Others argue that each of these conditions is a separate disorder that deserves a unique diagnosis. This controversy has not yet been resolved, but considerable empirical research is being devoted to it.

Other Diagnostic Difficulties. At least three other problems make reliable diagnosis of personality disorders difficult. First, as suggested in the discussion of comorbidity, the criteria used to define different personality disorders often overlap considerably. As a result, the same behavioral characteristics may be associated with several personality disorders. For example, impulsive behavior is symptomatic of both borderline personality disorder and antisocial personality disorder. Distress or impairment due to a lack of close friends and confidants is associated with schizoid, schizotypal, and avoidant personality disorders.

A second obstacle to reliable diagnosis of personality disorders is that, by definition, they refer to long-standing behavior patterns rather than acute, current symptoms. This definition requires that the clinician assess a person’s adolescence or childhood to determine whether the individual has been, for example, chronically mistrustful of people (in the case of paranoid personality disorder) or always aloof and emotionally cold (in the case of schizoid personality disorder). Yet an accurate social history of a person’s styles of interaction as a child or adolescent may be difficult to obtain. Memory of distant events can be faulty, but even accurate memories are sometimes distorted by clients who put their own “spin” on the past. Such distortions might be particularly likely in the case of personality disorders because of their long-standing nature and their tendency to affect many aspects of behavior, emotion, and thinking simultaneously.

Finally, the problems associated with the DSM-IV’s categorical approach to classification are particularly difficult in the case of personality disorders. As noted in Chapter 2, the DSM-IV requires the clinician to assign a diagnosis if a client meets a particular number out of a fixed set of criteria. If this number is met (for example, five out of nine for narcissistic personality disorder) the diagnosis is made. But there is little or no evidence to support a particular cutoff (such as five of nine instead of six of nine criteria) as being the “true” boundary between normal and abnormal personality (Widiger & Trull, 1991). Furthermore, if the rule requires that five of nine criteria be met, two people could be diagnosed as displaying narcissistic personality disorders even though they share only one defining feature. And two other people who share four defining features might receive different diagnoses because they do not share a fifth criterion.

**Dimensional Descriptions of Personality Disorders**

The difficulties in diagnosing personality disorders have encouraged the development of dimensional approaches (Cloninger, 1987; Costa & Widiger, 1994; Watson, Clark, & Harkness, 1994; Widiger & Costa, 1994; Wiggins & Pincus, 1989). Recall from Chapter 2 that a *dimensional* approach involves describing individuals along various dimensions or traits of personality. These traits span normal and abnormal levels of functioning. Because personality disorders are viewed as extreme, rigid extensions of personality traits, dimensional approaches that rely on reliable, well-validated measures of basic personality are especially appealing. Two systems for measuring personality characteristics have proved particularly useful for distinguishing personality disorders: the Big Five model of personality and the Interpersonal Circumplex. Both these models have been proposed as alternatives to the DSM-IV system of categorizing personality disorders.

The Big Five model is so named because, on the basis of factor analyses and other multivariate methods, various researchers have found that important personality traits can be organized into five basic factors. Individuals can score high or low on any of these factors, based on their answers to a large number of items that assess how they are likely to behave in a wide range of situations. Big Five theorists argue that any personality can be described and distinguished from others in terms of the following five factors:

1. **neuroticism**: the tendency to experience negative emotions such as anxiety, anger, and depression accompanied by disruptions of behavior and distressed thinking. Neuroticism is contrasted with emotional stability, which is typical of people who tend to remain calm even in stressful situations.

2. **extroversion**: a preference for social interaction and a tendency to be active, talkative, optimistic, and affectionate. Introverts tend to prefer solitude and are less active than extroverts. Introverts appear sober, aloof, quiet, and task-oriented. They seem to have less need for stimulation.
3. openness: interest in new experiences and receptivity to new activities and ideas for their own sake. People who score high on this dimension are creative, curious, and untraditional. People who score low on this dimension tend to be more interested in concrete or practical pursuits. They appear set in their ways and emotionally unresponsive.

4. agreeableness: compassionate interest in others. People who score high on this dimension are usually trusting and tender-hearted. They are generous in caring for others, sometimes to the point of putting others’ needs before their own or even appearing gullible. People who score low on agreeableness are apt to be competitive and are more likely to be manipulative, cynical, skeptical, and openly hostile or rude.

5. conscientiousness: well-organized dedication to work. People who score high on this dimension are ambitious and persistently strive to be achievers. Those who are low on this dimension are less demanding of themselves and others and may seem unreliable and careless.

According to Big Five theorists, extreme scores on one or more of these dimensions may be sufficient to describe the maladaptiveness of a personality disorder. For example, an extremely high score on neuroticism points to probable adjustment problems. If this score were coupled with an extremely low score on extroversion, suggesting extreme discomfort in most social situations, the essential features of avoidant personality disorder have been captured.

A more elaborate description of two Big Five traits—extroversion and agreeableness—is given with the Interpersonal Circumplex or Circle created by Timothy Leary (1957). Drawing on Harry Stack Sullivan’s view of personality as the enduring pattern of an individual’s interpersonal relationships, Leary’s model analyzes different personalities as combinations of just two basic dimensions of interpersonal behavior: dominance/submission and love/hate. The interaction of these dimensions produces the eight personality styles appearing around the outside of the interpersonal circle shown in Figure 12.2.

Individuals diagnosed with personality disorders seem virtually to “live in” one of the wedges of the circle; their behavior is fixed into a narrow and extreme reliance on one personality style. Numerous studies have shown that most personality disorders can be meaningfully described through these dimensional models (Costa & McCrae, 1990; Soldz et al., 1993; Trull, 1992; Wiggins & Pincus, 1989). The descriptions of specific personality disorders in the next section takes into account both DSM-IV criteria and dimensional models.
Odd/Eccentric Personality Disorders

In the DSM-IV, the odd/eccentric personality disorders includes paranoid, schizoid, and schizotypal personality disorders. Table 12.2 on page 416 describes the primary characteristics of these disorders and their relationship to the dimensions of the Big Five model.

The results of empirical studies have consistently supported the dimensional descriptions in this table.

Paranoid Personality Disorder. People with paranoid personality disorder are habitually suspicious, constantly on guard, and mistrustful. They assume that...
others will take advantage of or harm them unless carefully watched and prevented from doing so. They are prone to anger and intense jealousy, and they tend to misinterpret innocent actions or remarks as threats or insults directed at them. Often, these attitudes are accompanied by an air of moral superiority and condescension based on a strong belief that other people are usually corrupt or conniving.

As a result of their chronic irritability and thinly disguised hostility, paranoid personalities succeed at creating exactly the kind of social interactions that confirm their most dire predictions about others. They are drawn toward litigation and other official proceedings as a way of settling their grievances and evening the score over perceived slights. You might say that people with paranoid personality disorder burn their bridges before they get to them. They appear to dislike other people, and seem incapable of intimacy. Paranoid personalities’ loner tendencies, coupled with their chip-on-the-shoulder attitudes, lead others to avoid them, a response that only heightens their paranoid suspicions.

Humorless and unemotional, people with paranoid personality disorder generally avoid groups unless they can lead or otherwise control them. For example, they may be attracted to cults and other fringe organizations either as a leader or as an ambivalent follower of a charismatic figure whose power they covet. Paranoid personalities typically display an undertone of envy toward those in authority or with power.

The features of paranoid personality disorder are illustrated by Bill A., a 45-year-old auto mechanic who worked in a large car dealership.
For the first two years on the job, Bill performed well, according to his supervisor. But in the next few months, his work and his relationships with coworkers deteriorated. These problems started when Bill accused a fellow mechanic of sabotaging his work by putting grease on his tools. Bill insisted that the coworker was jealous because Bill was a better mechanic. Now, Bill insists that he be given a detailed, written description of every repair job he is to complete and that his supervisor inspect his progress every 20 minutes. Bill believes the other mechanic, whom he calls a “management mole,” has turned everyone in the agency against him, and he has asked the police to investigate the telephoned death threats he claims to have received as well as the flat tires that he is convinced have been caused by nails that coworkers have put under his car.

Because of the secretiveness and isolation of persons with paranoid personality disorder, accurate assessment of its prevalence is difficult, but estimates range from 0.5 to 2.5 percent of the general U.S. population (Bernstein, Useda, & Siever, 1993). Its effects are most often observed in occupational settings where, as was the case with Bill A., it leads to frequent conflicts with superiors and coworkers. It is diagnosed more often in men than in women.

**Schizoid Personality Disorder.** The hallmarks of schizoid personality disorder are an indifference to social relationships and a pervasive emotional blandness. People with this disorder usually lack close friends, and they appear to take no pleasure from positive events and to feel no unhappiness after setbacks. It is as though emotional color has been bleached from their lives. They lack social skills and seem to be lethargic and aloof, like the Beatles’ “Nowhere Man.”

Schizoid personalities prefer solitary activities and occupations. The work of nighttime security guard or lighthouse keeper would be ideally suited to them, although their interpersonal apathy and lack of initiative make it less likely that they would succeed at any job. They prefer mechanical or abstract activities over those that involve working with other people. Often, they drift into marginal living arrangements, such as skid rows, cheap hotels, and rundown boarding houses. Although they may passively accept sexual attention from others, they are typically indifferent to potential romances or friendships.

Diagnosed slightly more often among males, the overall prevalence of schizoid personality disorder is not known, but it is probably less than 1 percent (Weissman, 1993). It is rarely seen in formal clinical treatment settings. Schizoid personality disorder may be a precursor to delusional disorder or schizophrenia in some cases, but the hypothesis that it shares a genetic basis with these serious disorders has not received strong empirical support.

**Schizotypal Personality Disorder.** The former rock group The Doors captured the schizotypal personality disorder in their song “People Are Strange.” People with schizotypal personality disorder are like
schizoids in that they, too, are socially isolated and tend to shun close relationships. However, schizotypal personalities are more noticeable because they tend to act, dress, and talk in odd ways. In addition, schizotypal personalities, unlike schizoids, are socially anxious and apprehensive. This anxiety appears to be tied to general self-consciousness and discomfort with others that does not diminish with further acquaintance. The person with schizotypal personality disorder often appears quirky and reacts stiffly in social situations. Schizotypal people seldom have close friends outside their own families, and other people tend to see them as silly and absurd.

The odd thinking and speech associated with schizotypal personality disorder is not so eccentric as to qualify as psychotic, but they are certainly strange and strange enough to draw attention and sometimes frighten other people. Schizotypal personalities frequently express superstitions and beliefs in telepathic or extraterrestrial phenomena (Widiger, Frances, & Trull, 1987). Ideas of reference, which involve the belief that one is being monitored or talked about by others, are prominent as are associated feelings of paranoia and suspiciousness. People with this disorder also often report bizarre perceptual experiences, such as holding conversations with dead relatives or believing that spirits or nonexistent people are inhabiting a room. They may sometimes talk to themselves or others in vague, confusing, or tangential ways, but their speech is seldom incoherent, as is often the case with schizophrenia.

In his award-winning book about Savannah, Georgia, Midnight in the Garden of Good and Evil, John Berendt (1994) describes several examples of schizotypal behavior among the townspeople. One recluse had invented the flea collar and the no-pest strip during his spare moments as a technician whose job it was to test insecticides by injecting them into weevils and beetles. As a hobby, this man would anesthetize flies and glue thread to their backs. Then, when the flies woke up, he would take them on walks through downtown, each fly in tow behind him, on its individual leash. On other occasions, he would trim one wing shorter than the other so the fly would constantly buzz around in a circle. These actions made many Savannahians uneasy, particularly those who feared the man would follow through one day on his threat to poison the city’s water supply.

As the term schizotypal implies, this disorder has often been viewed as a mild form of schizophrenia or as part of the schizophrenia spectrum. Although there is evidence that schizophrenia and schizotypal disorder are genetically related (Thaker et al., 1996), other studies have found considerable familial and genetic overlap between schizotypal personality disorder and mood disorders as well (Kotsaftis & Neale, 1993). Currently, it appears that schizotypal personality disorder may be a mild or an early form of a psychotic disorder, but we cannot say for sure that it is specific to schizophrenia.

The prevalence of schizotypal personality disorder in the United States is in the 2 to 4 percent range. Most studies suggest that it occurs more frequently among males (Kotsaftis & Neale, 1993). Reliable diagnosis of this personality disorder has proved challenging, in part because of its substantial overlap in symptoms with schizoid, avoidant, and borderline personality disorders.

Dramatic/Emotional/Erratic Personality Disorders

The dramatic/emotional/erratic personality disorders include histrionic, narcissistic, borderline, and antisocial personality disorders. Table 12.3 summarizes the Big Five descriptions of these disorders, which tend to be typified by active, sometimes uncontrolled, behaviors. This cluster contains the two personality disorders—antisocial and borderline personality disorders—that have received the most attention from researchers. This extra attention is given because individuals diagnosed with either of these disorders often get into trouble with legal authorities or are forced into treatment as a result of their socially disruptive behavior.

Histrionic Personality Disorder. The major features of histrionic personality disorder are a set of attention-getting behaviors that include seductiveness, exaggerated displays of emotions, and demands for reassurance and praise. Histrionic personalities love to be the center of attention and frequently use physical attractiveness or flamboyant emotionality to gain attention. They describe events with hyperbolic speech that sounds empty in spite of its hyperbole; phrases such as “totally awesome,” “incredibly beautiful,” and “horribly awful” characterize the speech of histrionic persons. All their actions, even their manner of dress, are designed to make others notice them.

These strategies may at first strike others as creative, entertaining, or even charming, but tend,
in most cultures, to wear thin over time, revealing the strategies to be shallow exhibitions driven by self-centered needs. As the charm wears off and people grow weary of paying constant attention and tribute, histrionic individuals must seek new audiences. When their social charm or physical attractiveness fails to gain the stimulation that these people crave, they may develop attention-getting physical complaints.

The interpersonal style of histrionic people has been described as “actively dependent”: “Their clever and often artful social behaviors give the appearance of an inner confidence and independent self-assurance; beneath this guise, however, lies a fear of genuine autonomy and a need for repeated signs of acceptance and approval” (Millon, 1990, p. 121). People with histrionic personality disorder are easily bored and susceptible to group pressures and to joining in fads. They are also suggestible and therefore drawn to strong authority figures whose admiration they especially desire.

Histrionic personality disorder occurs in about 2 to 4 percent of the U.S. population (Weissman, 1993), and it appears to be diagnosed more often in females than in males. The reasons for this gender difference remain controversial. It may reflect cultural influences that lead females, especially, to believe that physical beauty is necessary for a satisfying life, or it may be due to the diagnostic biases described in Chapter 2. Recall the study by Maureen Ford and Tom Widiger in which clinicians were asked to diagnose fictitious cases. One case involved a typical description of antisocial personality disorder for which the person was said to be either a man or a woman; the other described a histrionic personality disorder, again presented as either a man or woman. The results showed that clinicians were more likely to diagnose a female with histrionic personality disorder even when she met the criteria for antisocial personality disorder. Likewise, histrionic behavior attributed to a female increased clinicians’ use of the histrionic diagnosis. On the other hand, being identified as a male had a smaller effect on the differential use of the two diagnoses.

Researchers’ interest in histrionic personality disorder appears to have declined recently; it may be diagnosed less frequently in the future since it overlaps considerably with other personality disorders in the dramatic/emotional/erratic cluster.

Narcissistic Personality Disorder. When Carly Simon sang “You’re So Vain,” she no doubt had in mind someone who is narcissistic. The term narcissism derives from the Greek myth of Narcissus, who was so enthralled with his reflection in a pool that he died of protracted longing after his own beauty. The main feature of narcissistic personality disorder is an overinflated sense of importance and worth leading to a sense of entitlement to special privileges and to exemptions from the rules that apply to others. Narcissists entertain grandiose ideas about their abilities and importance, and they are prone to feelings of rage or humiliation if others overlook or criticize them. Indeed, people with narcissistic personality disorder sometimes behave irresponsibly because they do not feel that normal social constraints should apply to them; at such times, their behavior may turn antisocial.

Like histrionic personalities, those diagnosed with narcissistic personality disorder crave attention and feature themselves as stars in fantasies of success and power. Preoccupied with their own status, narcissistic personalities lack empathy for others and exploit social relationships for their own gain. They

<table>
<thead>
<tr>
<th>DSM-IV category</th>
<th>Primary characteristics</th>
<th>Description based on Big Five model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histrionic</td>
<td>Shallow; always seeking attention; exaggerated emotions; seductive</td>
<td>High extraversion and high neuroticism</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Inflated self-esteem; low empathy for others; feels entitled to special privileges</td>
<td>Low agreeableness</td>
</tr>
<tr>
<td>Borderline</td>
<td>Unstable moods; impulsive behaviors; angry; lack of a coherent sense of self; interpersonal turmoil</td>
<td>High neuroticism, low agreeableness, low conscientiousness</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Constantly violating rights of others; callous, manipulative, dishonest; does not feel guilt</td>
<td>Low agreeableness and low conscientiousness</td>
</tr>
</tbody>
</table>

Source: Costa & McCrae (1990); Soldz et al. (1993); Trull (1992); Wiggins & Pincus (1989).
are frequently envious or believe that others envy them. If criticized or reprimanded, their arrogance often turns to hostility and even abuse. Unable to admit weaknesses or to appreciate the effect their behavior has on others, narcissists are poor candidates for psychotherapy.

The prevalence of narcissistic personality disorder is not clearly established, but most estimates place it at less than 1 percent of U.S. samples (Zimmerman & Coryell, 1989). This disorder appears to have grown more common over the past decade or so. It is unclear whether the increased incidence represents a genuine upswing in new cases or simply greater clinical interest in and attention to the disorder. Males are diagnosed with narcissistic personality disorder slightly more often than females.

**Borderline Personality Disorder.** Because it is a frequent disorder that involves potentially destructive behavior, clinicians have studied borderline personality disorder extensively. In fact, it now rivals antisocial personality disorder as the most frequently studied personality disorder. One survey indicated that over 40 percent of journal articles about personality disorders were devoted to borderline personality disorder (Widiger & Frances, 1989).

The clinical term *borderline* has carried different meanings over the years (Widiger, Miele, & Tilly, 1992). Some professionals use it to capture the similarity between borderline personality disorder and brief or mild schizophrenic symptoms. In the DSM-IV, the essential qualities of *borderline personality disorder* are impulsivity and instability in several areas of functioning, including mood, behavior, self-image, and interpersonal relationships. In fact, borderlines are often described as being stable only in their unpredictability. During periods of increased stress, borderlines may display psychotic symptoms for a brief time. Nancy, a 23-year-old veterinary assistant, exemplifies borderline personality disorder.

Three months before Nancy’s admission to a hospital, she learned that her mother had become pregnant. She began drinking heavily, ostensibly in order to sleep nights. While drinking, she became involved in a series of “one-night stands.” Two weeks before admission, she began feeling panicky and having experiences in which she felt as if she were removed from her body and in a trance. During one of these episodes, she was stopped by the police while wandering on a bridge late at night. The next day, in response to hearing a voice repeatedly telling her to jump off a bridge, Nancy ran to her supervisor and asked for help. Her supervisor, seeing her distress and also noting scars from a recent wrist slashing, referred her to a psychiatrist, who then arranged for her immediate hospitalization.

In the hospital, Nancy appeared as a disheveled and frail, but appealing, waif. She was cooperative, coherent, and frightened. Although she did not feel that hospitalization was needed, she welcomed the prospect of relief from her anxiety and depersonalization. Nancy acknowledged that she had had feelings of loneliness and inadequacy and brief periods of depressed mood and anxiety since adolescence. Recently she had been having fantasies that she was stabbing herself or a little baby with a knife. She complained that she was “just an empty shell that is transparent to everyone.”

Nancy’s parents divorced when she was 3, and for the next 5 years she lived with her maternal grandmother and her mother, who had a severe drinking problem. She had night terrors during which she would frequently end up sleeping with her mother. At age 6, she went to a special boarding school for a year and a half. When Nancy was 8, her maternal grandmother died; and she recalls trying to conceal her grief about this from her mother. She spent most of the next 2 years living with various relatives, including a period with her father, whom she had not seen since the divorce. When she was 9, her mother was hospitalized with schizophrenia. From age 10 through college, Nancy lived with an aunt and uncle, but had ongoing and frequent contacts with her mother. Her school record was consistently good.

Since adolescence, Nancy had dated regularly, having an active, but rarely pleasurable, sex life. Her relationships with men usually ended abruptly after she became angry with them when they disappointed her in some apparently minor way. She then concluded that they were “no good to begin with.” She had several roommates but had trouble establishing a stable living situation because of her jealousy about sharing her roommates with others and because of her manipulative efforts to keep them from seeing other people.

Since college she worked steadily and, at the time of admission, was working a night shift in a veterinary hospital and living alone. (Based on Spitzer et al., 1994)

As this case illustrates, borderline personality disorder may involve a combination of symptoms that are more severe versions of those seen in several other personality disorders, including the schizotypal, histrionic, narcissistic, and antisocial. Borderlines’ interpersonal relationships are especially turbulent.